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Form Approved OMB
No. 0938-0391

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	02/24/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation, interview, and record review, a staff member removed a resident's oxygen for the provision of care, knowing it was necessary to maintain the resident's oxygen levels, and the resident showed signs of signs of hypoxia prior to being placed back on the oxygen, for 1 (#5) of 5 sampled residents. Findings include: Review of a complaint made on 2/4/25 showed resident #5 was admitted to the facility on [DATE], and during the admission process the resident's oxygen was removed for a period of time while a staff member wheeled the resident down the hallway to obtain an admission weight. The complaint showed resident #5 became nauseated and vomited while his oxygen had been removed. Review of the signed and typed personal statement from staff member G, dated 1/31/25, showed: . the CNA had taken his (resident #5's) Oxygen cannula off to get his weight and brought him back to the room. The resident's family was present and then [staff member G] was called to the room because the family thought he was having a seizure. Review of a facility grievance, dated 1/31/25, showed: . Patient became hypoxic and took time to recover. Complainant remarks: I just want to ensure this doesn't happen again. During an interview on 2/24/25 at 9:03 a.m., staff member C stated they would never take a resident to get a weight without their required oxygen. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 12:13 p.m., staff member E stated they reported any concerns about neglect to their nurse. Staff member E stated the situation with resident #5 vomiting after seven liters of oxygen had been removed, was reported to staff member G on 1/31/25. Staff member E stated on 1/31/25, they were floated to another hall. Staff member E stated that day had felt busy and was a cluster. Staff member E stated they had known nothing about resident #5, but had been instructed to obtain a weight and vitals. Staff member E stated she had trouble getting an oxygen reading from the pulse oximeter for resident #5. Staff member E stated usually for an admission, the room was set up with the needed supplies (such as a portable oxygen cylinder). Staff member E stated on 1/31/25 and with resident #5's incident, the room had not been set up and there was not a portable oxygen cylinder in the room. Staff member E noticed resident #5 had originally been on five liters of oxygen with a concentrator when staff member E had first walked into the room. Staff member E stated they did go look for a portable oxygen cylinder in the clean utility storage room, but there were none. Staff member E stated this was unusual. Staff member E also stated even if they would have found a portable cylinder that day, it still would not have gone high enough for resident #5's seven liter requirement. Staff member E explained and showed the surveyor that the portable oxygen cylinders went to a maximum of six liters. Staff member E stated they were unaware of any oxygen cylinders or tanks with a regulator that could have gone up high enough to accompany for the seven liter requirement for the resident. Staff member E stated prior to this incident, they voiced knowing it was wrong to take a resident's oxygen off during cares, and felt they had been in a sticky situation. During an interview on 2/24/25 at 2:18 p.m., staff member G stated they highly discouraged taking off a resident's oxygen to do any cares for a resident. Staff member G stated they thought this was basic knowledge for all staff members in the facility. During an interview on 2/24/25 with staff member A and B at 2:38 p.m., both staff members A and B stated they did not think this was a willful act of abuse. Review of a facility policy, titled Abuse and Neglect - Clinical Protocol, dated March 2018, showed: . 2. Neglect, as defined at S483.5 means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on interview and record review, the facility failed to report an incident of neglect where a resident's oxygen was removed for care, which resulted in the resident exhibiting symptoms of hypoxia during the admission process. The facility did not report the incident to the State Survey Agency within 24 hours, and failed to report a follow up investigation within 5 working days, as required, for 1 (#5) of 5 sampled residents. Findings include: Review of a complaint made on 2/4/25 showed resident #5 was admitted to the facility on [DATE], and during the admission process the resident's oxygen was removed for a period of time while a staff member wheeled the resident down the hallway to obtain an admission weight. The complaint showed resident #5 became nauseated and vomited while his oxygen had been removed. Review of the Facility Reported Events for the facility, submitted to the State Survey Agency, showed the event was not entered into the the reporting system for resident #5. During an interview on 2/24/25 at 12:13 p.m., staff member E stated they reported any concerns about neglect to their nurse. Staff member E stated the situation with resident #5 vomiting had been reported to staff member G on 1/31/25. During an interview on 2/24/25 at 1:06 p.m., staff member F stated they would first notify the physician of abuse, neglect, or misappropriation if it occurred and then notify a manager. Staff member F stated they would also call directly to the State Survey Agency if an abuse or neglect concern occurred. During an interview on 2/24/25 at 2:18 p.m., staff member G stated if they had a concern about abuse, neglect, or misappropriation, they would notify staff member A or H. Concerning the incident on 1/31/25, with resident #5's oxygen being removed. Staff member G stated they had told staff member H about the situation. During an interview on 2/24/25, with staff member A and B at 2:38 p.m., both staff members A and B stated they did not think this event needed to be reported to the State Survey Agency as it was not a willful act of abuse. Review of a facility policy, titled Abuse and Neglect - Clinical Protocol, dated March 2018, showed: . 2. Neglect, as defined at S483.5 means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on interview and record review, the facility failed to ensure 1 (#5) of 5 sampled residents received appropriate respiratory services on admission, and failed to have physician orders and necessary equipment on hand, and staff were not aware of or educated on the resident's respiratory care needs or risks related to them, and this resulted in neglect of care when a staff member removed the resident's oxygen, and then the resident showed signs of hypoxia. Findings include: Review of a complaint made on 2/4/25 showed resident #5 was admitted to the facility on [DATE], and during the admission process the resident's oxygen was removed for a period of time while a staff member wheeled the resident down the hallway to obtain an admission weight. The complaint showed resident #5 became nauseated and vomited while his oxygen had been removed. During an interview and observation on 2/24/25 at 12:13 p.m., staff member E stated on 1/31/25, they were floated to another hall to work. Staff member E stated that day had felt busy and was a cluster. Staff member E stated they had known nothing about resident #5, but had been instructed to obtain a weight and vitals and then staff member E had trouble getting a reading on resident #5's oxygen saturation. Staff member E stated the family said this was not an uncommon problem, so staff member E tried some other interventions regarding the oxygen saturation but was unsuccessful and eventually gave up moving on to the weight. Staff member E stated usually for an admission, the room was set up with the needed supplies (such as a portable oxygen cylinder). Staff member E stated on 1/31/25 and with resident #5's incident, the room had not been set up and there was not a portable oxygen cylinder in the room. Staff member E stated they noticed resident #5 had originally been on five liters of oxygen when staff member E had first walked into the room. Staff member E stated they knew resident #5 required seven liters of oxygen. Staff member E stated they did go look for a portable oxygen cylinder in the clean utility storage room, but there were none. Staff member E stated this was unusual. Staff member E then stated even if they would have found a portable oxygen cylinder that day it still would not have gone high enough for resident #5's seven liter oxygen requirement. Staff member E demonstrated with a portable oxygen cylinder to show the maximum was six liters. Staff member E stated they were unaware of any oxygen cylinders or tanks with a regulator that could have gone up high enough to accompany for the seven liter requirement for resident #5. Staff member E stated they had taken off resident #5's oxygen for a few minutes while the weight was obtained because they felt they had been in a sticky situation. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 2:18 p.m., staff member G stated the day of 1/31/25 was really chaotic and resident #5 arrived at the facility at around 1:45 p.m. Staff member G stated they had received two admissions around the same time and still had medications to pass before the end of the shift. Staff member G stated the timing of the admissions could have been better in their opinion. Staff member G stated they sent staff member E to get resident #5's weight and vitals, and then quickly after that time, staff member E reported resident #5 was physically grey and was vomiting. Staff member G stated, Oh my god, it's (resident #5's oxygen was) low. Staff member G stated they turned up the oxygen, and left the room to notify staff member H because staff member G had no physician orders as resident #5 was a new admission. Staff member G stated when they got back to resident #5's room, they felt resident #5 was more stable and was no longer vomiting. Staff member G stated they did not receive a report from the hospital so knew almost nothing about resident #5. Staff member G stated this was not a new problem and, It depends, if the hospital would call to give report or not, and the facility would hand out a green admission paper that showed general admission information such as diagnosis and oxygen needs. Staff member G stated this was the only information they had known about resident #5 during this incident. Staff member G stated they had received the green admission paper right before the incident happened. Staff member G stated they were so busy the day of resident #5's incident that they had forgotten to write an admission progress note. Staff member G stated they thought this issue happened with resident #5 because of a combination of communication and staffing. During a return call interview on 2/24/25 at 3:18 p.m., NF1 stated during the admission, resident #5's family member was very frustrated and upset with the facility. When NF1 had walked in the door, resident #5 was vomiting but did have his oxygen on. NF1 stated, That first day he looked so bad. I thought he might die that day. NF1 stated resident #5 had gotten pretty sick during the admission process. NF1 stated resident #5 was frail, thin, short of breath while at rest and with oxygen, so the smallest thing could throw him off. NF1 stated, It was a sad unfortunate situation, and, A big oops. NF1 stated employees make stupid mistakes sometimes. NF1 stated resident #5 looked uncomfortable and did eventually get morphine while NF1 was there. Review of a facility policy, titled Admission Criteria, dated 3/2019, showed: . 5. Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least: ., b. medication orders, including (as necessary) a medical condition or problem associated with each condition; and, c. routine care orders to maintain or improve the residents function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan. 6. Residents are admitted to this facility as long as their needs can be met adequately by the facility. Examples of conditions that can be treated adequately in this facility include: . b. COPD. Review of resident #5's EHR showed a primary diagnosis of COPD.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided for a new resident admitted on a high rate of oxygen, and this the oxygen was removed by a staff member, which resulted in signs of hypoxia for 1 (#5). The facility also failed to ensure physician orders were followed for 3 (#s 1, 2, and 4) of 5 sampled residents receiving oxygen. This deficient practice showed a potential concern for neglect and serious adverse effects to residents receiving oxygen services. Findings include: Review of a complaint made on 2/4/25 showed resident #5 was admitted to the facility on [DATE], and during the admission process the resident's oxygen was removed for a period of time while a staff member wheeled the resident down the hallway to obtain an admission weight. The complaint showed resident #5 became nauseated and vomited while his oxygen had been removed. 1. Review of resident #5's EHR showed an admitted [DATE]. Review of resident #5's EHR showed no oxygen saturation reading was entered into PCC until 2/1/25. Review of resident #5's EHR showed no admission nursing note was entered into PCC when resident #5 was admitted on [DATE]. During an interview on 2/24/25 at 9:03 a.m., staff member C stated they would never take a resident to get a weight without their required oxygen. Staff member C stated during an admission, they were instructed to obtain a weight first and then vitals on a resident. Staff member C stated the nurse would then come in the room to do their assessment. During an interview and record review on 2/24/25 at 10:32 a.m., staff member A stated the situation that occurred with resident #5 was wrong. Staff member A stated staff member E had taken resident #5's oxygen off to obtain a weight down the hall. Staff member A stated the oxygen had been removed for a few minutes. Staff member A stated they thought an admission note had been completed by staff member G summarizing the situation that occurred on 1/31/25 with resident #5, but was unable to find it. Staff member A was able to attain a typed statement from staff member G and a document titled Admission & Baseline Care Plan/Summary that was filled out by staff member G. Review of the document, Admission & Baseline Care Plan/Summary, dated 1/31/25, showed no record of the incident that occurred with resident #5's oxygen being taken off. The document showed: Does the resident currently have altered respiratory status? Yes . No oxygen saturation, no overall events, no summary, no interventions, or note contacting the physician/hospice/administration were documented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the signed and typed personal statement from staff member G, dated 1/31/25, showed: . the CNA had taken his (resident #5's) Oxygen cannula off to get his weight and brought him back to the room. The resident's family was present and then [staff member G] was called to the room because the family thought he was having a seizure. When [staff member G] arrived, [resident #5] was in his w/c, the oxygen cannula was in place under his nose, and he looked kind of gray. [Staff member G] checked his SpO2 and it was low, so [staff member G] started to turn up the oxygen. He was throwing up and [staff member G] grabbed gloves and a tow-el (towel), and the CNA went to get a basin. One of the CNA's suggested we get him to the bed so he could be turned on his side and supported in case he got weaker, the family insisted that he not be moved from the w/c. [Staff member G] was notified that [entity name] was on the way .so [staff member G] stepped out of the room to count with the oncoming shift and give over keys and report what was going on with him. [Staff member G] asked [a staff member] to give him an oxy mask (type of oxygen mask), now that he was no longer vomiting, since she had the keys . By this time, [entity name] was in the room with the resident and his family. [sic] During an interview on 2/24/25 at 11:30 a.m., staff member D stated the process of an admission for them was to get a weight and then obtain vitals. Staff member D stated the process of obtaining a weight and the total distance to the spa room where the scale was located would usually take a couple of minutes depending on where the resident's room was located. During an interview and observation on 2/24/25 at 12:13 p.m., staff member E stated on 1/31/25, they were floated to another hall. Staff member E stated that day had felt busy and was a cluster. Staff member E stated they had known nothing about resident #5, but had been instructed to obtain a weight and vitals. They stated they had trouble getting a reading on resident #5's oxygen saturation. Staff member E stated the family said this was not an uncommon problem, so staff member E tried some other interventions regarding the oxygen saturation but was unsuccessful and eventually gave up moving on to the weight. Staff member E stated usually for an admission, the room was set up with the needed supplies (such as a portable oxygen cylinder). Staff member E stated on 1/31/25 and with resident #5's incident, the room had not been set up and there was not a portable oxygen cylinder in the room. Staff member E stated they noticed resident #5 had originally been on five liters of oxygen when staff member E had first walked into the room. Staff member E stated they did go look for a portable oxygen cylinder in the clean utility storage room, but there were none. Staff member E stated this was unusual. Staff member E then stated even if they would have found a portable cylinder that day it still would not have gone high enough for resident #5's seven liter oxygen requirement as the maximum liters was six liters. Staff member E stated they were unaware of any oxygen cylinders or tanks with a regulator that could have gone up high enough to accompany for the seven liter requirement. Staff member E stated prior to this incident, they knew it was wrong to take a resident's oxygen off. Staff member E stated they felt they had been in a sticky situation. During an interview and observation on 2/24/25 at 12:51 p.m., staff member C stated, I don't know what I would do, when they referred to if a resident had been admitted to the facility on a high amount of oxygen such as 10 liters. Staff member C stated they would ask their nurse or use a bunch of tubing down the hall to obtain the weight. They stated this would not be the ideal solution. Staff member C then opened the door near the nurse's station that was labeled 'Oxygen,' which showed about 15 unopened tanks of oxygen with approximately two regulators. Staff member C stated they were unaware of these oxygen tanks because they never had to use them, but stated these would work in a situation where a resident needed 10 liters of oxygen. (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 2/24/25 at 1:06 p.m., staff member F stated anything over four or five liters of oxygen they would consider a high amount in this facility. Staff member F stated signs of hypoxia were gasping, low oxygen saturations, and physical signs such as a resident's face turning blue. They stated if a resident had a low oxygen saturation, it was important that they called the physician and notified administration.

During an interview on 2/24/25 at 2:18 p.m., staff member G stated the day of 1/31/25 was really chaotic. They stated resident #5 arrived at the facility at around 1:45 p.m., and they had sent staff member E to get a weight and vitals. They stated quickly after that time, staff member E reported resident #5 was physically grey and was vomiting. Staff member G stated, Oh my god, it's (resident #5's oxygen was) low. Staff member G stated they could not remember the exact number or even an estimate from the pulse oximeter reading on 1/31/25, but remembered thinking it was low and turned the oxygen up for resident #5. Staff member G stated they told staff member H because staff member G had no orders in PCC as resident #5 was a new admission. Staff member G stated when they got back to resident #5's room, they felt resident #5 was more stable and was no longer vomiting. Staff member G stated they did not receive a report from the hospital so knew almost nothing about resident #5. Staff member G stated, It depends, if the hospital would call for report or not. They stated, the facility would hand out a green admission paper that showed general admission information such as diagnosis and oxygen needs. Staff member G stated this was the only information they had known about resident #5 during this incident. Staff member G stated they had received the green admission paper right before the incident happened. Staff member G stated they highly discouraged taking off a resident's oxygen to do any cares for a resident. Staff member G stated they thought this was basic knowledge for all staff members in the facility. Staff member G stated they would not know what to do if a resident was admitted and required a high amount of oxygen such as 10 liters. Staff member G stated they would go to management for guidance. Staff member G stated they were so busy the day of resident #5's incident that they had forgotten to write an admission progress note. Staff member G stated they thought this issue happened with resident #5 because of a combination of communication and staffing.

During a return call interview on 2/24/25 at 3:18 p.m., NF1 stated during the admission resident #5's family member was very frustrated. When NF1 had walked in the door, resident #5 was vomiting but did have his oxygen on. NF1 stated, That first day he looked so bad. I thought he might die that day. NF1 stated resident #5 had gotten pretty sick during the admission process. NF1 stated resident #5 was frail, thin, short of breath while at rest and with oxygen, so the smallest thing could throw him off. NF1 stated, It was a sad unfortunate situation, and, A big oops. NF1 stated employees make stupid mistakes sometimes.

Review of a facility policy, titled Oxygen Administration, revised 10/2010, showed: . Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin .) . 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion) .

Review of a facility policy, titled Admission Criteria, revised 3/2019, showed:

Our facility admits only residents whose medical and nursing care needs can be met .

1.Our objectives of our admission criteria policy are to: .

c. address concerns of residents and families during the admission process .

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