No Food for You

The nursing home failed to: a. protect residents from abuse by staff members for resident 10. This failure caused ongoing feelings of resident 10 being scared and had the potential to affect all residents in the nursing home; b. implement the nursing home's policy to protect resident 10 from abuse; c. report allegations of abuse or mistreatment, and the results of all investigations to the State Survey Agency for resident 10; and d. promptly investigate, prevent, and correct all allegations of abuse for resident 10.

During an observation on a Monday at 9:04 AM, resident 10 told staff member E that she had been mistreated three days earlier when she was forced to stay in bed. She stated she had woken up and wanted to get out of bed, and staff members G and O told her, "No." She stated that staff members G and O told her she had to stay in her bed and that she was not going to get any dinner. Staff member E told resident 10 he would fill out a grievance and inform staff member B.

Later that day at 1:32 PM, resident 10 stated staff members G and O told her they were not going to get her up after her nap and they were not going to bring her supper. Resident 10 said she was scared, and she had called her son and told him about this when it happened. The resident stated her son had to call the nursing home to get her supper.

The following morning at 7:30 AM, resident 10 was sitting in the hall across from the nursing station. The resident said that staff members G and O were there and she was scared. She added that staff members E and B had not talked to her yet. During an interview at 8:15 AM on that day, staff member B stated resident 10 told her yesterday about the incident. She stated resident 10 told her the two staff members would not let her get up. Staff member B said she was going to talk with staff members G and O that day as they had not been on shift. She stated the nursing home had not started the investigation.

During an observation on the same day at 8:24 AM, resident 10 was sitting in the dining room finishing her breakfast. Staff member O was in the same dining room assisting another resident with her meal. Four minutes later, resident 10 stated she was afraid that staff members G and O were going to retaliate against her because she had said she had been mistreated.

The nursing home failed to protect resident 10 from alleged abuse. The nursing home was notified of the allegation on Monday at 9:04 AM but failed to act on the allegation and it allowed staff members G and O to work with resident 10 during the next day without an investigation or interviewing resident 10 or other residents on the unit about abuse. Resident 10 continued to voice to the surveyor that she was scared.

Name of Nursing Home	Continental Care and Rehabilitation / Provider ID: 275103
Address	2400 Continental Drive, Butte, Montana
Date investigation completed	July 21, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/275103/health/standard?date=2021-07-21