STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275103	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on interviews, and record review, the facility failed to provide the scheduled showers for 3 (#s 1, 3, and 8) of 6 sampled residents for hygiene care. Findings include: During an interview on 10/22/24 at 11:51 a.m., NF1 stated resident #1 visited [Facility Name] and was . so filthy our staff didn't want to touch her. NF1 stated resident #1 visited [Facility Name] on 10/11/24, had significant body odor, and her ponytail was matted at the base of her hair. NF1 stated the staff was concerned resident #1 might have hair loss because the ponytail had been in so long. During an interview on 10/22/24 at 11:25 a.m., resident #3 stated his last shower was last Saturday. Resident #3 stated, I don't seem to be asked a lot (if he wanted a shower). He stated he rarely refused showers except when the staff would offer him a shower at 9:30 p.m. or 10:00 p.m. Resident #3 stated this was too late in the day, and he wanted to go to bed at this time. Resident #3 stated he did not get asked about a shower the morning of 10/22/24 (at 3:00 a.m.). Review of resident #3's EHR showed resident #3 refused a shower on 10/22/24 at 3:00 a.m. During an interview on 10/22/24 at 12:04 p.m., resident #8 stated, I could use a shower. I get a shower when they get to me. Resident #8 stated she had never refused a shower at the facility. Review of resident #8's EHR showed an admitted [DATE]. Review of resident #8's EHR showed: Bathing/Shower days are Wednesday and Sunday and as necessary. There was no documentation for the shower scheduled on 10/13/24 (Sunday). Resident #8's bathing task showed a refusal on 10/17/24 (Thursday) and Not Applicable on 10/20/24 (Sunday). Therefore, the record showed no showers were given to resident #8 since admission. During an interview on 10/22/24 at 12:07 p.m., resident #1 stated her last shower was last week. Resident #1 stated she never refused showers. Review of resident #1's EHR showed: Bathing/Shower days are Sunday and Thursday and as necessary. The EHR showed resident #1 received four showers in the past 30 days (9/26/24, 9/29/24, 10/3/24, and 10/13/24). On 10/6/24, resident #1 showed a documentation of a shower refusal.

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation, interview, and record review, the facility failed to schedule a sufficient number of CNAs as identified in the facility assessment recommendations, resulting in 2 (#s 18 and 19) of 20 sampled residents waiting over 20 minutes for the call light to be answered timely; 6 (#s 8, 9, 16, 18, 19, and 20) of 20 sampled residents expressing concern and complaints regarding long call light times and short staffing; and for 2 (#s 1 and 8) of 20 sampled residents not receiving enough showers; and 5 nursing staff expressed concerns with staffing ratios and not recieving breaks. Findings include: During an interview on 10/21/24 at 12:22 p.m., resident #9 stated he had waited up to 40 minutes for his call light to be answered. During an interview on 10/21/24 at 4:37 p.m., staff member B stated the facility did call light audits, kind of indirectly, but never kept a record of this. Staff member B stated they would test the call light times once a month by pushing the button in a resident's room and testing the staff's reponse time. Staff member B stated they would test this more often if there was an issue. During an interview on 10/21/24 at 1:55 p.m., staff member E stated sufficient staff was important for meeting toileting and feeding needs for each individual resident, and sufficient staff was needed to provide the necessary safety for each resident. During an interview on 10/21/24 at 2:38 p.m., staff member F stated they often got done with their shift at 6:40 p.m. Staff member F stated her shift ran from 6:00 a.m. to 6:00 p.m. Staff member F stated the showers were getting done on their shift, but they never recieved any breaks throughout the shift due to high acuity residents, low staffing, frequent call lights, and scheduled showers. During an observation on 10/21/24 at 5:11 p.m., three call lights were on (for resident #16, resident #18, and resident #19). During an interview on 10/21/24 at 5:15 p.m., resident #16 stated she consistently waited 15 minutes for staff to answer her call light. During an observation and interview on 10/21/24 at 5:27 p.m., the three prior call lights were still on (for resident #16, resident #18, and resident #19), in addition to one more call light. When speaking with resident #19, who had previously been yelling out of his room for attention and help, he stated he really needed to use the restroom. Resident #19 was squirming in his bed and sat up very quickly when the surveyor walked in, hoping someone would take him to the restroom. Resident #19 stated he often waited 15 minutes or more for his call light to be answered which he felt was frustrating and as if he was disregarded by staff because his needs were not being met. During an interview on 10/21/24 at 5:29 p.m., resident #20 stated he commonly waited 15 minutes for his call light to be answered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/21/24 at 5:34 p.m., resident #18 was sitting on the edge of her bed and stated she needed to urgently use the restroom. Resident #18 stated, They need more help, definitely. Resident #18 stated, One night I almost peed, I waited so long. During an observation and interview on 10/21/24 at 5:35 p.m., staff member H stated there was one nurse on the B wing and one nurse on the A wing. One CNA was assigned to deliver trays between the two halls and one CNA answered call lights. There were currently four call lights on. Staff member H stated it was common that they did not get any breaks or lunch throughout the day because they felt if they took a break they would get even farther behind and then leave even later at the end of their shift. Staff member H stated they would often leave 30 minutes to an hour late every day. Staff member H stated they tried to answer a call light in five minutes or less, but due to insufficent staffing, the high number of residents requiring lifts, and the tasks required each shift, they often found it difficult to uphold this standard. Staff member H stated they felt the the resident's needs were not always being met to the best of staff member H's abilities, and the residents were waiting a long time for help. During an observation on 10/21/24 at 5:38 p.m., resident #18's call light was still on, for a total time observed of 27 minutes. During an interview on 10/21/24 at 5:39 p.m., resident #19's call light was turned off a few minutes prior to this time, and resident #19 stated, Yeah, they took me now. Resident #19 was now laying calmly in his bed. Resident #19's call light was answered in approximately 25 minutes. During an interview on 10/21/24 at 5:44 p.m., staff member I stated they usually had to help the other staff member as one hall was worse than the other, and there were not enough CNAs for the acuity of residents, and the number of residents requiring mechanical lift transfers. Staff member I stated they were aware of call lights being on for more than 40 minutes at times. During an interview on 10/21/24 at 5:50 p.m., staff member J stated she felt we (staff) are often running around, due to low staffing numbers and consistent call lights going off. During an interview on 10/22/24 at 7:48 a.m., staff member K stated, C wing definitely needs more help, due to high call light times and the resident to staff ratios. During an interview on 10/22/24 at 11:22 a.m., staff member K stated she was pulled from her wing to help the A and B wings catch up on call lights. Staff member K stated this happened often. During an interview on 10/22/24 at 12:04 p.m., resident #8 stated, There are not enough of them (CNAs). They need more CNAs . I get a shower when they get to me. Review of resident #8's EHR showed an admitted [DATE]. Review of resident #8's EHR showed: Bathing/Shower days are Wednesday and Sunday and as necessary. There was no documentation for the shower scheduled on 10/13/24. Resident #8's bathing task showed a refusal on 10/17/24 (Thursday) and Not Applicable on 10/20/24. Showers were not always provided as scheduled. During an interview on 10/22/24 at 12:07 p.m., resident #1 stated her last shower was sometime last week. Resident #1 stated she never refused showers, and she felt she did not receive enough of them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 3:09 p.m., staff member F stated they were going to put their feet up for ten minutes as they would not be able to get their full 30-minute break to eat. Staff member F stated this happened often. When asked why staff member F was not going to be able to get their full 30 minute break, they stated there were too many tasks to be completed still for the day and the staff member that called off earlier in the morning only added more tasks for staff member F to complete. Review of the document, Facility Assessment, dated 4/26/24, showed: - .1.2. Average facility daily census: (range) 65-75 . - .Staffing plan - [Facility Name] is very conscientious to the needs of the resident including the facility staff, the nursing staff and resident ratio is monitored daily to achieve the highest practicable well-being of the resident . - CNAs 6 a.m.-6:00 p.m. 1:14 CNA per resident ratio - CNAs 6 p.m.-6:00 a.m. 1:14 CNA per resident ratio . Review of the Resident List, the facility census was 86 total residents upon entrance, and 18 residents resided in the dementia unit, 31 residents were in the C wing, 22 residents in the A wing, and 15 residents in the B wing. Review of the Daily Staffing Schedule showed: - the dementia unit was assigned two CNAs, - the C wing was assigned two CNAs, - the A and B wings were assigned two CNAs together. - On 10/21/24, there was one call off. The C wing (31 residents) had a CNA to resident ratio of 1:15. - The A and B wings combined had a CNA to resident ratio of 1:37 with the call off considered. Without the call off considered, the A wing had a ratio of 1:22, and the B wing had a ratio of 1:15. - With 86 residents, these staffing ratios did not follow the CNA staffing recommendations identified in the Facility Assessment (1:14 CNA per resident ratio).

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on interviews and record reviews, the facility failed to identify the root cause, address, and obtain necessary services for the behavioral health care needs for 1 (#2) of 20 sampled residents which could result in harm to staff or other residents, and it did affect 1 (#15), due to resident #1's aggressive behaviors. Findings include: Review of a Facility Reported Incident, with an initial report date of 10/5/24, showed both resident #2 and resident #15 resided in the dementia care unit. Resident #2 punched resident #15 in the jaw which resulted in resident #15 hitting resident #2 back. During an interview on 10/21/24 at 12:02 p.m., staff member C stated resident #2 had moments of being verbally aggressive and would yell at staff or residents. Staff member C stated they worked the night prior to resident #2 hitting resident #15. Staff member C explained a situation where resident #2 had been confused and was wearing resident #15's belt. Staff member C stated resident #2 would often go through resident #15's clothing or try to wear his clothing. When staff member C asked resident #2 to take the belt off, resident #2 lunged at staff member C. Staff member C was able to get out of the way, but staff member C stated, He gets these bursts of energy, and he's strong. Staff member C stated resident #2 and resident #15 had been arguing, and resident #2 jumped off the bed very quickly, to go over to resident #15. Staff member C stated she intervened in this situation and was able to prevent anything from happening. Staff member C stated, I did notify [upper management]. During an interview on 10/21/24 at 1:55 p.m., staff member E stated resident #2 had aggression, and there was an instance in the past, where they were told resident #2 had his hands around a staff member's neck. Staff member E stated this incident was reported to upper management. During an interview with staff member A and B on 10/21/24 at 4:37 p.m., staff member B stated after an incident the nurses will do a pain and/or fall assessment if applicable. Staff member B stated IDT would talk about the situation and would complete a root cause analysis of the situation. The surveyor asked for more in-depth information regarding the root cause analysis and reports of resident #2's behavior assessments, other applicable assessments (ie: falls, pain), number of incidences, interventions after the incidences, and a re-evaluation of resident #2's activities. Staff member A stated there were no other reports of resident #2 being aggressive than the incident on 10/5/24. When asked about the situation with resident #2's hands around a staff member's neck, staff member B stated there was only the initial nursing note about the incident where resident #2 had placed his hands near another staff member's neck. Staff member B stated it was their understanding that resident #2 had placed his hands on the staff member's upper chest, near their neck, and this was why they felt no report or investigation was needed. When asked if it was acceptable or appropriate for a reasonable person or any resident to touch a staff member anywhere near their neck, staff member B stated, No. When asked if either staff member would feel uncomfortable if a resident would touch them anywhere near their neck, staff member B stated, Yes. Staff member B stated they felt resident #2's aggression seemed to stem from a person in his past. When asked if staff member B or A had asked resident #2 who [Name] was or why [Name] made him upset, staff member B stated they did not get a chance to ask resident #2. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 7:48 a.m., staff member K stated [Name] seemed like a friend to resident #2. Review of a nurse's note, dated 10/15/24, showed, About 1720 today this resident got upset with staff . he (#2) started to swing his walker at the staff member . Then at about 1900 resident put his hands around a staff members throat. Staff member thought that he was just playing around because he didn't put any pressure on him when he did it . 911 was called for assistance. 911 sent a cop over first to assess the situation. He then called the ambulance to come pick him (#2) up . During an interview with staff member A and B on 10/22/24 at 8:10 a.m., staff member B stated resident #2 did have behaviors but did not show signs of aggression prior to hitting resident #15 on 10/5/24. Staff member A stated, We talked about it, the facility had tried telehealth options for resident #2. Staff member A stated behavioral health options were difficult to find in the state. Staff member A stated staff member M was supposed to be working on behavioral health appointments. Review of resident #2's EHR showed a prior physician's note, dated 8/4/24, which showed for #2, His mood seems to be very agitated, and he gets very frustrated easily. Review of resident #2's EHR showed a prior nurse's note, dated 9/30/24, which showed, Resident is noncompliant with staying in his room and is refusing to wear his mask (isolation) when not in his room. He was in his neighbors room when his neighbor started to yell at him telling him to get out of his room. [Resident #2] refused to leave this room. Staff tried to redirect him out of that room, but he was refusing to leave. When staff was able to get him out of the neighbors room he tried to hit staff with his walker. Staff then asked him to put on his mask if he was going to be out with the rest of the residents and he refused. He then started to walk into a female's room and when staff stepped in front of him, he started swearing at staff and throwing his walker around at the staff member in his way. Another staff member came and was able to redirect him back to his room. Resident has been going into his neighbors' room and telling everyone that it's his room and his stuff. In the past he was usually easy to redirect. He has been getting aggressive at random times usually between 5pm and 9 pm. [sic] Review of resident #2's EHR nurse's notes showed dates where aggressive behavior continued: 10/8/24, 10/15/24, 10/20/24. Review of a physician's note showed, .S [NAME] he is so agressive with violent outbursts I did not feel safe to continue the appointment once he became more aggressive toward me. [sic] Review of resident #2's EHR showed no pain assessments, fall assessments, behavioral health assessments, re-evaluations or updates to the individualized care plan regarding activities (last revised 6/25/24) after the incident on 10/5/24. Resident #2's Care Plan showed generic activities and did not show person-oriented activities specific to resident #2. During an interview with staff member A, B, and M, on 10/22/24 at 10:37 a.m., staff member A stated, Yes, we could button up on that more, related to using root cause analyses after incidents. Staff member M stated resident #2 had seen psychiatry in the past, but was not currently seeing anyone. Staff member M stated a referral was not completed, but the facility had received signatures from resident #2's POA (on 10/7/24) concerning permission to schedule the appointment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Authorization for the Use and Disclosure of Health Information for [Provider Name], Licensed Clinical Social Worker, dated 10/7/24, showed a blank line and no signatures where the authorized representative and/or client would sign. During an interview on 10/22/24 at 12:13 p.m., staff member M stated they followed up with all nursing staff daily about the resident's behaviors; however, staff member M stated they did not document anything regarding these follow ups or the noted behaviors. Staff member M stated, . I have not been as good as I should be.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observations, interviews, and record review, the facility failed to provide therapeutic meals that followed physician orders for 2 (#13 and 14) of 2 sampled dialysis residents. Findings include: During an interview on 10/22/24 at 11:51 a.m., NF1 stated the facility did not properly provide appropriate meals for dialysis patients. NF1 stated, They just can't properly care for . dialysis patients. NF1 stated residents often told them their meals were commonly high in salt, and the meal would consist of something like a ham sandwich and chips. NF1 stated this extra salt would lead the residents to drink more water which had a negative impact on their kidneys, and required more dialysis. During an observation and interview on 10/22/24 at 1:39 p.m., the surveyor had walked into resident #13's room and he stated, That soup was really really salty. When asked, resident #13 stated he can control his dialysis better with water, but his water limit was one liter per day. Resident #13 stated he commonly had diarrhea. Resident #13 had a roast beef sandwich (no cheese), plain green beans and kidney beans mixed together, a bowl of soup, a cup of mandarin oranges, two glasses of juice, and a glass of a protein drink. The sandwich and green bean/kidney bean mix was untouched by the resident as he stated he did not like them. Review of resident #13's EHR showed the physician order: Renal diet . Deli meats (such as roast beef, turkey, or ham), most cheeses, and chips, are high in sodium. Concerning dialysis patients, the CDC (Centers for Disease, Control and Prevention) showed, Foods to limit: Eat less salt/sodium. Over time, your kidneys lose the ability to control your sodium-water balance. Less sodium in your diet will help lower blood pressure (CDC, 2024). The FDA (Food and Drug Administration) showed: .about 40% of the sodium consumed by Americans comes from the following foods: Deli meat sandwiches .soups . (FDA, 2024). According to Dr. [NAME], a researcher for the Mayo Clinic School of Medicine in the Nephrology and Hypertension Division showed diarrhea was a common side effect of electrolyte imbalances particularly sodium ([NAME], 2019). High sodium levels (or hypernatremia) could cause the symptom of loose and watery bowel movements due to hypotonic fluid loss (also referred to as osmotic diarrhea) ([NAME], 2019). [NAME] showed, Sustained hypernatremia can cause irreversible cell/organ damage and high mortality ([NAME], 2019). During an interview on 10/22/24 at 1:41 p.m., staff member H stated the food was often served late and each tray had very similar food which did not follow the physician therapeutic orders. Staff member H stated therapeutic orders were not followed for many types of diet orders, not just the dialysis residents. Review of the posted meal Serve Times showed lunch was scheduled to be served for resident #13 at 11:30 a.m. to 12:00 p.m. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 10/22/24 at 1:50 p.m., resident #14 stated she received dialysis regularly (Monday, Wednesday, and Fridays). Resident #14 stated the food was kind of salty. Resident #14's tray consisted of a turkey sandwich (with cheese), a bowl of soup, a cup of mandarin oranges, two glasses of juice, and two packets of saltine crackers. Review of resident #14's EHR showed the physician order: Renal diet . During an observation on 10/21/24 at 1:57 p.m. resident #19's plate consisted of turkey sandwich (with cheese), a cup of mandarin oranges, green bean/kidney bean mix, a glass of juice, and a bowl of tomato soup. Review of resident #19's EHR showed the physician order: Regular diet . References: Centers for Disease Control and Prevention. (2024, May 15). Diabetes and Kidney Disease: What to Eat? Centers for Disease Control and Prevention. https://www.cdc.gov/diabetes/healthy-eating/diabetes-and-kidney-disease-food.html Food and Drug Administration. (2024, March 5). Sodium in Your Diet. Food and Drug Administration. https://www.fda.gov/food/nutrition-education-resources-materials/sodium-your-diet [NAME], Qi. Hypernatremia. Clinical Journal of the American Society of Nephrology 14(3):p 432-434, March 2019. | DOI: 10.2215/CJN.12141018