

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Continental Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Continental Dr Butte, MT 59701	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of practice by administering an opioid medication in conjunction with a benzodiazepine. This deficient practice had the potential to cause an increase in respiratory depression, over sedation, increased confusion, coma, or death for 1 (#1) of 16 sampled residents. Findings include:</p> <p>During an interview on 8/12/24 at 1:58 p.m. NF1 stated, The nursing staff were giving [Resident #1] oxycodone and Ativan at the same time. I had asked the nurses repeatedly not to give them together because it would cause him (the resident) to be too sedated. I also worried about the possibility for other side effects, like slowed breathing. That really worried me because he (the resident) has COPD. There was one nurse that just would not listen to us.</p> <p>During an interview on 8/13/24 at 2:03 p.m., staff member B stated, The expectation for medication administration is following the five rights of medication administration. The nurses are expected to administer medications using the safest route. Staff member B stated if a warning comes up while administering a certain medication, the nursing staff is expected to follow the warning or recommendation.</p> <p>During an interview on 8/14/24 at 7:50 a.m., staff member M was administering morning medications. Staff member M stated it was not acceptable to give an opioid medication at the same time as a benzodiazepine because of the increased risk of side effects. Staff member M stated, In the MAR, if you give medications that have potential side effects or adverse reactions, a warning will pop up and you have to acknowledge and accept it before it (EHR) will allow you to move on. Staff member M stated you can not give an opioid with a benzodiazepine because of the side effects and was not an acceptable nursing practice.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/14/24 at 1:25 p.m., NF5 stated when resident #1 was admitted to the facility a review of his medications was completed. NF5 stated there were no concerns with the prescribed medications. NF5 stated if there was a potential for a side effect or adverse reaction the MAR would issue a warning to the nursing staff, and nursing staff would have to address the warning. NF5 stated, We do not educate the nursing staff on the potential side effects or adverse reactions of medications, that is something that any nurse would know. NF5 stated, Due to the possibility of side effects from administering an opioid and a benzodiazepine at the same time it is not an acceptable practice. The side effects of administering those two medications can cause oversedation, respiratory depression, increased confusion and many other side effects like coma or death. The two medications should be given four to six hours apart, even on an as needed basis. The only time it is acceptable to give those two medications together is for a patient at end of life or for a patient with seizure disorder.</p> <p>Review of resident #1's admission diagnoses, dated 6/14/24 showed no diagnosis of seizure disorder, or a diagnosis that would require end of life care.</p> <p>Review of resident #1's physicians orders, dated, 6/14/24, showed:</p> <ul style="list-style-type: none"> - Oxycodone 10 mg, give 1 tablet by mouth every 6 hours as needed for pain for 30 days. - Lorazepam 0.5 mg, give 1 tablet by mouth every 12 hours as need for anxiety for 14 days. <p>Review of resident #1's MAR showed resident #1 received oxycodone 10 mg and lorazepam 0.5 mg concurrently on the following days by staff member Q.</p> <ul style="list-style-type: none"> - 6/14/24 at 7:48 a.m., - 6/15/25 at 9:13 a.m., - 6/16/24 at 9:06 a.m., - 6/19/24 at 8:27 a.m., - 6/20/24 at 10:11 a.m., and - 6/24/24 at 1:15 p.m. <p>Staff member Q was not available for interview during the survey.</p> <p>Review of a facility document titled, Clinical Systems and Implementation Guide, with a completion date of 6/11/24, showed staff member Q had completed the nursing competencies in medication management and opioid prevention and management.</p> <p>Review of a facility document titled, Medication Administration, undated, showed:</p> <p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .</p>		