| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **275103** | A. BUILDING _____ B. WING _____ | **08/06/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CONTINENTAL CARE AND REHABILITATION** | **2400 CONTINENTAL DR BUTTE, MT 59701** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0677<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br><br>Based on observation, record review, and interview, the facility failed to ensure residents are provided basic ADL care and assistance in accordance with their plan of care for 5 (#s 1, 2, 3, 5, 6) of 20 sampled residents. Findings include: 1. During an observation and interview on 8/5/20 at 11:27 a.m., resident #5 recounted an incident of a CNA being upset with him because he refused to be transferred with only the help of one CNA. Resident #5's care plan stated he is to be transferred using a slide board with the help of two people assisting him. He stated he was afraid of falling due to his size and his jerky muscle movements. The CNA became irate and could be heard yelling about how bad he smelled. Resident #5 stated he needs his baths because, I am a big guy, and I will get ripe if I can't get washed. But he stated that if he fell and damaged his ankle any more, the doctor would not be able to fix it, therefore he is particular about how he is transferred. Resident #5 was in his wheelchair, he appeared to be groomed and comfortable at the time of the interview. Review of resident #5's bathing record reflected from the time of admission on 6/9/20, he had not received a bath, shower, or bed bath until 6/28/20. The record did show he refused three times on 6/10/20, and once on the day shift on 6/14/20. The other scheduled bath days in June (6/17/2020, 6/21/2020, and 6/24/2020) were all marked NA in his bath record. During an interview on 8/5/20 at 2:40 p.m., staff member J stated NA is marked when we are short-handed and don't get to the shower. 2. Review of resident #6's bathing record reflected the resident did not receive a bed bath, shower, or bath from 6/17/20 to 7/16/20, 30 days between baths. All of the scheduled days between 6/17/20 and 7/16/20 were marked with NA, or left blank. At no time did the resident refuse a bath. In an interview on 8/5/20 at 3:46 p.m., resident #6 was upset about the showers, she stated, They can sometimes be far apart. A sample of resident records from the Solana Memory Care Unit identified the following related to bathing: 3. Review of resident #3's bathing record reflected from the time of admission on 7/21/20, he had not received a bath or shower. The scheduled bath days of 7/24/20, 7/28/20, 7/31/20, and 8/4/20 were all marked NA in his bath record. Between the following listed days, resident #3 did not have at least one bath per week: 7/21/20 - 8/6/20; 16 days 4. Review of resident #2's bathing record from 4/1/20 thru 8/5/20 showed weekly baths scheduled on Tuesday, Thursday and Saturday were not received and were marked as NA on 4/4/20, 4/23/20, 5/2/20, 5/16/20, 5/23/20, 5/26/20, 6/25/20, 7/7/20, 7/25/20, 7/28/20. Between the following listed days, resident #2 did not have at least one bath per week: 5/21/20 - 5/28/20; 7 days 7/23/20 - 7/28/20; 7 days 5. Review of resident #1's bathing record showed weekly baths scheduled for Tuesday and Friday. From 4/1/20 to 8/5/20, resident #1 received a bath on 4/3/20, 5/26/20, 6/30/20, 7/10/20; NA was marked on 5/12/20, 5/22/20, 6/2/20, 6/5/20, 6/9/20, 6/16/20, 6/26/20, 7/17/20, 7/28/20, 7/31/20; all other bathing dates reflected RR or combination of NA and RR. Between the following listed days, resident #1 did not have at least one bath per week: 4/3/20 - 5/26/20; 33 days 5/26/20 - 6/30/20; 35 days 6/30/20 - 7/10/20; 10 days 7/10/20 - 8/5/20; 26 days During an interview on 8/6/20 at 8:41 a.m., staff member A stated, NA was marked for Solana residents when the resident was agitated and refused, or not enough staff; not enough staff was the main reason for picking NA when charting bathing. Staff member A stated, It was way better with the bath aide; but if someone called off, they pulled the bath aide; residents and staff were yelling at the bath aide because of not getting baths, but there was no back up for the bath aide. Staff member A stated management pulled the bath aide, but there was no system or plan of coordination of knowing how or who to bath when the bath aide left. Staff member A stated the resident bathing schedules are now on the computer, but the CNA staff can only see the current day's schedule for the residents. |
| F 0725<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide adequate nursing staff for 4 (# 1, 2, 3, 38) out of 20 sampled residents, and failed to provide adequate staff to assist and complete ADL care for bathing or showering, and staff failed to administer scheduled medications on time for the majority of residents in the facility; and failed to provide a safe environment for staff and residents. These failures increased the risk of negative affects, for the residents physical and psychosocial well-being. Findings include: A. During an interview on 8/5/20 at 8:07 a.m., staff member A stated he had worked at the facility for over a year and there were staffing issues at the facility, especially since the recent scheduling changes that happened two to three weeks ago. This change had taken away the nurse in the Solana unit, leaving just one CNA scheduled for the entire day to take care of the 10 to 15 residents. Staff member A stated it was difficult to watch all 13 residents when alone in the unit, and difficult to get help from the nurse up front when help was needed in the unit. Staff member A stated he felt like the residents on the Solana unit were being neglected and was also concerned about medications not being given on time. Staff member A stated resident #3 had not received his hourly [MEDICAL CONDITION] medication, resident #1 had not had blood sugars checked yet, and resident #2 had not received her scheduled breathing treatment. Staff member A stated he was very concerned about the residents' well-being. Staff member A stated it was super difficult to get residents' bathing completed, and he tried to get the easiest residents done first and then asked the nurse or charge nurse to help with the others that required additional help with bathing. Staff member A stated he knew that he had missed a couple resident showers last week. Staff member A stated, I am concerned we are being set up for failure, being forced to do more with less and we just have to suck it up and give good care. During an interview on 8/5/20 at 8:35 a.m., staff member C was administering medications on the A wing and stated she had just started working at the facility and was working her 3rd shift. Staff member C stated she really didn't get an orientation, since she had already used the facility's electronic health record, and had been a nurse for [AGE] years. Staff member C stated she had 10 residents on the A wing and 13 residents in the Solana unit, and also a new admit on the Solana unit. Staff member C stated, I think all nursing homes are the same, forced to do more with less and suck it up and give good care. During an interview on 8/5/20 at 11:03 a.m., staff member B stated she had worked at the facility for the past six months and they had a high turnover rate due to the challenges of the jobs and had just made staffing changes in the Solana unit. Staff member B stated prior to 7/27/20, there was 1 RN and 1 CNA scheduled from 6:00 a.m. to 10:00 p.m. and 1 CNA from 10:00 p.m. to 6:00 a.m. Now, there was 1 CNA in the Solana unit, and the RN covered the Solana unit and Hall A, administering medications and providing patient cares. Staff member B stated she wasn't sure about the medication administration policy, but staff member D would know since the facility was changing medication administration procedures to use pill packs. During an interview on 8/5/20 at 4:00 p.m., staff member J was seated at the nurses' station in the Solana unit. Staff member J stated she was supposed to have left at 2:00 p.m., but was helping the staff in the Solana unit |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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| F 0725<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>for awhile and picking up extra hours. During an interview on 8/5/20 at 4:05 p.m., staff member F stated she had worked at the facility for over a year and worked the 2:00 p.m. to 10:00 p.m. shift in the Solana unit. Staff member F stated, I worry in the evenings due to severe sundowners in some of the residents and trying to get them to bed. Staff member F stated when she needed help, she had to radio for help or page the other CNAs or the nurse passing meds. Staff member F stated, One night a few weeks ago I had a resident that became very abusive when I was changing her for bed, and I radioed for help; there were 2 other CNAs in the building and I had to use my personal cell to call the nurse for help, but she was on break across the street; I waited 20 minutes for help, while I was in the resident's room. Staff member F stated the scheduling just changed last week and management had not told the CNAs prior to the changes. Staff member F stated, On the 17th we're supposed to switch to 12's (12-hr schedule) and my schedule will be 7 to 7; the day shift is a heavy shift with 3 meals, especially since we lost the nurse a week ago. Staff member F stated that when she had spoken to management about any concerns, management had told her, It will take time to get better, thank you for your concerns. Staff member F stated, There have been problems with falls when working alone, especially with a new resident with [MEDICAL CONDITION] that pushes himself out of his wheelchair. During an interview on 8/5/20 at 4:30 p.m., in the Solana unit, staff member C stated, I don't feel like I can administer meds on time with two wings; I'm totally behind on charting, I have the L shape and memory units; I missed 2 neb noon treatments and gave at 1:30; I honestly think they need help for the CNA that is taking care of combative residents and showers since some are 2 person showers; Who's going to watch the unit, that's just what I'm seeing; it's a difficult med pass for a seasoned nurse. During an interview on 8/6/20 at 8:35 a.m., staff member K stated, There is not enough staffing here. These residents are not being cared for. Med pass is always late. Staff member K went on to state, Bubble packs help, but it was hard before they took away a nurse from Solana. Now A wing and Solana are combined and the nurse is hardly ever in Solana. The one CNA is left alone in there and can't get everyone to bed. During an interview on 8/6/20 at 8:41 a.m., staff member A stated One day I was working 3 wings helping the CNA out front and a new CNA in Solana; I felt like a super thin layer of jelly; At the end of the day, I felt like I had just worked fast all day with nothing accomplished, just picking up people and doing vitals; This is getting to be the norm; I don't like it; I love the residents and I don't have time to spend with the residents like I like to; I'm concerned about resident safety and care and keeping residents comfortable; It worries me being spread so thin, bad things like falls, injuries and weight loss are going to happen. B. During an observation on 8/5/20 at 7:30 a.m. while trying to gain access to the facility, this surveyor stood at the front door and rang the bell several times and did not observe any staff members. No staff were visible from the front door and no one came and let the survey team in. Upon trying to open the front door we discovered that it was unlocked and we entered the facility and then were able to make contact with staff members and be properly screened for COVID-19. During an interview on 8/3/30 at 12:40 p.m. with Resident #38's responsible party, she stated that residents in the facility were not getting the care that they needed because of the facility not having enough staff. She stated that residents were not receiving baths, receiving medications late, and being left unattended for hours. During an observation and interview on 8/5/20 at 8:25 a.m., resident #38 was found in her bed. She stated that the facility had changed bathing to two days a week instead of three because they were short staffed. Resident #38 was again observed at 9:45 a.m. still in bed eating breakfast. During a record review on 8/5/20 at 10:00 a.m. it was noted in resident #38's care plan that she is to have a bath/shower every Tuesday, Thursday, and Sunday. Scheduled baths were missed 7/12, 7/14, 7/16, 7/19, 7/21, 7/23, 7/26, 7/28, and 7/30 of 2020. Baths were noted on some alternate dates. On 7/7 the record showed, NA. During an interview on 8/5/20 at 10:15 a.m. staff member J stated that the facility has a bathing schedule, some residents have two showers a week but it is resident preference that drives the schedule. Residents can choose anywhere between 1 and 3 showers a week. Staff member J stated that NA means that they were short staffed and could not get to that shower. It was observed that staff member J left her shift at 4:00 p.m., her shift ended at 2:00 p.m., and she was heard to say, I'm Finally leaving. The Continental Care and Rehab Facility Assessment, updated 9/30/19, showed the following: Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident . Licensed nurses, hand written changes denoted from 3 full-time Unit Managers to 1. MDS (hand written) changed from 2.0 FTE to 1. Van driver (hand written) changed from 1.25 to 0.5 FTE. The facility was cited on 3/5/20 for not having Sufficient Staff and they have not reviewed/updated the facility assessment. The facility was cited by the State Survey Agency on 3/5/20 for not having Sufficient Staff, but the facility continued to cut direct nursing staff as stated by several nurses. As of July 2020, now only one nurse is responsible for memory care and Hall A. During an interview on 8/5/20 at 11:03 a.m., staff member B stated that as of 7/27/20 they had eliminated a nurse from the memory care unit. During a record review on 8/6/20 it was noted on the late administered medication report that all of the reviewed residents had hundreds of late medications,over the past several months. Review of the facility's Medication Admin Audit Report for 8/5/20, showed 30 of 52 residents in the facility had received medications administered late. All 13 residents in the Solana unit received late medications on 8/5/20. During an interview on 8/6/20 at 8:45 a.m. with staff member E, he stated that the census and acuity of residents influenced staffing so they do not take residents that have a high acuity. The census had dropped since Covid and they have not adjusted since. He admits that staff turnover is high, especially the CNAs, but he does not admit a percentage. He stated that he feels that it is safe to only have 1 CNA in the memory care unit all alone because they have a radio if they need help. |

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| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure the medications were administered at the correct time, which affected 5 (#s 1, 2, 3, 11, and 38) of 20 sampled residents. This had the potential to cause medication interactions, and loss of medication efficacy, for relief of symptoms for the residents. Findings include: During an interview on 8/3/20 at 12:40 p.m., the legal representative for resident #38 stated that she was concerned because resident #38 was not receiving her medications on time. She stated that there was a high risk of something really bad happening in the facility. During an interview on 8/5/20 at 8:07 a.m., staff member A stated he felt like the residents on the Solana unit were being neglected and was also concerned about medications not being given on time. Staff member A stated that morning resident #3 had not yet received his hourly [MEDICAL CONDITION] medication, resident #1 had not had his blood sugars checked yet, and resident #2 had not received her scheduled breathing treatment. Staff member A stated resident #3 receives hourly medications for his [MEDICAL CONDITION] and gets to shaking if he doesn't get his medication. During an interview on 8/5/20 at 11:46 a.m., staff member D stated the facility's medication administration policy is medication can be given 1 hour before and 1 hour after the time ordered. During an interview on 8/5/20 at 4:30 p.m., staff member C stated, I don't feel like I can administer meds on time with two wings; I'm totally behind on charting, I have the L shape and memory units; I missed 2 neb noon treatments and gave at 1:30; I honestly think they need help for the CNA that is taking care of combative residents and showers since some are 2 person showers; Who's going to watch the unit, that's just what I'm seeing; it's a difficult med pass for a seasoned nurse. Review of the facility's policy titled, Administering Medications, showed, 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of the facility's Medication Admin Audit Report for 8/5/20, showed 30 of 52 residents in the facility had received medications administered late. All 13 residents in the Solana unit received late medications on 8/5/20. Resident #1's late medications included: - NAME] DR (for Acid Reflux) scheduled for 08:00, administered at 09:33 - [MEDICATION NAME] Capsule (for [MEDICAL CONDITION]) scheduled for 08:00, administered at 09:33 - Glucerna shake (for Dietary Supplementation) scheduled for 08:00, administered at 09:33 - [MEDICATION NAME] Solution Pen-Injector (for Type 2 Diabetes with Diabetic [MEDICAL CONDITION]) scheduled for 08:00, administered at 09:37 - [MEDICATION NAME]/30 KwikPen<br>Suspension Pen-Injector (70-30) (for Type 2 Diabetes with Diabetic [MEDICAL CONDITION]) scheduled for 08:00, administered at 09:37 - [MEDICATION NAME] Capsule (for [MEDICAL CONDITION]) scheduled for 20:00, administered at 21:06 Resident #3's<br>late medications included: - [MEDICATION NAME]-[MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) ordered 7 times daily,<br>scheduled for 07:00, administered at 09:59 - Lactobacillus Tablet (for Diarrhea) scheduled for 08:00, administered at 09:59 - [MEDICATION NAME] Hcl Tablet (for Depression) scheduled for 08:00, administered at 09:59 - Polyethylene [MEDICATION NAME] (for Constipation) scheduled for 08:00, administered at 10:02 - [MEDICATION NAME]-[MEDICATION NAME] ER Tablet Extended<br>Release (for [MEDICAL CONDITION]) ordered 3 times daily, scheduled for 08:00, administered at 9:59 - [MEDICATION NAME]-[MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) ordered 7 times daily, scheduled for 11:00, administered at 12:11<br>- [MEDICATION NAME]-[MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) ordered 7 times daily, scheduled for 19:00,<br>administered at 22:44 - [MEDICATION NAME]-[MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) ordered 7 times daily,<br>scheduled for 20:00, administered at 22:44 - [MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) scheduled for 20:00, |

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| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>administered at 22:44 - Quetiapine [MEDICATION NAME] Tablet (for [MEDICAL CONDITION]) scheduled for 20:00, administered at<br>22:44 Resident #2's late medications included: - Aspirin 81 mg (for [MEDICAL CONDITIONS]) scheduled for 08:00 administered at 10:43 - [MEDICATION NAME] Tablet (for Supplement) scheduled for 08:00, administered at 10:43 - Tums (for Supplement) scheduled for 08:00, administered at 10:43 - [MEDICATION NAME]-Salmeterol Aerosol Powder Breath Activated (for [MEDICAL CONDITION]) scheduled for 08:00, administered at 10:43 - [MEDICATION NAME] Nebulization Solution (for Shortness of Breath)<br>scheduled for 04:00, administered at 05:10 - [MEDICATION NAME] Nebulization Solution (for Shortness of Breath) scheduled for 20:00, administered at 21:29 - [MEDICATION NAME] Nebulization Solution (for Shortness of Breath) scheduled for 08:00, administered at 10:43 - Health Shake (for Supplement) scheduled for 20:00, administered at 21:29 Resident #11's late medications (June 1-14 2020) included: -[MEDICATION NAME] Solution (Insulin [MEDICATION NAME]) Inject as per sliding scale: ordered 06:30 administered 07:35 -Basaglar KwikPen Solution Pen-injector 100 UNIT/ML ordered 08:00 administered 10:40 -[MEDICATION NAME] Tablet 5 MG ordered 09:00 administered 10:40 -Aspirin Tablet 81 MG Give 81 mg ordered 09:00 administered 10:40 -[MEDICATION NAME] Tablet 80 MG ordered 09:00 administered 10:40 -[MEDICATION NAME] Solution ordered 06:30<br>administered 07:56 -[MEDICATION NAME] Solution ordered 11:30 administered 13:42 -[MEDICATION NAME] Solution ordered 06:30<br>administered 11:35 -Basaglar KwikPen Solution Pen-injector 100 UNIT/ML ordered 08:00 administered 11:35 -[MEDICATION NAME]<br>Tablet 10 MG ordered 08:00 administered 16:13 -[MEDICATION NAME] Tablet 80 MG ordered 09:00 administered 11:36 -Aspirin Tablet 81 MG Give 81 mg ordered 09:00 administered 11:36 -[MEDICATION NAME] Tablet 5 MG ordered 09:00 administered 11:36<br>-[MEDICATION NAME] Solution ordered 11:30 administered 15:49 -[MEDICATION NAME] Solution ordered 06:30 administered 07:45<br>-[MEDICATION NAME] Solution ordered 06:30 administered 07:31 -[MEDICATION NAME] Solution ordered 06:30 administered 07:58<br>-[MEDICATION NAME] Solution ordered 06:30 administered 07:35 -[MEDICATION NAME] Tablet 5 MG ordered 09:00 administered<br>10:18 -Aspirin Tablet 81 MG Give 81 mg ordered 09:00 administered 10:18 -[MEDICATION NAME] Tablet 80 MG ordered 09:00 administered 10:18 -[MEDICATION NAME] Solution ordered 16:30 administered 17:56 -[MEDICATION NAME] Solution ordered 06:30<br>given 10:52 -Basaglar KwikPen Solution Pen-injector 100 UNIT/ML ordered 08:00 administered 10:53 -[MEDICATION NAME] Tablet<br>5 MG ordered 09:00 administered 10:53 -[MEDICATION NAME] Tablet 80 ordered 09:00 administered 10:53 -Aspirin Tablet 81 MG<br>Give 81 mg ordered 09:00 administered 10:53 -[MEDICATION NAME] Solution ordered 06:30 administered 09:14 -Basaglar KwikPen<br>Solution Pen-injector 100 UNIT/ML ordered 08:00 administered 11:31 -Aspirin Tablet 81 MG Give 81 mg ordered 09:00 administered 10:38 -[MEDICATION NAME] Tablet 80 MG ordered 09:00 administered 10:38 -[MEDICATION NAME] Tablet 5 MG ordered<br>09:00 administered 10:38 -[MEDICATION NAME] Solution ordered 06:30 administered 08:10 |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interview, and record review, the facility failed to modify communal dining and implement social distancing precautions for the residents in the C-wing dining hall. Findings include. During an observation and interview on 8/6/20 at 8:18 a.m., the C-wing dining area on the southwest side of the corridor was inspected during breakfast service. There were two table pushed together with five residents sitting around the table. The residents were not sitting 6-feet apart or even on opposite sides of the table from each other. It appeared they were sitting this close so that one CNA could assist more than one resident in eating. Staff member K stated, Oh that's right, I will tell them they can't be like that, referring to the lack of social distancing. Staff member K, walked into the dining room and had the CNAs move the tables apart and separate the residents to social distancing standards. In an interview on 8/6/20 at 8:23 a.m., staff member E stated the residents in the dining room should be social distanced. It is tricky in there because they are all assisted. We will be talking to them about that. A review of the facility infection prevention and control program policy reflects the facility standards are based on accepted national infection prevention and control standards. According to the CMS Covid 19 survey tool, when there is sustained community transmission, efforts are to be made to either maintain social distance or suspend communal dining. |