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	05/19/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on observations, interviews, and record reviews, the facility failed to ensure residents were assessed and found safe to self-administer their own medications, prior to doing so; and the facility failed to document the assessments or a physician order in the EHRs, for 4 (#s 23, 45, 49, and 53) of 25 sampled residents. This deficient practice increased the risk of a negative outcome for the residents, in the event the medication and self/staff monitoring were not handled properly. Findings include: 1. During an observation and interview on 5/18/25 at 7:50 a.m., staff member G entered resident #45's room and placed a cup of pills on his bedside table. Staff member G then left the room without the resident taking the medications. The cup of pills contained loratadine (antihistamine), nifedipine Extended-Release (calcium channel blocker), and a Velphoro chew (treats hypocalcemia). Resident #45 stated he did not like to take his pills without food, and meals were often late, so the nurses routinely left the medications with him to take on his own. Review of resident #45's Nursing care plan, revised on 4/11/25, reflected a focus area of: - [Resident #45] has impaired cognitive function r/t Disease Process (ESRD), Impaired decision making, with an intervention reflecting: - Administer medications as ordered. Monitor/document for side effects and effectiveness. The Nursing Care Plan did not contain a reference to resident #45's ability to self-administer medications, to include if it was safe for the resident to administer the medications or how this would be monitored. Review of resident #45's EHR did not reflect an assessment for safety of self-administration of medications, or a physician's order for the resident to self-administer medications. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview on 5/18/25 at 9:42 a.m., staff member G entered the room of resident #53, and then placed a cup of pills on her meal tray, which was on her bedside table. Staff member G asked resident #53 if she needed anything, and then left the room, without the resident taking the medication. The cup of pills contained aspirin, levothyroxine (thyroid hormone), vitamin D3, amiodarone HCl (antiarrhythmic), and Eliquis (anticoagulant). Resident #53 set the pills aside and began to eat her breakfast. Resident #53 stated the nurses routinely leave the medications with her to take on her own. Resident #53 stated she was not sure what the pills were in the cup or what conditions the pills were treating. Review of resident #53's Nursing Care Plan, revised on 4/15/25 reflected a focus area of: - [Resident #53] has a dx of MDD and delusional disorders. She is at risk for alterations in mood status, with an intervention of: - Administer medications as ordered. Monitor/document for side effects and effectiveness . The Nursing Care Plan did not contain a reference to resident #53's ability to self-administer medications. Review of resident #53's EHR did not reflect an assessment for safety of self-administration of medication or a physician order for the resident to self administer the medications. 3. During an observation and interview on 5/15/25 at 9:45 a.m., resident #49 was sitting in bed. A bedside table was over his lap, and a cup of pills had been placed on the bedside table. Resident #49 stated the nurses left the medications with him, and he decided whether he would take them after eating. Resident #49 stated, when discussing him taking the medications, Sometimes I do, and sometimes I don't, you just never know. Resident #49 stated he knew the medications upset his stomach if they were not taken with food, and he often received meals much later than scheduled. He was not sure why all the medications were being taken, the side effects, or what monitoring he should be doing after taking, or not taking, the medications. The pill cup contained Famotidine (treats and prevents ulcers), lisinopril (lowers blood pressure), multivitamin, potassium, zinc, and furosemide (a diuretic). 4. During an interview on 5/18/25 at 9:38 a.m., resident #23 stated They leave my pills on my tray, and I take them. During an interview on 5/18/25 at 9:55 a.m., staff member G stated meal services were often late, and most residents could take their own medications without her standing there. Staff member G stated some residents were very slow to take their medications, and she would not be able to complete the medication pass if she had to wait on each resident to take their medications. Staff member G stated most residents were receiving their medications late, due to the [NAME] meal services. Staff member G stated the self-administration of medications did not require a physician's order, a resident assessment, or additional documentation as far as she was aware. During an interview on 5/18/25 at 10:07 a.m., staff member F stated the procedure for self-administration of medication required a physician's order, an assessment for safety, and a risk/benefit conversation with the resident. (continued on next page)

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	275103	A. Building B. Wing	05/19/2025

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/18/25 at 1:02 p.m., staff member C stated all resident assessments for the self-administration of medications would be under the evaluations tab, in a resident's EHR. Staff member C stated if a self-administration assessment was not showing up in the evaluations tab, then it was not done. Review of the facility's policy, Resident Self Administration of Medication, dated 2025, reflected: - .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. - . The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Form, which is placed in the resident's medical record. - . The care plan must reflect resident self-administration and storage arrangements for such medications and CGM devices.

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	275103	A. Building B. Wing	05/19/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 44769 Based on interview and record review, the facility failed to failed to correctly reflect the code status of a resident in the EHR for 1 (#68) of 25 sampled residents, and this failure increased the risk of the resident being resuscitated in a health crisis, when that was not the resident's preference or what was documented on the resident's POLST form. Findings include: During an interview on 5/19/25 at 7:59 a.m., staff member E stated social services assures the POLST is reviewed and accurately completed for the resident upon admission. Staff member E further stated the code status on the POLST form should be the same as the code status in the EHR. A review of resident #68's POLST form showed Section A, under the heading Treatment options the box for Do Not Attempt Resuscitation was checked. A review of resident #68's EHR showed his code status as Full Code/Full Treatment A review of a facility policy titled Residents' Rights Regarding Treatment and Advance Directives, with a copyright date of 2025, showed: Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives . 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care .

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on interviews and record reviews, the facility failed to ensure gradual dose reductions were attempted, unless the prescriber documented a rationale for the contraindication of the change, for 3 (#s 10, 19, and 54) of 25 sampled residents. Findings include: A review of the State Operations Manual, Appendix PP, under F605, showed: Adequate Indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. 1. Review of resident #10's EHR diagnosis list reflected a diagnosis of dementia. Review of resident #10's Note To Attending Physician/Prescriber, dated 2/19/25, reflected a recommendation from the pharmacist for a gradual dose reduction on resident #10's Seroquel, 50 mg, which was given for depression. The response from the prescriber reflected a declination to complete a gradual dose reduction, but she documented the following rationale: - . At this time patient is stable from a mood standpoint. Continued dosing is appropriate. [sic] No other Gradual Dose Reducations were located in the medical chart for resident #10. 2. Review of resident #19's Note To Attending Physician/Prescriber, dated [DATE]-March 30 [sic], reflected a recommendation from the pharmacist for a gradual dose reduction on resident #19's Sertraline, 100 mg. The document showed the prescriber documented the following, which failed to show the rationale for the continued use of the medication, at the continued dose: - . Things look good . [sic] 3. Review of resident #54's Note To Attending Physician/Prescriber, dated May 23- June 21 [sic], reflected a recommendation from the pharmacist to complete a psychotropic medication review on resident #54's Duloxetine - 30 mg, Trazodone- 50 mg, and Provigil - 100 mg, and all three were all recommendations for gradual dose reductions. The response from the prescriber reflected declinations of the pharmacist's recommendation, but the prescriber failed to document the patient-specific rationale for why the gradual dose reduction was not attempted, or a reasoning for this decision. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/25 at 11:15 a.m., staff member M stated she was unaware of the requirements for documentation related to supporting or declining the support a gradual dose reduction. Staff member M stated she was trying to catch up on gradual dose reduction recommendations from the pharmacy, specifically for March and April 2025, due to personal issues. Review of the facility's policy, Gradual Dose Reduction of Psychotropic Drugs, not dated, reflected: - Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. - . 5. For an individual who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia, the GDR may be considered clinically contraindicated for reasons that include, but are not limited to: - a. A resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and - b. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. - . 7. Rationale for clinical contraindications may be documented on the Clinically Contraindicated Dose Reduction Form. [sic] Further review of the State Operations Manual, Appendix PP, under F605, showed: Comprehensive Assessment and Behavioral (Nonpharmacological) Interventions The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of non-pharmacological approaches, in accordance with S483.45(e)(2), are determined by evaluating the resident ' s physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. The use of nonpharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. The resident ' s medical record should include documentation of this evaluation and the rationale for chosen treatment options. 52362

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 52362 Based on observation, interview and record review the facility failed to accurately assess the vision needs of a resident on the comprehensive assessment, for 1 (#23) of 25 sampled residents, and the resident was unable to read or see her food when eating. Findings include: During an observation and interview on 5/17/25 at 1:05 PM, resident #23 stated her vision started to deteriorate in October of 2024, due to cataracts. Resident #23 showed this surveyor she could not read the book her roommate had given her. Resident #23 stated, I can't see you, my food, anything now. During an interview on 5/18/25 at 4:23 p.m., staff member K stated there was no vision concerns or appointments needed that she could think of for resident #23. Staff member K stated she would bring up vision needs for residents during care conferences, and if there were any, it would get reported on the MDS, and staff member K stated questions were asked, like, do you need glasses? Staff member K also looked into making appointments if there was a need. Staff member K stated during the last care conference resident #23 was being treated for an ear infection; no vision needs were addressed. Review of resident #23's MDS, with an ARD of . showed for Section B1000 and B1200: - B1000 - sees fine detail, such as regular print in newspapers/books . - B1200 - corrective lenses used in completing B1000, and the response was marked as, No Review of a facility policy titled, Resident Assessment - RAI, copyright 2024, reflected: . This facility makes a comprehensive assessment of each resident's needs, strengths, goals . . The assessment will include at least the following: . e. Vision . . The assessment process will include direct observation and communication with the resident .

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	275103	A. Building B. Wing	05/19/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44769 Based on interview and record review, the facility failed to implement a comprehensive care plan to include bowel and bladder incontinence for 1 (#241) of 25 sampled residents. Findings include: Review of resident #241's Admission MDS, with an ARD of 5/12/25, showed the resident was always incontinent of bowel and bladder. Section V, Care Area Assessment Summary, showed the bladder incontinence care area had triggered and should be care planned. A review of resident #241's Baseline Care Plan, dated 4/30/25, showed the resident was frequently incontinent of bowel and bladder. A review of resident #241's comprehensive care plan failed to show the resident was incontinent of bowel and bladder. During an interview on 5/18/25 at 4:22 p.m., staff member B stated the nurse managers and MDS Coordinators developed the residents care plans, and she assumed that bowel and bladder incontinence should be on the care plan. Staff member B further stated that resident #241 was relatively new to the facility, and his care plan may not be completed yet. A review of a facility policy titled, Care Plan Revisions Upon Status Change, undated, showed: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan . b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52362 Based on observation, interview, and record review, the facility failed to assist with making appointments and arranging timely transportation for a resident with impaired vision needs, and this failure caused an eye surgery to be canceled, and appointments were not able to be scheduled due to missed appointments, for 1 (#58) of 25 sampled residents. The resident had difficulty doing things she loved, as well as fear of leaving her room, because she may run into someone due to her poor eyesight. Findings include: During an observation and interview on 5/17/25 at 1:05 p.m., resident #58 stated her biggest concern living at the facility was getting vision appointments, and then getting transportation to the appointments on time. Resident #58 stated the facility had made and canceled several appointments for her since November of 2024, without telling her, or the doctor's offices. Resident #58 stated some of the provider offices will not see her now as a patient because, I have been late or missed so many appointments, and once you're late they won't see you, and after so many times they won't let you come back. Resident #58 stated her vision started to deteriorate in October of 2024, and the one appointment she was able to get in January of 2025, she was told she needed cataract surgery. Resident #58 stated because she was late to the surgeon's appointment in February of 2025, she could not come back, and now they will not perform the surgery. Resident #58 stated when she called the scheduler at the surgeon's office herself, she was told, I know it's out of your hands, I'm sorry. Resident #58 showed this surveyor she could not read the book her roommate had given her. Resident #58 stated, I can't see you, my food, anything now. Resident #58 stated the facility had a new scheduler, but she had not heard anything for two weeks regarding when the next appointment was able to be made. During an interview on 5/18/25 at 4:17 p.m., staff member J stated she was the scheduler for all outside facility appointments. Staff member J stated there were no vision appointments scheduled for resident #58, and followed that comment with stating, None that I know of, I just took over three weeks ago. Staff member J looked at the list of all appointments that had been made for resident #58, and stated the last vision appointment for resident #58 was in January of 2025 at [local clinic name]. During an interview on 5/18/25 at 4:23 p.m., staff member K stated staff member E would know about appointments. During an interview on 5/19/25 at 8:18 a.m., resident #58 stated she met another resident in physical therapy recently, and They got their eye appointment and surgery so fast, it made me so mad, why won't they help me like that. During an interview on 5/19/25 at 9:57 a.m., staff member L stated she cares for resident #58 on a regular basis, and she was unaware of any vision concerns. During an interview on 5/19/25 at 10:06 a.m., staff member E stated she was not the right person to ask about helping residents with appointments. Review of the Care Plan Report for resident #58, with an admitted [DATE], showed no goals or interventions to assist or accommodate vision appointments. (continued on next page)

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	275103	A. Building B. Wing	05/19/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility progress note entries for resident #58 from 11/18/24 to 5/12/25 showed: - Entry on 1/28/25 at 11:00 p.m., (resident) stated, . She is on her way to an eye appt . - Entry on 2/4/25 at 3:30 p.m., (resident) stated, . Resident has been upset about a pre-op appointment for her eye surgery . an appointment has been made. Resident reports that she called there [local clinic], and they do not have an appt. [sic] - No other eye appointment entries were noted in the six month time frame in the resident's record. Review of a Social Service progress note entry for #58's Care Conference Summary, dated 3/13/25, showed, Getting eye surgery/cataract procedure done in [City Name], based on surgeon availability. No questions or concerns at this time. [sic]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48261 Based on observations, interviews, and record reviews, the facility failed to follow smoking assessment safety recommendations for residents who were smoking; failed to monitor the location were residents were smoking; failed to ensure the residents signed out of the facility when smoking (as needed); and failed to follow and adhere to the facility policy related to resident smoking. These failures occurred throughout the survey period, for multiple shifts and days, and multiple staff failed to adhere to the policy, for 3 (#s 40, 75, and 238) of 5 sampled residents who smoke. This deficient practice placed all residents entering the activities room at risk of exposure to second-hand smoke and risk for fire. This deficient practice placed residents at risk of injury while smoking, increased risk of fires, and accidents related to smoking. Findings include: 1. During an observation and interview on 5/18/25 at 2:15 p.m., resident #75 was sitting immediately outside the activity door smoking. Resident #75 stated staff member B stated he could smoke outside the door. Resident #75 stated he was blind and could not get out to the gate when there was bad weather. Resident #75 stated he felt the ground with his feet, and he could get out to the smoking area at the gate, and he would know when his foot kicked the cigarette butt can, he had reached the smoking area. Resident #75 stated he kept his lighter, vape pen, and cigarettes on him, or in his room, on his bedside table. Resident #75 stated he did not usually sign anything (such as a facility sign out sheet) to go outside and smoke, he just went when he wanted. Dozens of cigarette butts littered the ground around outside the activity room windows, door, tables, and the grassy area. Resident #75 stated he, resident #40, and #238, regularly smoked outside the activity door under the awning. Staff member A approached resident #75 and asked that he go to the gate to smoke and resident #75 reiterated his statement that staff member B told him he could smoke in this spot, and he refused to move. Staff member B arrived and told resident #75 he could not smoke near the door, and she would assist him to the gate to smoke. Staff member B pushed resident #75's wheelchair out to the smoking area while resident #75 yelled at her about his rights to smoke where he wants. During an interview on 5/18/25 at 3:00 p.m., staff member F stated residents #40, 75, and 238 smoke independently and they are not supervised. Staff member F stated smoking residents keep their own smoking paraphernalia and do not check in with nursing. Staff member F stated the floor staff knew who the smokers were and knew when they would be outside. Staff member F stated she was aware of the cigarette butts and smoking occurring outside the activity's door. Staff member F stated the residents refused to follow the rules and often became belligerent if approached to move out to the gate. During an interview on 5/18/25 at 3:14 p.m., staff member H stated the smoking residents were not supervised and she was aware they were smoking outside the activity's door. Staff member H stated, I leave those issues for the nurse to handle and stay out of it. During an observation on 5/18/25 at 3:15 p.m., resident #75 was smoking on the sidewalk halfway between the smoking area and the door, on the property. (continued on next page)

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	275103	A. Building B. Wing	05/19/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/18/25 at 3:16 p.m., staff member I stated she saw residents smoking outside the activity's door regularly, but was not aware it was not allowed because smoking had been happening there for as long as she could remember. Staff member I stated it seemed they would go out to the gate sometimes and other times, like when it was raining or there was too much snow, they would all huddle by the door. During an interview on 5/18/25 at 3:58 p.m., NF1 stated the facility was aware of the smoking problems when they accepted resident #75 to the facility. NF1 stated resident #75 nearly burnt down his apartment with ash everywhere and had caused so much smoke damage at another apartment that he was evicted. NF1 stated she did not know resident #75 was leaving the facility to smoke at all and did not believe he would be safe to smoke off property without supervision because he was blind and reckless with his smoking. Review of resident #75's, Clinical Admission Evaluation Smoking Safety Evaluation, dated 3/31/25, reflected resident #75 was not able to smoke safely and was a high fall risk. Review of resident #75's Nursing Care Plan, revision date 5/6/25 reflected: - [Resident #75] desires to use tobacco products but has been deemed unsafe to smoke d/t blindness, balance problems, medications, use of oxygen and refusal to remove prior to leaving facility property, unable to safely smoke independently and risk for falls/injury. - .[Resident #75] has gone against medical advice regarding smoking and is given 4 cigarettes when off campus per his preference/wishes. Review of resident #75's Brief Interview for Mental Status, dated 4/1/25, reflected resident #75 had a BIMS of 8.0 (Moderate impairment). 2. During an interview on 5/18/25 at 2:49 p.m., resident #238 stated he usually smoked outside the gate when the weather was good, but he and others would stay under the awning by the door sometimes to smoke. Resident #238 stated the staff had not talked to him about the rules until one day when the staff saw him going to smoke and he had oxygen on him. Resident #238 stated, The cna came and got me and told me the smoking rules then so now I try to remember to not bring my oxygen tank out with me anymore. Resident #238 stated he kept his smoking paraphernalia with him or in his room. Resident #238 stated he was not aware of a smoking apron he was to wear while smoking. Review of resident #238's, Clinical Admission Evaluation Smoking Safety Evaluation, dated 5/15/25, reflected resident #238 needed to wear a smoking apron to safely smoke. Review of resident #238's Nursing Care Plan did not reflect resident #238 was a smoker and required an apron to smoke. 3. During an observation and interview on 5/18/25 at 2:56 p.m., resident #40 stated he had never been assessed or asked by staff to watch him safely smoke. Resident #40 had a pack of cigarettes and a lighter sitting on his bedside table. Resident #40 stated he usually would go out to smoke by the activity door or the gate, if the weather was good, about four times a day. (continued on next page)

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	275103	A. Building B. Wing	05/19/2025

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/19/25 at 8:08 a.m., residents #75 and 238 were out smoking on the property. Resident #238 did not have an apron on and neither had signed out to smoke as they left the facility through the activity room door. During an interview on 5/19/25 at 8:11 a.m., staff member E stated resident #40 was a repeat offender with smoking on the property. Staff member E stated resident #40 was also social and would pull others into a group around the door to smoke socially. Staff member E stated resident #75 was a bully to staff and would not follow rules around smoking. Staff member E stated resident #75's POA had voiced concerns with history of damage to his apartments and burns from ash everywhere. Staff member E stated the only thing she could do would be repeat education and then hand the smoking noncompliance off to leadership to handle. During an interview on 5/19/25 at 8:31 a.m., staff member M stated she was concerned about resident #75's safety smoking while blind, had to feel his way down the hallway using the rail, and history of recent hyperkalemic/hypervolemic episodes requiring he be airlifted to the hospital and intubated. Staff member E stated resident #75 became belligerent if the staff took smoking away from him in the past so the facility was in a bit of a spot on how to handle resident #75. Review of the facility's policy, Tobacco-Free Facility and Campus Policy, no date, reflected: - . No accommodations for smoking and/or tobacco products will be made. Tobacco and other, smokeless, tobacco products are not permitted on the premises.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on observation, interview, and record review, the facility failed to provide meals at the regular scheduled times for 5 (#s 23, 24, 36, 49 and 76) of 25 sampled residents. This deficient practice had the potential to affect all residents of the facility. Findings include: 1. During an observation and interview, on 5/17/25 at 1:01 p.m., resident #49 was lying in bed with no lunch tray. Resident #49 stated food was always late, especially the breakfast and lunch meals. Resident #49 stated he had not received his lunch yet. He stated lunch would often be delivered between 1:30 p.m. and 2:30 p.m. Resident #49 stated he would order food from local restaurants to be delivered if he was really hungry or did not like the food when he finally got it. During an observation on 5/17/25 at 1:10 p.m., eight residents were seated at tables in the C dining room, with drinks in front of them, but no food. Room trays had not been delivered on the unit yet to the residents in their rooms. During an observation on 5/17/25 at 1:12 p.m., in the A/B dining room, some residents had their food, others were waiting. Room trays had not been delivered for the unit. During an observation on 5/17/25 at 1:16 p.m., the posted mealtimes, for residents and staff to see, showed: -Breakfast for A/B wing at 8:00 a.m., Solana at 8:15 a.m., and C wing at 8:45 a.m. -Lunch for A/B wing at 12:00 p.m., Solana at 12:15 p.m., and C wing at 12:45 p.m. -Dinner for A/B wing 5:00 p.m., Solana at 5:15 p.m., and C wing at 5:45 p.m. During an observation and interview on 5/17/25 at 2:32 p.m., staff member P was passing lunch trays and stated, [Staff member O] is cooking today so trays will come out late, food is cold when its late, and residents complain a lot. During an interview on 5/17/25 at 4:11 p.m., staff member N stated dietary staffing had fluctuated a lot for several months. Staff member N stated she had a new process she was about to implement in the next week, so that all the facility dining rooms would be served at the same time. During an observation on 5/18/25 at 8:25 a.m., the A/B dining room had 13 residents seated at tables with drinks. No residents had any food, and no room trays were delivered. During an observation and interview, on 5/18/25 at 8:37 a.m., resident #76 was lying in bed and had no breakfast delivered. Resident #76 stated he never knew when his meals would be delivered, it was not consistent. Resident #76 stated the food seemed late, but he would eat whenever the food tray was delivered. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/18/25 at 9:02 a.m., in the C dining room at least nine residents were seated at tables with drinks, but no food. The dining cart was being set up. No room trays had been delivered on the unit. During an observation and interview, on 5/18/25 at 9:07 a.m., resident #49 was lying in bed waiting for his breakfast tray. He stated he would probably get his tray at 10:00 a.m. Resident #49 stated he received his lunch around 2:00 p.m., and his dinner between 6:00 p.m. and 6:30 p.m. the day prior. During an interview on 5/18/25 at 9:55 a.m., staff member G stated most residents were receiving their medications late as it was, due to the [NAME] meal services. During an interview on 5/18/25 at 11:00 a.m., staff members N and O stated breakfast was late because a staff member was sent home for respiratory symptoms. Staff member N stated the mealtimes were what was on the newest form provided with breakfast starting at 8:00 a.m., lunch at 12:00 p.m., and dinner at 5:00 p.m. During an observation and interview on 5/18/25 at 2:39 p.m., resident #36 was sitting in a dining chair in his room by the sink. Resident #36 stated he was hungry but did not eat. Resident #36's room tray was observed on his nightstand, untouched. 2. During an interview on 5/17/25 at 3:00 p.m., resident #23 stated all the meals are late, I got lunch at 2:30 today and it was cold. During an observation and interview on 5/17/25 at 3:02 p.m., resident #24 was sitting in a chair with the overbed table in front of her with a meal tray on it. She stated she was served her lunch about 40 minutes prior. During an observation on 5/18/25 at 12:53 p.m., the meal cart was in the C wing dining room and a staff member was beginning to serve the residents in the dining room. During an observation and interview on 5/18/25 at 12:54 p.m., resident #24 was sitting in her room and stated she had not been served lunch yet. Resident #24 further stated she was hungry. During an observation and interview on 5/18/25 at 1:30 p.m., staff member P was outside of resident #24's room on C hall, getting a tray out of the meal cart. Staff member P stated that A and B halls, and Solana were served meals before C hall residents. Staff member P further stated that it was normal for C hall residents to receive their meals late. During an observation on 5/18/25 at 1:35 p.m., staff member P brought resident #24's lunch tray to her room. Review of the facility provided mealtime form, gathered from the survey entrance request, showed mealtimes were at: -Breakfast for A/B wing and Solana at 7:30 a.m. to 8:00 a.m., and C wing 8:00 a.m. to 8:30 a.m. -Lunch for A/B wing and Solana at 11:30 a.m. to 12:00 p.m. and C wing at 12:00 p.m. to 12:30 p.m. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dinner A/B wing and Solana 4:30 p.m. to 5:00 p.m. and C wing 5:00 p.m. to 5:30 p.m. The mealtime policy was requested, which showed mealtimes were documented to be held at: -Breakfast for the A/B wing at 8:00 a.m., Solana at 8:15 a.m., and C wing at 8:45 a.m. -Lunch for the A/B wing at 12:00 p.m., Solana at 12:15 p.m., and C wing at 12:45 p.m. -Dinner for the A/B wing at 5:00 p.m., Solana at 5:15 p.m., and C wing at 5:45 p.m. 44769

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44769 Based on interview and record review, the facility failed to accurately complete a POLST form with the resident's first name, for 1 (#241), and failed to have the resident/POA sign the POLST form placed in the EHR, for 1 (#24) of 25 sampled residents. These deficient practices had the potential to create complications, or hinder emergency treatment necessary, related to a resident's DNR wishes. Findings include: During an interview on 5/19/25 at 7:59 a.m., staff member E stated social services assures the POLST is reviewed and accurately completed for the resident upon admission. Staff member E stated the code status is in the residents EHR within seven days after admission. Staff member E further stated the code status on the POLST form should be the same as the code status in the EHR, the POLST form should accurately reflect the residents first name, and it was very important the POLST form was signed by the resident or the residents POA. 1. A review of resident #241's POLST form showed the first name was not the resident's first name, middle name, or a name the resident used. 2. A review of resident #24's POLST form showed the box labeled Signature of Patient or Decision-Maker (required) [sic], was blank.