

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>51111</p> <p>Based on interview and record review, the facility failed to ensure nursing staff transcribed and initiated physician orders of prescribed medications, and failed to ensure the completion of the full course of medication treatment for a resident who returned from a hospital for 1 (#5) of 5 sampled residents. Findings include:</p> <p>During an interview on 11/19/24 at 2:21 p.m., resident #5 stated she had been to the hospital recently for bronchitis. Resident #5 stated medications she had taken after her return from the hospital helped with her coughing and breathing, and she did not have those issues currently. Resident #5 stated the prescribed medications were not started when she returned from the hospital, they were a day or so late.</p> <p>During an interview on 11/19/24 at 3:35 p.m., NF3 stated there was a delay in the antibiotic and steroid medication ordered by the hospital provider for resident #5 to start on her discharge from the hospital. NF3 stated the physician discharge orders were entered a few days after resident #5 was discharged . NF3 stated when she asked the nursing staff about the discharge orders not being started, they stated the orders were not entered until later in the week when the resident had returned from the hospital. NF3 stated she was concerned physician orders for resident #5's acute condition were not started when the resident returned to the facility from the hospital. NF3 stated it was facility nursing staff's responsibility to receive paperwork from the ED and start those physician orders accordingly. NF3 stated, There is a disconnect for the facility and pharmacy with new orders and it has not gotten any better.</p> <p>During an interview on 11/20/24 at 11:42 a.m., staff member A stated when a resident returned from a hospital with physician orders, those new orders needed to be started by nursing staff. Staff member A stated it was the receiving staff nurse's responsibility to assess the resident upon return from a hospital, and review discharge paperwork for instructions and orders. Staff member A stated the previous process was the assistant director of nursing was responsible for the review of discharge paperwork and orders for residents who returned from a hospital. Staff member A stated the assistant director of nursing would clarify with pharmacy about medication orders if needed. Staff member A stated the facility received medications from the pharmacy daily except for Sundays.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/24 at 2:11 p.m., staff member B stated she did not always let facility staff know when there was an issue with orders or medication. Staff member B stated since nurse staffing had been inconsistent, and due to nurse management turnover, she did not always know of who to notify for order transcription issues. Staff member B stated she usually went into the medical record to make needed changes to orders. Staff member B stated late order entry by nurses, or not entering an order at all for residents, seemed like a facility system issue. Staff member B stated it did not seem there was a process in place for nursing staff to check on new medication orders or whether orders were received or not by staff.</p> <p>Review of resident #5's electronic medical record showed the resident was admitted and discharged from the emergency department on 10/28/24, and did not start or receive hospital physician ordered medications until 11/2/24. This was a five day delay of resident #5's prescribed medications being started.</p> <p>Review of a facility document titled, eINTERACT Transfer Form, dated 10/28/24, showed:</p> <p>1. Transfer/Discharge Details . Sent to: [Hospital Name] Date: 10/28/24 . Reason(s) for Other: Per MD request for Chest XRay and dsicomfort . [sic]</p> <p>Review of resident #5's hospital discharge paperwork, dated 10/28/24 and electronically signed by a hospital physician at 11:00 a.m., showed:</p> <p>.ED Provider Notes .presents to the ED via EMS with cough and shortness of breath. She states the symptoms started a week ago and have been worsening. She felt like she had a fever the last couple of days but did not documented temperature . Will treat as bronchitis with bronchospasm . Plan: Prescription Provided . Medication Changes: dexamethasone 6mg Oral DAILY WITH BREAKFAST, doxycycline 100mg Oral 2 TIMES A DAY . Care Timeline: 1052 Arrived . 1530 discharged . [sic]</p> <p>Review of resident #5's nursing progress note, dated 10/29/24 at 10:37 a.m., showed:</p> <p>Resident was seen yesterday at [Hospital Name], for Bronchitis. Resident continues to recover. VS are WNL. Staff continues to monitor, and care is ongoing. [sic]</p> <p>Review of resident #5's medication administration record, dated November 2024, showed:</p> <p>DexAMETHasone Oral Tablet 4 MG (Dexamethasone) Give 6 mg by mouth one time a day for bronchitis for 5 Days, and showed the medication was administered on 11/2/24 - 11/6/24. The order for Doxycycline 100mg showed, Doxycycline Monohydrate Oral Tablet . Give 100 mg by mouth two times a day for bronchitis for 7 Days, -Start Date- 11/01/2024 1700 and showed the medication was administered on 11/2/24 - 11/8/24 with one missed dose.</p> <p>Review of a facility document for stock medications showed the antibiotic Doxycycline 100mg was available to administer to residents.</p> <p>Review of a facility policy titled, Pharmacy Services, revised April 2019, showed:</p> <p>. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency, or as needed) in a timely manner.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration.</p>