STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275060	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Health and Rehabilitation Center	3251 Nettie St 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)
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. 44770 Based on observation of a facility security video, interview, and record review, the facility failed to protect 1 resident (#3) who could not consent to sexual contact from 1 resident (#2), of 7 sampled residents for abuse. Findings include: During an interview on 11/21/24 at 10:26 a.m., staff member A stated there had been an incident on 11/3/24 between resident #2 and resident #3. Staff member A stated resident #2 was witnessed by a staff member in resident #3's room with his hands under her covers touching her. Staff member A said resident #3 was not capable of consenting to sexual contact. Staff member A stated resident #2 was capable of understanding what he was doing but had impulse control issues. Staff member A stated she interviewed both residents after the incident, and resident #3 told her resident #2 had touched her breasts and vagina. Staff member A stated resident #2 told her he had touched resident #3's breasts and her vagina. Staff member A stated the police were called, and they arrived and interviewed the residents. Staff member A said resident #3 could not tell the police what happened and resident #2 stated he would not talk to the police without an attorney. Staff member A said the CNA who witnessed the residents together said resident #3's brief was intact, and the velcro was still attached on both sides of the brief. They could not determine if resident 2's hand was actually inside resident #3's brief, or if his hand was just under the blanket. Staff member A stated there had been an earlier incident, on 5/13/24, between the two residents, in which resident #2 put his hand on resident #3's breast in the hallway. The interviews staff member A did with witnesses from that incident said it looked like resident #2 just placed his hand on her breast but was not groping her. Staff member A stated the facility put resident #2 on medication to decrease libido and increased staff supervision of resident #2. Since resident #2 had some other hypersexual behaviors. They felt it was appropriate to put resident #2 on one to one observation to make sure he was not targeting female residents. Staff member A said they took resident #2 off of one to one observation, after the May incident, after he was placed on the medication, and because he had not shown any more hypersexual behaviors. Staff member A stated since the 11/3/24 incident, the facility placed resident #2 back on one to one monitoring any time he was out of his bed, and he would continue to be on the one to one until the facility could find other placement for resident #2. The resident was unable to get out of bed alone, but needed staff assistance. Staff member A said the facility had been working with mental health, and the state mental health nursing home, in an attempt to place the resident there since the state mental health nursing home had better facilities for him, and also because his family lived near the state mental health nursing home. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of a facility security video, dated 11/3/24, resident #2 was observed wheeling himself down the hallway in his wheelchair. There were two other residents in the hallway. Resident #2 turned his wheelchair and backed into resident #3's room. The time stamp on the video showed 1 minute and 30 seconds elapsed between the time resident #3 backed through the threshold of resident #3's doorway until staff member J entered resident #3's room, to separate the two residents. During an interview on 12/3/24 at 1:00 p.m., NF1 stated he was disappointed resident #2 was able to get to [Resident #3] for a second time. He stated he has asked [Resident #3] about the incident on 11/3/24, but she did not seem to remember it, and she didn't have any changes in her behavior after or since either incident occurred. NF1 stated he really would like to see resident #2 find alternate placement in another facility to meet his needs. During an interview on 12/4/24 at 9:49 a.m., staff member J stated she was working on 11/3/24, when the incident between resident #2 and 3, occurred. She said she entered resident #3's room immediately upon seeing resident #2 was in the room. Staff member J stated she knew those two residents needed to be kept separated. Staff member J stated she observed resident #2 had his hand under resident #3's blanket, and resident #3 was laying in her bed. Staff member J stated it did not appear that resident #2's hand was inside of resident #3's brief, and the velco on the brief was still attached securely on both sides. She did not believe resident #2 was able to get his hand inside of resident #3's brief. Staff member J stated she asked resident #3 what happened and resident #3 verbalized resident #2 touched her, and then resident #3 pointed to her breasts and peri area, to show staff member J where resident #2 touched her. Staff member J was also present during the incident on 5/13/24. Staff member J stated it looked like resident #2's hand just brushed up against resident #3's breast, and then resident #3 swatted her hand at him. Staff member J said that was when the facility put resident #2 on a one to one the first time. Staff member J stated she had not seen resident #2 try to touch any other female resident in a sexual manner nor had she seen him behave inappropriately in a sexual nature to other staff or herself. During an interview on 12/4/24 at 11:47 a.m., staff member E stated she was a travel nurse, and she worked at the facility occasionally. Staff member E stated the facility had a great method of communicating changes in resident Care Plans, and she was aware resident #2 needed increased supervision. She stated the facility had been trying to get resident #2 into a facility with a higher level of care and oversight, so the facility was documenting any encounters with other residents. Staff member E stated she wrote a nursing note on 6/6/24 showing resident #2 reached out towards resident #3, and resident #3 attempted to slap resident #2. Staff member E said neither resident made physical contact, and she stated it did not appear sexual in nature at all. Staff member E contacted the administrator on call and wrote a note. She stated she would have done a risk assessment had there been actual physical contact but there had not been. Staff member E stated she only wrote the note in this case because the communication from the facility was to document any behaviors for resident #2. Review of a facility provided document, not titled, dated 11/3/24, showed resident #3 stated the following during the facility investigation into the incident, He touched my head, breasts, and privates. The same document showed resident #2 stated, Yeah, I did, she is telling the truth. I pulled her blankets down and touched her chest and her vagina. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #3's EMR (electronic medical record) showed a nurse note, dated 11/3/24 at 2:53 p.m., which reflected resident #3 was observed in her bed with a male resident in her room, with his hand underneath her blanket, touching her. Resident #3's care plan showed she experienced an adverse event with another resident in facility. Resident #3's comprehensive care plan reflected resident #3 had dementia and exhibited cognitive impairments as evidenced by impaired orientation, forgetfulness/confusion, poor recall, impaired decision making, and judgement. Review of resident #2's EMR, showed his care plan included a one-to-one observer (a staff member dedicated to observing resident #2) initiated on 11/3/24, for inappropriate sexual behavior. A one-to-one was also initiated on 5/14/24 for inappropriate sexual behavior, and was discontinued on 5/22/24. Resident #2's care plan revealed resident #2, . has a behavioral complex care plan due to behavioral presentations, to include socially inappropriate behaviors, physical behavioral presentations towards others, and hypersexuality/inappropriate sexual behaviors towards staff and others at times. It also showed resident #2 would engage in self-masturbation at times, and staff were to ensure a safe and private place for this behavior, which was identified, with the date of initiation on 10/12/22, and revised on 5/20/24. Resident #2's chart showed: - A nursing note, dated 5/14/24 at 10:52 a.m., showed resident #2 had been involved in an incident involving a female resident (resident #3), and he would be put on one-to-one observation anytime he was out of his bed. -A social service note, dated 5/22/24 at 6:34 p.m., showed one-to-one observation had been discontinued. - A progress note, dated 5/29/24, showed, . has been exhibiting some inappropriate sexual behavior towards fell ow female residents. Several months ago, he had a demented female resident walk into his room, and he encouraged her to fondle his genitals. More recently he touched another female resident's breasts (found not to be the case). We have chosen to place him on a low dose of estradiol and monitor his behaviors. - A progress note, dated 11/20/24, showed He is currently on one-to-one observational status secondary to some inappropriate sexual advances towards a female resident. This is actually his second offense. Review of a facility policy titled, Abuse and Neglect, revised 2022, showed: . 3. 'Sexual abuse' is defined at 483.5 as non-consensual sexual contact of any type with a resident . Review of a facility policy titled, Identifying Types of Abuse, revised 2022, showed: . 1. Abuse of any kind against residents is strictly prohibited . Sexual Abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Sexual abuse is non-consensual sexual conduct of any type with a resident. Sexual abuse includes, but is not limited to: a. unwanted intimate touching of any kind especially of breasts or perineal area . 2. Generally, sexual contact is nonconsensual if: a. The resident appears to want the contact to occur, but lacks the cognitive ability to consent .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44770 Based on interview and record review, the facility failed to care plan interventions to keep a resident safe from unwanted sexual advances or abuse from another resident, for 1 (#3) of 7 sampled residents for abuse. Findings include: During an interview on 11/21/24 at 10:26 a.m., staff member A said resident #3 had been the subject of another resident's sexual advances on 5/13/24 and on 11/3/24. Staff member A said the first incident was just a quick touch of her (#3's) breast on 5/13/24, but the most recent incident on 11/3/24, the same male resident was found in resident #3's room with his hand under her bed covers. Resident #3 told staff the male resident had touched her breasts and her vagina. During an interview on 11/21/24 at 1:35 p.m., staff member A stated there had not been any changes made to resident #3's care plan after the 5/13/24 incident, or after the 11/3/24 incident, to protect resident #3 from the male resident. Staff member A said they made multiple changes to the male resident's care plan but not resident #3's. Review of resident #3's care plan, revised on 11/3/24, showed she experienced an adverse event with another resident in facility. There were no interventions related to the entry documented on the care plan related to keeping resident #3 safe from the specific male resident or how staff were to ensure she was monitored closely or removed from his vicinity.