STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

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F 000	INITIAL COMMENTS	F 000		

A Complaint survey was completed on 9/16/2021. Facility Reported Incidents were investigated during the survey.

The facility census on entrance was 70.

DEFICIENCIES CITED:
Refer to FORM CMS-2567; Event ID: RU3E11 for findings.
Deficient practices were cited for the complaint(s) with Intake number(s): MT00051237, MT00051243, MT00051244, MT00051276, and MT00051282.

Deficient practices were cited for the Facility Reported Incidents with Intake numbers: MT00051125, MT00051136, MT00051269, MT00051286, MT00051299, and MT00051300.

DEFICIENCIES NOT CITED:
Refer to FORM CMS-2567; Event ID: BJOS11 for findings.
Deficient practices were NOT cited for the Facility Reported Incident(s) with Intake number(s): MT00051126, MT00051134, MT00051285, MT00051287, MT00051288, MT00051291, MT00051293, and MT00051294.

Glossary

ADL	activities of daily living
ARD	Assessment Reference Date
CNA	Certified Nursing Assistant
CPAP	continuous positive airway pressure
DON	Director of Nursing
MDS	Minimum Data Set
mg	milligram

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

Electronically Signed | 10/07/2021

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		10/31/21

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's provider and family were notified after a fall with injury, for 1 (#1); and failed to notify a resident's responsible party when a change of condition necessitated transfer to a hospital for 1 (#10) of 5 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had been made aware of a situation where resident #1 had sustained a fall with head injury on 9/9/21 at 6:00 p.m., and the provider and family were not notified until the morning of 9/10/21. NF3 stated she was also told the head wound had not been cleaned. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she received a call on the morning of 9/10/21 from a nurse at the facility. NF6 stated the caller apologized for not notifying her of resident #1's fall sooner, as she was, "so busy." During an interview on 9/14/21 at 1:40 p.m., staff member C stated she spoke with NF1 on the phone at 11:00 p.m. and had instructed NF1 to call resident #1's provider and family to let them know about the fall the resident had sustained	F 580	1) Notification of changes of condition for Resident # 1 and #10 cannot be made as changes happened in the past of and both their medical providers and representatives are now aware. Resident # 1 personal representative was notified on 9/10/21. Resident # 10 personal representative was not notified of hospital admission of 8/17/21. Personal Representative was notified of hospital admission of 8/27/21 on 8/27/21 (progress note dated 8/27/21). 2) All residents are at risk for failure to notify their provider and resident representative of a change of condition. A retrospective review of all residents going back to September 1, 2021 will be completed no later than 10/28/21 to ensure any resident changes of condition included documentation of medical provider and resident representative notification. 3) DON (Director of Nursing) or designee will reeducate staff of the Notification of Change of Condition to ensure resident representative and provider is notified of residents' changes of condition.	

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F 580	Continued From page 3 earlier in the evening. Staff member C stated she did not know the calls had not been made as instructed until she arrived at the facility at 6:00 a.m. on 9/10/21. During an interview on 9/16/21 at 10:55 a.m., NF9 stated resident #1's provider was out of the office, but she had access to the note dictated on 9/10/21. NF10 stated the note indicated the on-call provider was not notified on 9/9/21 when the fall occurred. The provider noted she became aware of the fall when she arrived at the facility on 9/10/21 for resident rounds. The head wound, with dried, matted, blood, was concerning for a head injury, and the provider sent resident #1 to the emergency room for evaluation. A review of resident #1's nursing progress notes for 9/9/21 failed to show any documentation of provider or family notification after the fall at 6:05 p.m. on 9/9/21. Refer to F658 Services Provided to Meet Professional Standards for additional detail related to resident #1's fall. 2. During an interview on 9/14/21 at 12:08 p.m., NF8 stated the facility had not notified her of resident #10's last two hospital admissions. NF8 stated resident #10 went to the wound clinic on 8/17/21 and was taken to the hospital from the wound clinic. The second hospital admission was on 8/27/21, and resident #10 had a fever. NF8 stated she found out about one of the admissions when the hospital called her asking questions. NF8 stated the facility called frequently about COVID-19 issues but did not call to notify her of changes in resident #10's condition necessitating admission to the hospital.	F 580	Education will occur no later than October 21, 2021 and will include new hires and contract or agency staff. Those not in attendance at education session due to vacation, sick leave, or casual work status will be reeducated prior to their first shift worked. 4) DON or designee will audit 5 residents' medical records to ensure medical provider and resident representative have been notified of any change of condition. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. DON or designee will report results of audits to QAPI on or before 10/28/21, then monthly for discussion and development of corrective action if needed to sustain compliance.	

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F 580	Continued From page 4 A review of resident #10's nursing progress notes, dated 8/17/21 and 8/27/21, failed to show NF8, the resident's representative, had been notified of either hospital admission. A review of the facility's policy titled, "Notification of a Change in Condition," dated 12/2019, showed the facility must immediately inform the resident's physician, and the resident's representative, of an accident resulting in injury, a need to alter treatment, or a decision to transfer the resident from the facility.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		10/31/21

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F 584	Continued From page 5 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's call light was the appropriate type as identified in the care plan, and failed to ensure the call light was accessible for use by the resident, for 1 (#1) of 8 sampled residents. Findings include: During an observation on 9/13/21 at 11:55 a.m., resident #1 was observed lying in bed on her left side with her eyes closed. Resident #1 did not open her eyes or awaken to her name being said in a normal volume voice. Resident #1's push button call light was found on the floor, wedged between the bedside table and the wall. During an observation and interview on 9/13/21 at 3:18 p.m., resident #1 was lying in her bed and her call light was on the floor between the bedside table and the wall. Staff member I was asked why resident #1 did not have her call light.	F 584	1) Resident #1 has a pad call light and is accessible for use. 2) All residents are at risk for being affected by not having an appropriate call light and not accessible for use. A full house audit has been completed on 10/18/21 to ensure that the 7 residents with special call lights are care planned have the appropriate call light and is accessible for use. An audit of all other residents was conducted on 10/18/21 to ensure their call light is accessible for use. Facility will make sure when a resident is moved, that requires a special call light, that the call light is also moved to ensure the resident has access to the special call and it is accessible for use. 3) DON or designee will reeducate staff on Call Light policy. Reeducation will occur no later than October 21, 2021 and	

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F 584	Continued From page 6 She said, "Did it fall? It should be there." Staff member I picked up the call light from the floor and placed it near resident #1's hand. A review of resident #1's fall prevention care plan, dated 4/12/21, showed she was at high risk for falls due to visual impairment, an anxiety disorder, fatigue, and poor safety awareness. Interventions included the use of a pancake call light within the resident's reach. The pancake call light was a round pad approximately four inches in diameter. During an interview on 9/16/21 at 8:20 a.m., staff member C was asked why resident #1 did not have a pancake call light as identified in her care plan. Staff member C stated it must have been left in the room resident #1 occupied prior to her current room.	F 584	will include new hires and contract or agency staff. Those not in attendance at education session due to vacation, sick leave, or casual work status will be reeducated prior to their first shift worked. 4) DON or designee will audit 5 residents rooms to ensure they have the appropriate call light and the resident has call light accessible for use. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. DON or designee will report results of audits to QAPI on or before 10/28/21, then monthly for discussion and development of corrective action if needed to sustain compliance.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		10/31/21

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F 600	Continued From page 7 by: Based on observation, interview, and record review, the facility failed to protect residents from neglect of care for the following areas: - when nursing failed to perform appropriate follow-up assessments, vital signs, neurological checks, and provider notification for a resident who sustained a fall with a head injury, for 1 (#1), - when a resident's dressing changes were not completed daily as ordered by the provider, for 1 (#7), - when direct care staff refused to assist a dependent resident with incontinence care which resulted in feelings of embarrassment and being unwanted, for 1 (#6), - when a resident's CPAP was not set up, per provider orders, after returning from a hospital admission for 1 (#2); and, - the facility failed to protect a resident from retaliation when a staff member failed to communicate with direct care staff the presence of a special meal brought by family to celebrate the resident's birthday, for 1 (#2) of 10 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had just received information regarding possible neglect related to resident #1's fall on 9/9/21 and follow-up nursing care. NF3 stated she had been told the provider and family had not been notified about the fall until 9/10/21. She also stated she had been told the resident's head wound had not been cleaned. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she received a call from a female travel nurse on the morning of 9/10/21. NF6 stated the nurse apologized for not calling sooner	F 600	1) The staff members involved in the allegation of abuse for Resident #1 have been terminated. Resident #7 discharged from the facility on 6/22/21. The staff member involved in the allegation of abuse for resident #6 has been terminated. Resident #2's CPAP has been set up with no further incidents. Staff member involved with Resident # 2 special meal not being delivered has been terminated. 2) All residents are at risk for abuse and neglect. All other current residents or personal representative will be interviewed to ensure they feel safe in the facility and free from abuse, neglect and retaliation on or before 10/28/21. 3) DON or designee will reeducate staff on the facility's Abuse and Neglect Policy. Education will include post fall assessments and documentation, failure to assist residents is considered neglect and retaliation of any kind is prohibited. Education will occur no later than Oct 21, 2021 and will include new hires and contact or agency staff. Those not in attendance at education session due to vacation, sick leave or casual work status will be reeducated prior to first shift worked. Residents and/or residents personal representative will be educated on abuse, neglect and retaliation during admission process. Abuse and neglect policy will also be reviewed at care conferences and as needed. 4) DON or designee will complete an audit of 5 random residents to ensure they understand the meaning of abuse, neglect	

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F 600	Continued From page 8 and told her resident #1 had fallen the previous evening, cutting her head; but that she, "was fine." NF6 stated she received a call from the facility at approximately 10:20 a.m. informing her the provider was concerned about a head injury and was transferring resident #1 to the emergency room for evaluation. During an interview on 9/14/21 at 1:40 p.m., staff member C stated she was notified regarding resident #1's fall at 11:00 p.m. on 9/9/21. Staff member C stated she instructed NF1 to notify the provider and the family, and to start neurological checks on resident #1. Staff member C stated when she arrived at the facility on 9/10/21 at 6:00 a.m., she found out NF1 had not done the notifications or neurological checks as instructed. Staff member C stated the subsequent investigation did not identify the reason for NF1's lack of action, and did substantiate neglect of care by NF1. During an interview on 9/16/21 at 10:55 a.m., NF10 stated she was aware of resident #1's fall and had access to the provider's note from 9/10/21. NF10 stated the note showed no provider had been notified regarding the fall on 9/9/21 until rounds on 9/10/21. The note showed the provider was not able to observe the head wound because of dried, matted blood on her head and blood on her pillow, and was concerned about a head injury. A request was made on 9/14/21 at 3:50 p.m., for any documentation related to resident #1's fall and follow-up care. The only documentation provided was two nursing progress notes describing the provider's visit and subsequent transfer to the emergency room.	F 600	and retaliation, that they feel safe in the facility and are free from abuse, neglect and retaliation. Any allegation discovered will be reported and investigated immediately. Audits of 5 random staff to determine if they have witnessed behavior changes or physical changes in non cognitive residents that could be a sign of abuse or neglect. Any reports of sudden behavior changes or physical changes will be reported and investigated immediately. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. DON or designee will report results of audits to QAPI on or before 10/28/21, then monthly for discussion and development of corrective action if needed to sustain compliance.	

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F 600	Continued From page 9	F 600		

See F658 for additional details related to resident #1's fall and follow-up care.

A review of resident #1's nursing progress notes, dated between 9/9/21 at 6:00 p.m. and 9/10/21 at 10:00 a.m., failed to show a fall, notifications to the provider or the family, any assessments related to the circumstances of her fall, or any post fall assessments.

A review of resident #1's nursing progress note, dated 9/10/21 at 11:20 a.m., showed the resident was examined at 10:30 a.m. by a provider. The note showed provider orders were received at 10:40 a.m. to send resident #1 to the emergency room for evaluation and a CT scan of her head. NF6 was notified of the transfer. At 11:20 a.m. resident #1 was transferred to the emergency room, and was, "very lethargic, slow to respond, [complained of] pain pointing to head. Able to follow very simple direction after several prompts."

2. During an interview on 9/15/21 at 3:27 p.m., staff member A stated NF11 called the facility and made an allegation of neglect regarding missed dressing changes over the weekend of 6/19/21 and 6/20/21. As part of the investigation, staff member A stated several other residents were identified as at risk for having missed dressing changes. Staff member A stated resident #7 was identified as one of these residents. Staff member A stated her investigation failed to show resident #7 had missed any dressing changes on either 6/19/21 or 6/20/21.

A review of resident #7's Treatment Administration Records, dated 5/2021 and

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F 600	Continued From page 10	F 600		

6/2021, showed 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21 did not have a check mark and initials which showed the treatment had been completed.

A review of resident #7's nursing progress notes, dated 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21, failed to show any documentation about resident #7's dressing changes.

During a follow-up interview on 9/16/21 at 8:20 a.m., staff member A stated when she investigated the issue of missed dressing changes, she only looked at 6/19/21 and 6/20/21. Staff member A stated she did not look at any other days and did not identify the five missed days noted above. Staff member A stated she should have, "looked at the bigger picture," and did not identify other dates which were missed and why they were missed.

3. During an interview on 9/13/21 at 12:11 p.m., resident #6 stated she had submitted a grievance in July 2021 alleging neglect by a CNA who refused to change her soiled brief. Resident #6 stated she had turned on her call light because she was soiled and needed to be changed. Resident #6 stated the CNA told her she would need to wait until the next shift. Resident #6 stated she did wait until the night shift came, and the CNA was a male. Resident #6 stated she was embarrassed to have him clean her up. Resident #6 described a more recent incident, on 9/5/21, which involved the same CNA. The more recent incident occurred when resident #6 put her call light on at 4:30 p.m. requesting to have her brief changed and to get ready for bed. Resident #6 stated she saw the CNA assisting other residents, but not her. After she had waited approximately

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45 minutes, resident #6 stated she called staff member A to report the incident. Staff member A told her she would take care of it. Resident #6 stated she did not want the CNA to take care of her anymore.

During an interview on 9/15/21 at 10:08 a.m., staff member G, accompanied by staff member C, stated part of the corrective action for the CNA involved in the 9/5/21 incident had been to move her to another unit so she would not be taking care of resident #6.

A review of the State Survey Agency's online incident tracking system showed an allegation of neglect was submitted on 7/6/21, by the facility. The submission showed resident #6 made an allegation of neglect related to a CNA refusing to assist her. The subsequent investigation substantiated neglect because the resident was left in a soiled brief for 45 minutes.

4. During an interview on 9/15/21 at 4:30 p.m., staff members A and C discussed grievances submitted by NF4 on behalf of resident #2. One of the grievances was submitted because resident #2's CPAP machine was not set up for use when she returned from a hospital stay on 8/9/21. Staff member A stated when resident #2 returned from the hospital on 8/9/21, she had a new bariatric bed. Staff member A stated the bed took up more room than a regular bed and made the power outlets difficult to access. Staff member C stated furniture would have needed to be moved. Staff member C stated resident #2 was moved to a larger room where the electrical outlets were accessible, and the CPAP could be plugged in. Staff member C stated the CPAP was set up and ready for use on 8/10/21.

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A review of the State Survey Agency's online incident tracking system showed an allegation of neglect was submitted by NF4 on 8/11/21. The alleged neglect on the part of the facility was for not setting up resident #2's CPAP on 8/9/21. The subsequent investigation substantiated the neglect.

5. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she was aware of an incident which had occurred approximately two weeks ago. NF3 stated a family member had brought a birthday dinner for resident #2. She stated the meal remained at the nurse's desk for a while. When resident #2 was called by her family to see if she enjoyed her birthday dinner, resident #2 told them she had not gotten anything special.

During an interview on 9/16/21 at 8:20 a.m., staff members A and C stated a family member brought resident #2 a surprise birthday dinner. As the facility was on lockdown because of a COVID-19 outbreak, the family member called beforehand to explain the dinner was a surprise for resident #2's birthday. The dinner was left with staff member S at the front desk. Staff member A stated staff member S called the unit to let them know there was something for resident #2. Staff member A stated staff member S, not able to reach the unit by telephone, delivered the bag to the empty nurse's station on the unit. Staff member A stated as there was no name on the outside of the bag, the staff on the unit did not look into the bag. Staff member A stated when the family member called later, resident #2 still had not received the bag. The conclusion of the investigation was staff member S could and should have done more to facilitate resident #2

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F 600	Continued From page 13 getting her birthday dinner, and determined staff member S was retaliating because of a previous incident with resident #2's family. A review of the State Survey Agency's online incident tracking system showed an incident was submitted by the facility on 9/10/21 which substantiated the allegation of retaliation by staff member S. A review of the facility's policy titled, "Abuse and Neglect," last revision date 5/15/19, showed neglect to be the failure to provide necessary and adequate (medical, personal, or psychological) care, and "All retaliation in any manner against residents for reporting abuse is considered abuse."	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		10/31/21

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F 610	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to thoroughly investigate allegations of neglect related to missed wound dressing changes for 1 (#7) of 4 sampled residents. Findings include: During an interview on 9/15/21 at 3:27 p.m., staff member A stated she received a call from a provider on 6/21/21 alleging neglect with regard to dressing changes for a resident not associated with this complaint. Staff member A stated the investigation involved dressing changes which should have been done over the previous weekend (6/19/21 and 6/20/21). Staff member A stated as part of her investigation she identified several other residents who may been affected by the missed dressing changes. Upon completion of the investigation, staff member A stated no dressing changes were missed on 6/19/21 and 6/20/21 for the residents investigated and the allegation of neglect was not substantiated for the specific days identified by the provider who made the initial allegation. Staff member A stated she did not look at any other dates to see if dressing changes had been missed. A review of resident #7's Treatment Administration Record, dated 5/2021 and 6/2021, showed no check mark or initial for dressing changes due on 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21. A review of resident #7's nursing progress notes, dated 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21, failed to show any documentation regarding dressing changes or why they may have been missed.	F 610	1) No immediate corrective actin can be taken for the failure to thoroughly investigate the allegation of neglect for Resident #7. Resident #7 discharged from the facility on 6/22/21. 2) All residents are at risk for failure to thoroughly investigate an allegation of abuse or neglect. Review of 16 incidents back to Sept 1, 2021 revealed that 4/16 were not thoroughly investigated to protect residents in similar situations. 1 Resident was discharged on 9/29/21 to hospital-did not return to facility;1 resident discharged home on 9/29/21 ; the staff member involved in 1 incident no longer works at the facility as of 10/14. On the 4th investigation, supplemental investigation will be completed on all residents that receive outpatient wound care to ensure that wound care is completed at wound clinic or at facility as ordered no later than 10/22/21. 3)The Corporate Regulatory Specialist will reeducate the Administrator and DON on how to complete a thorough investigation of abuse and neglect. Education will occur no later than October 21,2021. 4) Regional Nurse Consultant or designee will review 100 %, up to first 5, investigations each week for 4 weeks , then 50 % of investigations each month for 2 months of abuse and neglect to ensure the investigation were thoroughly completed. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. Regional Nurse consultant or designee will report results of audits to	

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F 610	Continued From page 15 During a follow-up interview on 9/16/21 at 8:20 a.m., staff member A stated she could not be sure if other dressing changes were missed because she only looked at documentation for 6/19/21 and 6/20/21. Staff member A stated a thorough investigation would have looked at, "The bigger picture," in order to determine if there was neglect for the other residents investigated, specifically resident #7. A review of the facility's policy titled, "Abuse and Neglect," last revision date 5/15/19, showed investigations should include interviewing any person who might have had knowledge of the allegation, focus on determining if abuse or neglect occurred, and thoroughly documenting the investigation.	F 610	QAPI no later than 10/28/21, then monthly for discussion and development of corrective action if needed to sustain compliance.	
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure contracted nursing staff used professional judgement when caring for a resident taking an anticoagulant medication, who sustained a fall with a head injury, increasing the risk of harm due to a delay in treatment of a more serious, undiagnosed head injury, for 1 (#1); and the facility failed to ensure nursing staff administered diuretic medications as ordered by the provider resulting in a worsening of the	F 658	1) The staff members involved in the allegation of abuse for Resident #1 have been terminated. Resident # 1 was assessed for high risk of falls because of co-morbidities. Medications for Resident #2 are being administered per physician orders. 2) All residents are at risk for failure to be assessed appropriately following a fall. Fall risk assessments are completed on	10/31/21

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F 658	Continued From page 16 resident's fluid retention, for 1 (#2) of 3 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had been notified resident #1 had fallen and injured her head at approximately 6:00 p.m. on 9/9/21. NF3 stated she had been told the wound had not been cleaned as of the morning of 9/10/21. The provider had not been notified on 9/9/21, regarding the fall with injury, and was not aware of the fall until she arrived at the facility on 9/10/21 to do resident rounds. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she was notified of resident #1's fall early on the morning of 9/10/21. NF6 stated she was, "in shock," when the nurse apologized for not calling the evening before. NF6 stated the nurse told her she did not call because she was, "so busy." NF6 stated she called the facility back about 10:00 a.m. to check on resident #1 and found out the resident had not been seen by a provider yet. NF6 stated someone from the facility called her at about 10:20 a.m. to say the provider had a concern for a head injury and was sending the resident to the emergency room for an evaluation. During an interview on 9/14/21 at 1:17 p.m., staff member R stated the facility's process for handling falls included protecting the resident from further injury, performing vital signs and neurological checks as part of a resident assessment, and notifying the provider, family, DON, and administrator. Staff member R stated an incident report and documentation associated with the Fall Check List were completed and then forwarded to the unit manager for review.	F 658	admission, quarterly and as needed. All residents are at risk for not receiving medications per their physician orders. There are no other residents in the facility that have similar medication time requirements. 3)DON or designee will reeducate staff on the facility's' Fall Management policy to ensure a complete assessment is performed, vital signs obtained, neurological checks are performed, and the medical provider and resident representative are notified and documented following a fall. DON or designee will reeducate staff on the facility's Following Physician Orders policy to ensure physician orders are being followed to include education on the diuretic medications specifically ordered for Resident #2. Education will occur no later than October 21, 2021 and will include new hires and contract or agency staff. Those not in attendance at education session due to vacation, sick leave or casual work status will be reeducated prior to their first shift worked. 4) DON or designee will audit 5 residents that have had a fall to ensure complete assessment is performed, vital signs are obtained, neurological checks are performed , and the medical provider and resident representative are notified and documented. DON or designee will audit 5 resident medication administrations, to include Resident #2, to ensure medications are being administered per physician orders. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. DON or designee will report	

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F 658	Continued From page 17 During an interview on 9/14/21 at 1:40 p.m., staff member C stated the fall protocol included a resident assessment, vital signs, and neurological checks if the fall was unwitnessed or if there was a head injury. Staff member C stated she was notified by NF1 at 11:00 p.m. of the fall sustained by resident #1 at 6:05 p.m. on 9/9/21. Staff member C stated she told NF1 to notify the on-call provider, the resident's family, and to begin performing neurological checks on resident #1. Staff member C stated when she arrived in the facility at 6:00 a.m. on 9/10/21, she found out NF1 had not done the notifications as instructed and had not been performing neurological checks on resident #1. Staff member C stated NF1 was immediately suspended, and the subsequent investigation showed there had been a miscommunication between NF1, the night shift nurse, and NF2, the day shift nurse. Each nurse believed the other was performing the required notifications. When asked why NF1 did not document resident #1's vital signs and neurological checks, staff member C stated, "I don't know why it (vital signs and neurological checks) didn't happen." Staff member C stated there was a binder at each nurse's station which contained training documents including falls management. Staff member C stated during the investigation of resident #1's fall and subsequent care, the facility identified a "gap" regarding orientation and training of agency or contract nursing staff. Staff member C stated the facility had started a performance improvement project in response the the findings of this investigation. A review of the facility's policy titled, "Falls Management," dated 11/2019, showed post fall resident management included a complete assessment, obtain vital signs, obtain	F 658	results of audits to QAPI no later than 10/28/21, then monthly for discussion and development of corrective action if needed to sustain compliance.	

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neurological checks with evidence of an injury to their head, contact the provider and the resident representative and document in the medical record.

A review of the facility's Fall Check List, not dated, provided by staff member R on 9/14/21, showed the following tasks were to be completed after a resident fall:

-Contact DON,
-Contact provider,
-Contact family,
-Fill out Fall Scene Investigation (paper form),
-Complete Risk Management in electronic medical record, and
-Initiate neurological checks if resident hits their head or if the fall is unwitnessed.

A request was made to staff members A and C on 9/14/21 at 3:50 p.m. for any documentation associated with resident #1's fall and post fall care. The only documentation received prior to the end of the survey was the two nursing progress notes identified below. No documentation of the Fall Check List, the Fall Scene Investigation, resident #1's assessments, vital signs, or neurological checks was provided prior to the end of the survey.

A review of resident #1's nursing progress note, dated 9/10/21 at 11:20 a.m., showed the resident was examined at 10:30 a.m. by a provider. The note showed provider orders were received at 10:40 a.m. to send resident #1 to the emergency room for evaluation and a CT scan of her head. NF6 was notified of the transfer. At 11:20 a.m. resident #1 was transferred to the emergency room, and was, "very lethargic, slow to respond,

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[complained of] pain pointing to head. Able to follow very simple direction after several prompts."

A review of resident #1's nursing progress note, dated 9/10/21 at 4:59 p.m., showed she returned from the emergency room, x-rays of her head, right hip and right hand were negative for injury. Resident #1 was, " ... alert, oriented times one only, disoriented and argumentative. Easily becoming agitated, wheeling self in [wheelchair]. Knocking into furniture, unable to redirect as she continues argumentative."

2. During an interview on 9/13/21 at 2:00 p.m., resident #2 stated the nurses have not been giving her pills on time and it has caused her to gain weight. Resident #2 stated it was an ongoing problem.

On 9/15/21 at 10:26 a.m., the surveyor received a voicemail from NF4 regarding the issue of proper administration of certain medications. NF4 stated he had spoken with resident #2's provider, staff member T, and the improper administration of specific medications which was raising a health issue for resident #2.

During an interview on 9/16/21 at 11:21 a.m., staff member T stated there was an issue with the administration of metolazone and bumetanide. Staff member T stated metolazone was a thiazide diuretic and bumetanide was a loop diuretic, and it was imperative the metolazone was given no more than 30 minutes before the bumetanide. If the medications were given more than 30 minutes apart, the potentiating effect was lost. Staff member T stated this had been explained to nursing several times, and the order specified the

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metolazone was to be given 30 minutes before the bumetanide. Staff member T stated the facility's inability to give the medications as ordered had caused resident #2 to gain weight. Staff member T stated the order specified metolazone was to be given 30 minutes before bumetanide to have the proper effect.

A review of resident #2's Medication Administration Audit Report, dated 9/16/21, showed the following:

-7/7/21 metolazone 5 mg given at 7:25 a.m., bumetanide 2 mg given at 8:41 a.m., 76 minutes apart,
-7/9/21 metolazone 5 mg given at 8:49 a.m., bumetanide 2 mg given at 9:57 a.m., 68 minutes apart,
-9/5/21 metolazone 5 mg given at 8:38 a.m., bumetanide 2 mg given at 9:48 a.m., 70 minutes apart,
-9/7/21 metolazone 5 mg given at 8:38 a.m., bumetanide 2 mg given at 9:50 a.m., 72 minutes apart,
-9/11/21 metolazone 5 mg given at 9:11 a.m., bumetanide 2 mg given at 9:54 a.m., 43 minutes apart,
-9/12/21 metolazone 5 mg given at 9:25 a.m., bumetanide 2 mg given at 10:21 a.m., 56 minutes apart, and
-9/14/21 metolazone 5 mg given at 8:15 a.m., bumetanide 2 mg given at 9:55 a.m., 100 minutes apart.

A review of resident #1's weights showed the following:

-8/9/21, return from hospital admission, 294 pounds,

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F 658	Continued From page 21 -9/11/21, 315.5 pounds, and -9/15/21, 310.5 pounds.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dependent residents received showers or baths as per their care planned frequency, for 2 (#s 2 and 3) of 5 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 had recieved a concern from NF5 regarding resident #3's care. NF3 stated she was told by NF5 that resident #3 did not want anything done with the concerns voiced as he did not want, "to rock the boat." During an interview on 9/13/21 at 10:13 a.m., NF5 stated she was concerned about resident #3 not receiving assistance with his personal cares and hygiene. NF5 stated resident #3 had a stroke a few years ago and needed help with taking care of himself. NF5 stated resident #3 was reluctant to ask for help with personal hygiene as he did not want to, "cause waves." During an observation and interview on 9/13/21 at 12:04 p.m., resident #3 was able to move his wheelchair using his left hand and foot. However, resident #3's right hand remained in his lap and was not used to move his wheelchair. Resident	F 677	1) Resident # 2 and Resident #3 have received a bath since time of survey. 2) All residents are at risk for not being bathed per their preference. A full house audit has been completed to determine every residents' preference for bathing and bathing schedule has been updated accordingly. 3) a. DON or designee will reeducate staff on facility Bathing policy to ensure bathing preferences are identified upon admission, added to care plan, added to bathing schedule and updated as preferences change. Education will occur no later than October 21,2021 and will include new hires and contact or agency staff. Those not in attendance at education session due to vacation, sick leave or casual work status will be reeducated prior to first shift worked. b. DON or designee will reeducate IDT on morning meeting review process of bathing completion, documentation and adjustments for necessary corrections. Education will occur no later than October 21, 2021. 4) DON or designee will audit 5	10/31/21

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F 677	Continued From page 22 resident #3 stated he did not want to talk any longer when he was asked about his care, and asked the surveyor to leave. Resident #3 stated talking about "these things," upset him. A review of resident #3's Quarterly MDS, with an ARD of 8/3/21, showed he was not cognitively impaired, required limited assistance with personal hygiene, and was totally dependent on the assist of one staff member for bathing. A review of resident #3's ADL care plan, dated 3/2/19, showed, "I prefer two showers per week. I like Tuesdays and Saturdays, but I am ok with what days work with the shower aide." A review of resident #3's shower completion documentation, dated 6/1/21 through 9/13/21, showed the following: -no shower between 6/1/21 and 6/9/21, 8 days, -no shower between 6/9/21 and 6/22/21, 12 days, -no shower between 6/22/21 and 6/29/21, 7 days, -no shower between 6/29/21 and 7/13/21, 14 days, -no shower between 7/13/21 and 7/27/21, 13 days, and -no shower between 8/28/21 and 9/9/21, 12 days. 2. During an interview on 9/13/21 at 11:30 a.m., resident #2 stated one particular CNA did not want to come in her room to help her. Resident #2 used call light to summon someone to assist her to the bathroom using the sit to stand lift. During an interview on 9/14/21 at 9:27 a.m., NF4 stated he had concerns with bathing and answering of call lights for resident #2. NF4 stated because it requires two staff to assist	F 677	dependent residents' bathing records to ensure they received a bath according to their care planned preference. Audits will be conducted weekly x4, then monthly x2 to ensure compliance. DON or designee will report results of audits to QAPI on or before October 28,2021, then monthly for discussion and development of corrective action if needed to sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

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F 677	Continued From page 23	F 677		

resident #2, it made providing timely care more difficult. NF4 stated he had heard the excuse of short staffing from both administration and direct care staff.

A review of resident #2's Significant Change MDS, with an ARD of 8/2/21, showed she had moderately impaired cognition, required limited assistance with personal hygiene, and was totally dependent on assistance from staff for bathing.

A review of resident #2's ADL care plan, dated 7/14/21, showed, "I will need assistance with and prefer to get 2 to 3 showers per week."

A review of resident #2's shower completion documentation, dated 6/1/21 through 9/13/21, showed the following:

-no shower between 6/1/21 and 6/15/21, 14 days,
-no shower between 7/2/21 and 7/13/21, 11 days,
-no shower between 8/17/21 and 8/24/21, 6 days, and
-no shower between 9/7/21 and 9/13/21, 6 days.