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	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Health and Rehabilitation Center	3251 Nettie St Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48261 Based on observation, interview, and record reviews, the facility failed to ensure residents were assessed and found safe to self administer their own medications, prior to doing so; and, the facility failed to document the assessments in the EHRs, for 4 (#s 22, 33, 36, & 49) of 6 sampled residents for self administration of medication. Findings include: During an observation on 3/27/24 at 11:01 a.m., staff member K entered the room of resident #49 to administer a nebulizer treatment of albuterol 0.5-2.5. After preparation of the treatment, staff member K offered the nebulizer mask to resident #49, who stated he would complete the treatment, in a bit. Staff member K left the room, returned to her cart, and proceeded to complete medication administrations for other residents. During an interview on 3/27/24 at 1:28 p.m., NF1 stated, [Resident #49] does not have orders to self-administer any medications. I saw him on Monday, and I'm not sure he is appropriate for self-administration. During an interview on 3/27/24 at 1:54 p.m., staff member K stated, [Resident #49] starts and stops the nebulizer himself when he wants to administer his nebulizer treatment. Record review of resident #22's Self-Administration of Medication Evaluation, dated 4/13/20, reflected resident #22 was not capable of independent self-administration of medication. Record review of resident #36's EHR reflected no assessment was completed for self-administration of medication. Record review of resident #49's EHR reflected no assessment was completed for self-administration of medication. During an interview on 3/27/24 at 3:40 p.m., staff member A stated the facility did not have physician orders for self-administration for resident #s 22, 33, 36, and 49. Staff member A stated the facility did not have self-administration assessments for resident #s 36 and 49 and resident #22's self administration evaluation showed she is not capable of self-administration of medications. A review of the facility's policy, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, reflected under the Steps In Procedure . 17. Remain with the resident for the treatment. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F695 Respiratory Services, for more information related to nebulizer treatments and oversight by nursing.

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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. 49554 Based on observation, interview, and record review, the facility failed to review and revise comprehensive care plan interventions for catheter care for a resident that is at risk of infection for 1 (#9) of 26 sampled residents. Findings include: During an observation on 3/25/24 at 3:31 p.m., resident #9's room smelled of strong urine, the catheter tubing was cloudy, and had chunks of white debris in it. During an interview on 3/27/24 at 8:45 a.m., staff member G stated catheters are changed based on the physician's order in the Medication Administration Record. Review of resident #9's physician's order for the catheter, dated 1/2/24 showed, Foley cath: 18fr. Inflate balloon to 30 cc for stage IV pressure sore to sacrum. Change for occlusion, leakage, dislodgement or s/s of infection. As needed. [sic] Review of resident #9's care plan, revision date of 2/19/21, showed, .change catheter monthly . The care plan was not revised for the physician's order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49554 Based on observations, interviews, and record review, the facility failed to provide incontinence care and repositioning for dependent residents, which had the potential to increase skin breakdown, and may cause discomfort for the residents, for 2 (#s 2 and 14) of 26 sampled residents. Findings include: 1. During an observation on 3/26/24 at 8:30 a.m., resident #14 was lying in bed flat on her back, with her head elevated. During an observation on 3/27/24 at 8:43 a.m., resident #14 was lying flat on her back in bed, her head was slightly elevated by her pillow, and she was attempting to eat breakfast. During an observation on 3/27/24 at 10:18 a.m., resident #14 was lying flat on her back with her head only elevated by her pillow. During an observation and interview on 3/27/24 at 10:43 a.m., resident #14 was in the same position, flat on her back with her head only elevated by her pillow. Resident #14 stated, Staff don't encourage me to get on my side. I use these positioning bars to help me relieve pressure (skin) but the staff don't help. During an observation on 3/27/24 at 12:46 p.m., resident #14 was lying on her back in bed with her head only elevated by a pillow. Review of Resident #14's comprehensive care plan showed: -Focus: has potential for altered skin integrity r/t impaired mobility . Interventions: Preventative care as follows: encourage and assist to change position 3-4 times a shift and PRN . During an interview on 3/27/24 at 1:00 p.m., staff member L stated, Resident #14 moves her arms herself, but not her body. Staff assist with pulling her up in bed because she slips down, but we don't turn her on her sides. During an observation on 3/27/24 at 3:20 p.m., resident #14 was lying flat on her back with her head only elevated by a pillow. 2. During an observation on 3/27/24 at 8:49 a.m., resident #2 had just finished with breakfast, and was sitting in her wheelchair, in the doorway of her room. During an observation on 3/27/24 at 9:33 a.m., resident #2 was sitting in her wheelchair, in the doorway of her room. During an observation on 3/27/24 at 10:16 a.m., resident #2 was asleep in her wheelchair, in the doorway of her room. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/27/24 at 10:42 a.m., resident #2 was asleep, in her wheelchair, in the doorway of her room. During an observation on 3/27/24 at 11:13 a.m., resident #2 was sitting in her wheelchair. She was asking for help in a soft voice. There was a strong odor of urine as this surveyor approached resident #2, her eyes were matted with a yellowish discharge, and her right eye was matted all the way shut. She attempted to open her eyes, and the left eye slightly opened, and the right one would not open. During an observation on 3/27/24 at 11:38 a.m., staff member A was observed talking to resident #2, who was still sitting in her wheelchair, in her doorway. Staff member A disconnected resident #2's oxygen in the room, connected resident #2's portable oxygen, and proceeded to transport resident #2 to the dining room for lunch. Personal hygiene care was not provided prior to the transfer or assistance with positioning. During an observation on 3/27/24 at 11:45 a.m., resident #2 was observed in her wheelchair, sitting in the dining room. During an observation on 3/27/24 at 12:50 p.m., staff transported resident #2 to her room, in her wheelchair. Resident #2 remained in her wheelchair. Assistance with positioning or personal hygiene care was not provided prior to the transfer. During an interview on 3/27/24 at 12:55 p.m., staff member L stated, Resident #2 does not position herself. She was supposed to be repositioned every two hours. She should have been checked and changed (her brief) prior to lunch. It didn't get done because she was already taken to the dining room. The last time she was repositioned was when she got up this morning at 7:30 a.m. During an observation on 3/27/24 at 1:20 p.m., staff members L and N, with the assistance of NF2, assisted resident #2 to bed, using a mechanical lift. Resident #2 was saying ouch every time she was moved. There was a strong smell of urine. Resident #2's pants appeared to be soaked with urine, including the incontinence pad, which had been under her. Review of resident #2's care plan showed: - Focus: Potential impaired skin integrity r/t incontinence and impaired mobility . Interventions: encourage and assist to turn and reposition 3-4 times per shift-resident will be able to reposition self in bed . monitor for incontinence and change 3 to 4 times per shift as needed . Review of resident #2's Quarterly MDS, dated [DATE], showed: -Brief Interview of Mental Status score of 99, (showing a significant mental impairment.) Mobility: Dependent - Helper does All of the effort. Resident does none of the effort to complete the activity . [sic] Review of a facility document titled, Repositioning, with a revision date of May 2013, showed: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Purpose: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning . - 2. Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. - 3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49554 Based on observations, interviews, and record review the facility failed to change a residents catheter, this had the potential to increase the risk of infection for 1 (#9) of 26 sampled residents. During an observation and interview on 3/25/24 at 3:31 p.m., resident #9's room smelled of strong urine. Resident #9 stated she had a catheter due to her wounds. The catheter tubing was cloudy and had chunks of white debris in it. Resident #9 could not remember if her catheter had ever been changed. During an interview on 3/27/24 at 8:45 a.m., staff member G stated catheters are changed based on the physician's order in the residents Medication Administration Record. Record review of resident #9's catheter order, dated 1/2/24, showed, Foley cath: 18fr. Inflate balloon to 30 cc for stage IV pressure sore to sacrum. Change for occlusion, leakage, dislodgement or s/s of infection. As needed. [sic] Review of resident #9's care plan, with a revision date of 2/19/21, showed, Change catheter monthly and prn per MD order using sterile technique. Review of resident #9's Treatment Administration Record for January 2024, February 2024, and March 2024 showed, resident #9's foley catheter had not been changed in the three-month lookback period. Review of a facility document titled, Catheter Care; Urinary revision date of August 2022, showed: - . Preparation: Review the resident's care plan to assess for any special needs of the resident .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 48261 Based on observations, interviews, and record review, the facility failed to administer respiratory treatments in accordance with professional standards of practice for 4 (#s 22, 33, 36, & 49) of 6 sampled residents for respiratory services. Findings include: During an observation on 3/27/24 at 11:01 a.m., staff member K entered the room of resident #49 to administer a nebulizer treatment of albuterol 0.5-2.5. The nebulizer machine canister already had a full dose of liquid in the chamber, the mask was soiled with a white film, and white chunks of an unknown substance was on the inside of the mask. Staff member K added the additional dose of albuterol to the dose already in the chamber and went to hand it to resident #49. When asked by the surveyor, what the liquid was that was already in the chamber, resident #49 stated it was an earlier nebulizer treatment dose, which he had forgotten to take. Staff member K then stopped and said, Oops, I should clean it out then. Staff member K cleansed the mask and chamber and went to get another dose of the albuterol nebulizer treatment. Staff member K put the new dose in the chamber. Staff member K offered the nebulizer mask to resident #49 who stated he would complete the treatment, in a bit. Staff member K left the room, returned to her cart, and proceeded to complete medication administrations for other residents. During an interview on 3/27/24 at 1:28 p.m., NF1 stated, [Resident #49]does not have orders to self-administer any medications. I saw him on Monday, and I'm not sure he is appropriate for self-administration. During an interview on 3/27/24 at 1:54 p.m., staff member K stated, [Resident #49] starts and stops the nebulizer himself when he wants to administer his nebulizer treatment. [Resident #33] also does his own nebulizer treatment and medications, we just put them in a cup, and he takes them when he's ready. Most other residents who had nebulizer treatments, we setup the nebulizer treatment and start it, then come back and turn it off in 10-15 minutes. We don't do vitals with nebulizers but the CNAs do vitals on their shifts. Staff member K stated resident #'s 22 and 36 also recieved nebulizer treatments. During an interview on 3/27/24 at 3:40 p.m., staff member A stated the facility did not have physician orders for self-administration for resident #s 22, 33, 36, and 49. Staff member A stated the facility did not have self-administration assessments for resident #s 36 and 49 and resident #22's self administration evaluation showed she is not capable of self-administration of medications. During an interview on 3/28/24 at 9:15 a.m., staff member L stated she was trained to be in view of the residents, except resident #33, and go back and shut off the nebulizer when the residents are done. During an interview on 3/28/24 at 9:25 a.m., staff member G stated, We are supposed to stay in the room with residents and assess their respiratory throughout the nebulizer treatment and watch them (the resident). During an interview on 3/28/24 at 9:30 a.m., staff member C stated, They should stay close, cart in doorway is fine because they can still watch them. They know better than moving on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident #22's Self-Administration of Medication Evaluation, dated 4/13/20, reflected resident #22 was not capable of independent self-administration of medication. Record review of resident #36's EHR reflected no assessment was completed for self-administration of medication. Record review of resident #49's EHR reflected no assessment was completed for self-administration of medication. Record review of resident #s 22, 33, 36, and 49's EHR reflected no documentation of pulses, respiratory rates, or lung sounds before and after nebulizer treatments. A review of the facility's policy, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, reflected: -Steps In Procedure . 15. Instruct the resident to take a deep breath, pause briefly and then exhale normally. 16. Encourage the resident to repeat the above breathing pattern until the medication is completely nebulized, or until the designated time of treatment has been reached. 17. Remain with the resident for the treatment. 18. Approximately five minutes after treatment begins (or sooner if clinical judgement dictates) obtain the resident's pulse. 19. Monitor for medication side effects, including rapid pulse, restlessness, and nervousness throughout the treatment . - .21. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup . - .23. Administer therapy until medication is gone . - .Documentation . 5. Pulse, respiratory rate, and lung sounds before and after the treatment. 6. Pulse during treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48261 Based on observations, interviews, and record review, the facility failed to remove and dispose of expired medications and medical supplies in three medication rooms, three medication carts, and one wound supply cart; and, failed to properly store medical supplies, keeping the supplies off the floor in one medication room. These failures increased the risk of expired medications and medical supplies being used for any resident at the facility. Findings include: During an observation on 3/26/24 at 8:10 a.m., with staff member G, the following was found in the 400-hall medication room and cart: - Wound vac supplies on the floor, including open cases of canisters with gel, Grandufoam dressings, unopened cases of Whitefoam dressings, and canisters with gel. - Expired medications, and medical supplies with expired dates, included: 1 box Pen needles box open 100, with dated expiration of 4/30/23 1 Sharp debridement tray, dated 11/20/23 2 Natural Dermal Templates, dated 1/31/24 1 box of anti-diarrheal, dated 8/16 1 bottle of nasal decongestant, dated 5/23 2 bottles of ear drops, dated 5/23 1 bottle of Xyzal allergy, dated 11/23 2 bottles of Oyster shell calcium, dated 4/23 1 bottle of prenatal vitamins, dated 6/23 1 bottle of Geri-dryl, dated 6/23 1 bottle of vitamin D-3, dated 11/23 1 bottle of gentle laxative, dated 2/23 1 bottle of Thimamin, dated 2/23 10 pills of Loperamide HCL anti-diarrheal, dated 2/24 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1 package of Promogran prism, dated 4/30/23 During an observation on 3/26/24 at 9:45 a.m., with staff member B, the following was found in the 300-hall medication room and cart: -Expired items with expiration dates included: 1 bottle of ear drops, dated 1/24 1 bottle of Preservision AREDS, dated 2/24 1 bottle of Potassium 99 mg, dated 1/24 1 bottle of folic acid, dated 9/23 1 bottle of stool softener, dated 12/23 5 tubes of sterile water, dated 3/23 1 full box of albuterol sulfate 2.5 mg, dated 1/24 24 pills of acid reducer, dated 12/23 1 tube of hydrocortisone cream, dated 2/24 24 blue top blood collection tubes, dated 1/31/24 During an observation on 3/26/24 at 10:20 a.m., with staff member B, the following was found in the 200-hall medication room, wound supply cart, and medication cart: -Expired items with expiration dates included: 1 tube of Glutose 15 oral gel, dated 12/23 1 bottle of Oyster shell calcium, dated 1/24 1 bottle of Folic acid, dated 9/23 1 bottle of Potassium 99 mg, dated 1/24 3 bags of Vancomycin 1.5g/300mL, dated 12/23 1 bag of Vancomycin 1g/200mL, dated 12/23 51 bluetop blood collection tubes, dated 1/24 12 gold top blood collection tubes, dated 12/23 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1 tube of antifungal cream, dated 11/23 1 bottle of nasal decongestant, dated 5/23 1 foley catheter 22 F, expiration date 11/28/21 3 catheter secure devices, dated 7/19/23 5 Dermafilm clear hydrocolloid dressings, dated 3/19/22 1 Unna Boot, dated 7/23 3 Promogran prisms, dated 4/23 1 tube of hydrogel amorphous dressing, dated 12/22 2 tubes of Muscle rub, dated 1/24 118 DermaView II Films, dated 2/24 1 open tube of Aspercreme, dated 6/23 1 povidone iodine swab, dated 3/23 During an interview on 3/27/24 at 10:25 a.m., after a second request for the audit forms from night shift medication room checks, staff member B stated, They were probably not done since the changeover in management. During an interview on 3/27/24 at 11:45 a.m., staff member A stated the facility did not have the audit forms for night shift medication room and cart checks because the audits were not done. A review of the facility's policy, Medication Labeling and Storage, revised February 2023, reflected: -Medication Storage . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48261 Based on observations, interviews, and record review, the facility failed to ensure staff used appropriate hand hygiene during catheter care or wound care, for 2 (#s 9 and 37) of 26 sampled residents. Findings include: 1. During an observation on 3/26/24 at 2:45 p.m., staff members B and I entered the room of resident #37 to complete pericare and catheter care. Resident #37 was sitting in his recliner. Staff member B stood at the entry and observed while staff member I completed the following resident care: Staff member I completed initial hand hygiene, closed the door, gathered supplies, then gloved. Staff member I then moved the wheel chair out of the way, grabbed a brief from the closet, placed a gait belt around resident #37, and stood him up. Staff member I removed the old brief and placed it into the garbage. Staff member I grabbed a package of wipes from the bathroom that were unopened and used her keys in her pocket to open the wipe package, then put the keys back into her pocket. Staff member I wiped the front peri area of resident #37 while he was standing. Staff member I took her old gloves off, washed her hands, put new gloves on, and cleaned resident #37's buttocks. Staff member I then took her old gloves off, placed new gloves on, and assisted resident #37 to sit on a pad in his recliner. Staff member I then emptied the catheter bag into a cylinder on the floor, and used alcohol wipes to clean the end of the bag spout. Staff member I then emptied the cylinder into the toilet, took her old gloves off, placed new gloves on, and put a clean brief on resident #37. Staff member I washed her hands and began to clean-up his room and organize his items. During an interview on 3/26/24 at 3:10 p.m., following the catheter change, staff member B stated, [Staff member I] should have completed hand hygiene between each glove change-everything is a learning opportunity. 49554 2. During an observation and interview on 3/26/24 at 10:16 a.m., staff member L and G entered resident #9's room to do a wound treatment. Both staff performed initial hand hygiene and donned gloves. Staff member L rolled resident #9 onto her right side while staff member G applied the iodine and saline, per the physician order. Staff member G then removed gloves, and with bare hands she prepared triad cream and closed the iodine and saline bottle. Staff member G then donned another pair of gloves and applied the triad cream, per the physician order. When done, staff member G removed the gloves and washed her hands with soap and water. Staff member G stated, . I changed gloves because they had cream on them. I didn't think I needed to wash my hands in between glove changes since it was the same resident. A review of the facility's policy, Handwashing/Hand Hygiene, revised August 2019, reflected: - 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternately soap (antimicrobial or non-antimicrobial) and water for the following situations: . b. Before and after direct contact with residents. (continued on next page)

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	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Health and Rehabilitation Center	3251 Nettie St Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. h. Before moving from a contaminated body site to a clean body site during resident cares . . k. After handling used dressings, contaminated equipment, etc. . l. After contact with objects in the immediate vicinity of the resident; . m. After removing gloves .