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	06/04/2026

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with indwelling urinary catheters received care to prevent urinary tract infections; failed to identify a root cause of repeated urinary tract infections for 2 (#s 6 & 9); and failed to follow up timely with urology referrals and appointments for 1 (# 9) of 19 sampled residents. Findings include1. Review of resident #9's medical record showed three hospitalizations occurring in 2026. Review of resident #9's hospital Discharge summary, dated [DATE] - 1/22/26 showed:- Diagnoses: Sepsis due to catheter associated Morganella morganii UTI with bilateral hydronephrosis .- Follow up Recommendations for PCP: Close follow-up with urology .Review of resident #9's hospital Discharge summary, dated [DATE] - 4/17/26 showed:-Diagnoses: Sepsis due to catheter associated Pseudomonas UTI with bilateral hydronephrosis-Follow up Recommendations for PCP: Once daily acetic acid irrigation ordered but can increase to 3 times daily if needed. This is an attempt to reduce the frequency of urinary tract infections with his chronic Foley.Review of resident #9's hospital Discharge summary, dated [DATE] - 5/8/26 showed:-Diagnoses: Sepsis secondary to UTI urine cultures positive for MRSA and Enterococcus faecalisA. Review of resident #9's care plan, initiation date 1/10/26, showed, [Resident #9] has a foley catheter in place he is at risk for trauma, infection and alterations in comfort. Interventions included, Urology as per referral dated 4/29/26.A request was made on 6/3/26 for urology notes for resident #9. None were provided by the facility. During an interview on 6/3/26 at 4:24 p.m., staff member A stated they were having difficulty getting resident #9 in to see a urologist due to his hospitalizations and dialysis schedule, which was limiting his availability. Staff member A stated there was no longer a urologist locally, so they were looking at referrals to outside cities.During an interview on 6/4/26 at 12:31 p.m., staff member A stated they did not have an answer as to why resident #9 could not see the local urologist that resident #6 saw.During an interview on 6/4/26 at 1:28 p.m., staff member L stated the referral to get resident #9 into a urologist had come back in April, but between his hospitalization in May and the three-times-weekly dialysis schedule, it had been difficult to schedule. Staff member L stated that if needed, the dialysis clinic could be contacted to arrange for dialysis on a different day. Staff member L stated an appointment was now made to see [traveling urology provider] in August, in addition to a referral to [NAME] if they had earlier availability. Staff member L stated they did not realize there was a local urologist as an option.B. During an interview on 6/4/26 at 8:03 a.m., staff member F stated that nursing did catheter care.During an interview on 6/4/26 at 8:07 a.m., staff member A stated that catheter care had always been a CNA task and was included in their training.During an interview on 6/4/26 at 12:31 p.m., staff member A stated that catheter care was considered a basic standard of care and there wasn't necessarily a check-off spot in the record for CNAs to document each time it was completed. Staff member A stated there was an order for nursing to monitor the catheter every shift. During an interview on 6/4/26 at 1:47 p.m., resident #9 stated, They haven't done anything with my catheter today. It gets done maybe once a week. I know you were hoping for a different answer.During an interview on 6/4/26 at 1:50 p.m., staff member E stated nursing did catheter care for resident #9 (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 0690 Level of Harm - Actual harm Residents Affected - Few	when there were flushes ordered, but not since those flushes had been discontinued. Staff member E stated there might be miscommunication about catheter care in the hallway. Review of the facility assessment, dated 3/26/26, showed, Competencies (as appropriate for staff per their respective responsibilities): - CNAS: . perineal care (female and male), .- Licensed Nurses: . Indwelling insertion/removal/care .Review of the facility policy, Catheter Care, not dated, showed, . Catheter care will be performed every shift and as needed .document care and report any concerns noted to the nurse on duty.Review of resident #9's medication administration record, dated 4/18/26 - 5/4/26, showed acetic acid irrigations once daily with one missed administration in April. The acetic acid irrigations were discontinued upon the resident's return from his May hospitalization.2. Review of resident #6's medical record showed three hospitalizations occurring in 2026. Review of resident #6's hospital Discharge summary, dated [DATE] - 2/9/26 showed:- Diagnoses: Severe sepsis due to UTI and pyelonephritis- Follow up Recommendations for PCP: follow up on susceptibility testing for candida glabrata in urine.Review of resident #6's hospital Discharge summary, dated [DATE] - 3/9/26, showed:- Diagnoses: sepsis . likely source is complicated UTI candida glabrata . chronic foley.Review of resident #6's hospital Discharge summary, dated [DATE] - 4/21/26, showed:- Diagnoses: Sepsis secondary to MRSA bacteremia . and catheter associated urinary tract infection .-Follow up Recommendations for PCP: monthly Foley exchange with [local urology provider name].A. During an interview on 6/4/26 at 8:22 a.m., staff member J stated that indwelling Foley catheters would be changed, dependent on the patient and what was recommended in the hospital discharge summary. Staff member J stated they would have to talk with the medical director for more guidance on when a long-term Foley catheter should be evaluated by urology.During an interview on 6/4/26 at 10:42 a.m., staff member K stated urology consults were variable, dependent on the patient and their ability to attend an outpatient appointment, and the travel time to get there. Staff member K stated that to address the high number of repeated urinary tract infections, the facility had done staff education on peri and catheter care. Staff member K stated resident #6 had a UTI that was Candida, which was a lot harder to treat.A request for monthly Foley exchange appointment documentation was made on 6/4/26. A calendar detail of an appointment for 4/27/26 was provided. During an interview on 6/4/26 at 1:30 p.m., staff member A stated they were trying to figure out if resident #6 had gone to a urology appointment in May.During an interview on 6/4/26 at 2:03 p.m., staff member A stated they had just gotten off of the phone with the urology office. Staff member A stated they were told the urology office did not want to see resident #6 monthly.B. Review of resident #6's treatment administration record, dated April 2026 - May 2026, showed the following orders: - Indwelling urinary catheter size FR#16/10ml balloon. Monitor placement every shift. Start date 4/21/26.Three out of 19 opportunities in April were not documented. 13 out of 62 opportunities in May were not documented.- Per [local urology provider name] irrigate bladder with 60ml acetic acid every shift BID allow to drain into foley catheter bag by gravity. Start date 4/28/26. [sic]Two out of six opportunities in April were not documented. 15 out of 62 opportunities in May were not documented.Review of resident #6's comprehensive care plan, with an initiation date of 5/1/26, showed a focus area:[Resident #6] has an indwelling catheter. The focus area was several months past the resident's Foley catheter initiation, and there were no interventions related to repeated infections.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to have a consistent process for finding or replacing missing clothing, and the resident had missing clothing, for 1 (#3) of 19 sampled residents. Findings include: During an interview on 6/2/26 at 10:30 a.m., NF1 stated, There was a time when the laundry machine was down and so the facility was taking clothing to the laundromat. NF1 stated all of resident #3's stuff disappeared. NF1 stated she came to visit and resident #3 was wearing a bra, a shirt and had a blanket on her lap. There were no pants in her entire room. NF1 stated all of resident #3's clothing was clearly labeled with her name, including each individual sock. NF1 stated the facility did not replace any of the missing clothing.During an interview on 6/3/26 at 9:09 a.m., staff member B stated if a resident reported something was missing facility staff would check against the resident's inventory sheet and start investigating. If the item was unable to be located the facility would replace it to the best of their ability.A request was made on 6/3/26 for the log of missing items and facility replacements. There was no mention of clothing replacement for resident #3.During an observation and interview on 6/4/26 at 8:52 a.m., there was a large laundry bin overflowing with clothing identified as being unlabeled. Staff member G stated it was the CNAs responsibility to label all new clothes. If clothing did not have a resident's name, it was difficult to return to the owner. Staff member G stated the facility did not have a process to investigate or return unlabeled clothing. Staff member G stated NF1 had looked through the bin of unlabeled clothing and did not find resident #3's missing socks or pants.Review of resident #3's Inventory of Person Items sheet, dated 3/23/26, showed an intake of three black, one grey, one dark grey, one brown, one black and white marble, and one green pair of leggings. During an observation on 6/4/26 at 11:29 a.m., resident #3's closet contained three total pairs of leggings, one green, one brown, and one grey.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure that a resident (#32) was free from physical abuse from another resident (#62) of the 19 sampled residents. The facility identified the failure and corrected it on 5/11/26, which was before the start of the survey period. This deficient practice is cited as past noncompliance. This failure had the potential to cause resident #32 physicial and or psychosocial harm. Findings include:During an observation on 6/1/26 at 3:54 p.m., resident #62 was sitting in her room with the light off and there was no noise. Resident #62 was unable to verbalize or answer questions.Review of a facility-reported incident dated 3/15/26, showed: [Resident #32's initials] reported that [Resident #62] hit him on the arm. No injuries noted and resident appears to be at baseline. Incident reported to family and provider. Order received to send accused party to the acute (hospital) for evaluation. Investigation initiated. [sic]During an interview with staff members N and M on 6/4/26 at 7:35 a.m., staff member N stated, We could have put more detail in the bounds report when referencing the event between #32 and #62. Staff member M stated resident #62 was flailing around and had an increase in behavior when she hit resident #32, so they sent her to the emergency department for assessment. Staff member M stated the hospital ended up keeping resident #62 due to a UTI and sepsis. During an observation and interview on 6/4/26 at 9:51 a.m., resident #32 was sitting in his room and appeared happy. Resident #32 stated he does not remember the incident with resident #62 and he was not worried about an incident happening again.Review of resident #62's Comprehensive MDS with a date of 4/5/26, showed resident #62 had a BIMS of 3 (severely cognitively impaired).Review of resident #62's care plan with a revision date of 5/11/26, showed: Focus: [Resident Name] at times, can demonstrate physically aggressive behaviors towards staff and peers. She has, at times, demonstrated behaviors of hitting, slapping, kicking, pushing.Goal: [Resident Name] will not harm self or others through the review date. Interventions: Analiyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Monitor/document/report to MD of danger to self and others. Redirect [Resident Name] from peers when agitated, as she will allow. [sic]Review of a facility document titled Internal Medicine History and Physical dated 3/15/26, showed: .presents to the ED from [Facility Name] due to altered mental status and aggressive behavior.patient was becoming combative and was sent to the ED for further evaluation. She is restless and agitated and was given multiple sedatives in the ED. [sic]Review of resident #62's nursing progress notes dated 3/15/26, showed: Pt sent to ER for dx. Fall x2 today behaviors all day hitting staff and throwing things and food. Pt refusing meds. Tachycardia when allowed to check pulse. Orders for labs and a ua. Threw meds across room. [sic] Review of a facility document titled IDT - Interdisciplinary Post Event Note dated 3/18/26, showed: Patient (resident #32) reported he was hit on the arm by peer [Resident initials], unprovoked, as they were crossing paths in the hallway. On 3/15/26 at 5:20 p.m. [sic]During an interview on 6/4/26 at 10:15 a.m., staff member A stated the process for resident-to-resident incidents would be for the facility staff to intervene immediately, remove the resident to a safe place, IDT would review the incident, the care plan would be updated, and appropriate notifications would be made. Corrective Measures:Review of the facility's Final Report for abuse allegation, dated 3/21/26, showed resident #32 was assessed for injury with none noted. Social service interviewed resident #32, and he reported that there were no other incidents related to resident #62, and he feels safe in the facility. Resident #62 was sent to the ER for evaluation and was admitted . Five other residents were interviewed with no issues noted. All required notifications were made to the physician and representatives, and care plans were updated. The facility identified this as a resident-to-resident incident and reported it to the State Certification Bureau. Review of the facility's investigation documents showed other residents were interviewed on whether they had similar experiences or if they felt safe in the facility on 3/17/26, and no other concerns with resident #62 were identified. As a corrective measure the facility (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed other residents to identify the potential of other residents effected. Social services followed up with resident #32 on three occasions (3/16/26, 3/17/26, and 3/21/26) following the incident for psychosocial monitoring. No negative effects from the incident were identified for resident #32. The facility followed up with the affected resident to ensure no negative outcome from the incident occurred. Resident #62's care plan was updated on 5/11/26 to include behavioral interventions. Education was provided to all nursing staff on abuse prevention and dementia on 3/18/26. This is cited at past noncompliance since the facility identified the resident-to-resident abuse occurred, immediately separated the residents and assessed them, interviewed other residents to identify others possibly effected, implemented interventions to prevent further incidents from happening, and educated staff on abuse and dementia. These steps were taken prior to the start of the survey period beginning on 6/1/26.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a resident had left the facility AMA and failed to inform the resident of the risks of leaving the facility AMA and their rights for 1 (#17) of 21 sampled and supplemental residents. This deficient practice put the resident at risk for a negative medical outcome. Findings include:Review of resident #17's Comprehensive MDS dated [DATE], showed: section C, Cognitive Patterns: BIMS Summary Score (C0500), 12 (Moderate Impairment). During an interview on 6/1/26 at 4:49 p.m., NF4 stated resident #17 never wanted to be at the facility and wanted to leave. NF4 stated that resident #17 had threatened to leave the facility AMA (Against Medical Advice) at one point and eventually did. NF4 stated, I am unsure of the facility's policy on AMA discharge, but there was no documentation filled out when she left.During an interview on 6/2/26 at 3:03 p.m., staff member O stated the facility's process for when a resident leaves is to have the resident sign out at the front desk and tell the nurse. Then the resident will sign back in when they come back. Staff member O stated that if the resident does not return, the nurse would call the on-call nurse and let management know. During an interview on 6/3/26 at 8:14 a.m., NF2 stated resident #17 never wanted to be in the facility and wanted to be discharged closer to home. NF2 stated, I was able to just walk in and take [Resident Name] out of the facility with no questions from staff or paperwork to fill out. During an interview on 6/3/26 at 8:55 a.m., staff member B stated the normal process when a resident leaves the facility for an outing or appointment would be for them to sign out at the front desk with the date and time. The resident would then communicate with the nurse and staff, and then sign back in to the facility when they return. Staff member B stated in resident #17's case, her friend was supposed to pick her up for her appointment out of town that was scheduled for 5/19/26. Staff member B stated she had worked out the transportation details with NF2 before the appointment. Staff member B stated NF2 arrived at the facility, and a former Ombudsman was with her. Staff member B stated NF2, and the former Ombudsman left the facility with resident #17 and all her belongings. Staff member B stated she called the Ombudsman's office, left a message for the local Ombudsman, and waited until around 6:00 p.m. for resident #17 to return to the facility. Staff member B stated the facility's normal process for a resident who leaves due to an AMA discharge is to educate the resident on the risks of leaving against medical advice and have them sign an AMA form. Staff member B stated the process was not followed for resident #17 because the facility staff thought she was going to an appointment out of town. During an interview on 6/3/26 at 9:33 a.m., NF3 stated she was asked to be a witness to interactions between the facility and NF2 when she picked [Resident Name] up for an appointment. NF3 stated she met NF2 in the lobby of the facility and asked the nurse where the residents' room was. The nurse on duty walked them to the resident's room, where resident #17 had been sitting with all of her belongings packed up. The nurse asked resident #17 if she had everything she needed for her appointment and left the room. NF3 stated resident #17, NF2, and herself left the room with all of the resident's belongings, then they all left the facility. NF3 stated, It was a three-minute ordeal. No one stopped us or asked us what we were doing.During an interview on 6/4/26 at 7:35 a.m., staff member M stated they had put together a timeline of events for resident #17, and they (staff) were aware resident #17 had left the facility with her belongings, her friend, and the ombudsman. Review of resident #17's electronic medical record showed an incomplete discharge evaluation was started on 5/21/26. Review of a timeline of events provided by the facility, undated, showed: 5/19/26, SSD was informed by staff that ombudsman was present in facility when [Non Facility Staff Name] coming to pick up [Resident Name] for a scheduled medical appointment in [Town Name] on 5/19/16 at approx 11:30 am. Staff then reported that [NF Name], [Resident Name], and ombudsman were moving all of [Resident Name] personal items from her room. SSD called ombudsman and left a message requesting call back. [sic]Review of (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #17's social service progress Note dated 5/19/26, showed: Attempted to call [NF2] regarding [Resident Name] return to facility. Left a message requesting call back. [sic]Review of resident #17's nursing progress notes failed to show the resident left for an appointment on 5/19/26, and failed to show resident #17 left with all her belongings. The facility failed to identify resident #17 had left the facility AMA.Review of a facility document titled Transfer and Discharge (including AMA), undated, showed: Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances.11. Discharge Against Medical Advice (AMA)a. AMA only applies when a resident expresses their wishes to be discharged earlier than outlined in the care plan. These situations do not apply if the facility offers to discharge a resident to a location which does not meet their health and/or safety needs, and the resident agrees.b. The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both.c. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility.d. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present.e. Notify Adult Protection Services, or other entity as appropriate.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a resident or resident representative with notice of bed hold or transfer/discharge, which could lead to the resident not knowing their rights for 1 (#10) of 21 sampled and supplemental residents. Findings include:Review of nursing progress notes dated 5/17/26, showed resident #10's family requested resident #10 be sent to the hospital and an ambulance was called for transport.Review of resident #10's electronic medical record failed to show the facility provided resident #10 or their representative with a notice of bed hold or transfer/discharge before the ambulance picked resident #10 up for transport to the hospital.During an interview on 6/3/26 at 4:30 p.m., staff member M stated staff would usually go up to the hospital and have the resident sign the bed hold and transfer notices, and that did not get done with resident #10 since she was sent to a hospital out of town. During an interview on 6/4/26 at 10:15 a.m., staff member A stated the admitting staff will review the bed hold notice policy with the residents when they are admitted to the facility, and then the discharging nurse is supposed to go over it again with the resident before they discharge. Staff member A stated it was a routine struggle to get them filled out when it was an emergency transfer. Review of a facility document titled Bed Hold Policy, undated, showed: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices, both well in advance and at the time of a transfer for hospitalization or therapeutic leave.2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. Resident #10 was admitted to the facility on [DATE]. The bed-hold policy was signed by resident #10 on 5/13/26. Resident #10 was sent to the hospital on 5/17/26. The facility provided an unsigned notice of resident transfer or discharge, and a bed-hold notice with the resident's discharge date of 5/17/26 and the resident's name. Showing it was never given to resident #10 before she was discharged to the hospital.