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	04/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 52362 Based on observation, interview, and record review, the facility failed to maintain areas of the building in need of repair for 3 (#s 11, 19, and 27) of 22 sampled residents; and, failed to maintain a clean environment related to housekeeping services, for 1 (#57) of 22 sampled residents. Residents were concerned about lack of repairs and unclean areas identified. Findings include: 1. Wall repairs a. During an observation and interview, on 4/7/25 at 12:30 p.m., resident #19's room had 13 circular shaped holes, approximately one centimeter each in diameter, in the wall next to a grab bar. Resident #19 stated she told staff member M a while ago, I guess he just forgot, it would be nice if he fixed it soon, someday I guess he will. b. During an observation and interview on 4/8/25 at 10:08 a.m., in resident #11's room, there was long vertical jagged gouges, in the wall and above the head of her bed, all approximately twelve to twenty inches in length and one inch in width. Resident #11 stated, My wall has been really banged up for a while. I'm not sure if there are plans to fix it. c. During an observation on 4/7/25 at 10:21 a.m., in resident #27's room, there was an area of wall damage, approximately two feet tall by two inches wide, with the plaster and paint missing. The baseboards below the damaged wall were hanging from the wall, at the corners, appearing to have come unglued from the wall. During an interview on 4/8/25 at 9:53 a.m., staff member L stated the wall gouges in resident #11's room was from having the bed pushed up against the wall repeatedly. Staff member L stated she would normally put room repairs needed in a maintenance log, but had not done so yet. During an interview on 4/8/25 at 11:16 a.m., staff member K stated for room repairs she would fill out a request on the computer. Staff member K stated it took a long time to enter information into the computer, it was easier to just ask staff member M if he could do a room repair. Staff member K did not inform staff member M or enter into the computer needed wall repairs for residents #11 or #19. During an interview on 4/8/25 at 1:25 p.m., staff member J stated for room repairs she would tell staff member M or let the Director of Nursing know what needed fixed. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 1:30 p.m., staff member A stated the Direct Supply TELS electronic system was used for maintenance requests. Staff member A stated any employee could log in and enter a maintenance request. Staff member A stated there were no work orders in the TELS system for resident #11 or #19 for needed wall repairs. During an interview on 4/8/25 at 8:11 a.m., staff member M stated he would find out about resident room repairs needed from the TELS system. Staff member M stated he was not aware of the wall repairs needed for residents #s 11, 19, and 27 until yesterday. Staff member M stated he fixed all three walls yesterday after finding out they needed repairs. Review of the facility's policy titled, Maintenance Inspection, dated 2025, showed, Policy: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents . 49554 2. During an observation on 4/7/25 at 10:19 a.m., there was a thick brown substance smeared on the commode seat, smeared on the handrail next to the toilet, and on the roll of toilet paper next to the toilet. There was a sticky substance spilled on the floor next to the bed and a plastic urinal full of a yellow substance on the bedside table. During an observation and interview on 4/8/25 at 9:14 a.m., resident #57 stated, They (housekeeping staff) come in and clean every day or so. I know the bathroom is a mess. It bothers me, but they (staff) will get to it. The bathroom still had a thick brown substance smeared on the commode seat and on the handrail next to the toilet. There was still a sticky substance spilled on the floor next to the bed and a full urinal on the bedside table. During an observation and interview on 4/8/25 at 3:48 p.m., resident #57 stated, They (staff) have not been in yet to clean. A thick brown substance was still on the commode seat and on the handrail next to the toilet. During an interview on 4/9/25 at 9:11 a.m., staff member N stated, We (staff) have a daily routine we follow while cleaning the rooms . The bathrooms should be cleaned daily, but I have been on another hall for a while, and staffing can be hit and miss. I'm not sure about this hall and if the bathrooms have been cleaned thoroughly. Review of a facility document titled, Daily Resident Room Cleaning, undated, showed: .8. Toilet W/Cloroxtoilet cleaner and wand or green scrubbie. 9. Wipe down all handrails and door nobs w/T. E. T or lemon cleaner. [sic] Review of a facility document titled, Toilet Care, undated, showed: Purpose: Daily cleaning of toilets for basic sanitary conditions. Control of bacteria and odor. 5. Wipe down entire toilet with Clorox disinfectant.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48261 Based on observations, interviews, and record reviews, the facility staff failed to ensure each resident had access to call lights for 4 (#s 16, 24, 49, and 54); and failed to prevent elopements for 1 (#54) of 22 sampled residents. These deficient practices placed residents at risk of falls, injuries, elopements, or a negative outcome if a medical crisis occurred, and the resident could not call for assistance. Findings include: 1. Call lights not in reach a. During an observation on 4/7/25 at 10:00 a.m., resident #16 was attempting to access his call light. Resident #16 had left-sided weakness from a stroke and was unable to maneuver his wheelchair to the call light hanging off the wall tied to his bed. Resident #16 continued to attempt to reach his call light for three minutes and then called for help by yelling at a staff member walking by. b. During an observation and interview on 4/7/25 at 2:29 p.m., resident #24 stated he needed help, and no one would help him. Resident #24 stated, I can't breathe. Resident #24's call light was not within reach. This surveyor pushed the call button for the resident, and staff member H arrived and assessed resident #24. c. During an observation and interview on 4/7/25 at 1:14 p.m., resident #49 stated she fell this morning. Resident #49 stated she fell because she did not call for help before getting up from bed. Resident #49 pointed to the signs around her room reminding her to call for help before getting up. Resident #49's call light was not in reach to use for calling for assistance. d. During an observation on 4/7/25 at 10:37 a.m., resident #54 was walking around in his room looking for something with the door closed. Resident #54 was unable to verbalize his needs. The call light was wound up in a circle and taped to the wall. The call light was not able to be pulled to call for help. During an interview on 4/7/25 at 10:47 a.m., staff member F stated resident #54's call light should be in reach and the door should be partially open so the staff could keep an eye on him. Staff member F stated she did not know who taped the call light to the wall. During an interview on 4/9/25 at 1:16 p.m., staff member A stated the facility did not have a policy related to call lights. 2. Elopement Risk a. During an observation on 4/7/25 at 10:37 a.m., resident #54 was walking around in his room looking for something with the door closed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/8/25 at 12:01 p.m., resident #54 was wandering the hallway and exit seeking, pushing on the door to exit the building. Staff member O redirected resident away from the door and resident #54 continued to walk. At 12:11 p.m., resident #54 was attempting to enter other resident's rooms. At 12:21 p. m., resident #54 entered another resident's room requiring redirection from staff. During an observation on 4/9/25 at 7:23 a.m., resident #54 was up walking alone in the hallways, unsupervised. No staff members were present on the unit to observe resident #54 while he walked. Staff members were in rooms, providing care to other residents. During an observation on 4/9/25 at 1:32 p.m., resident #54 was in his room with the door closed. During an interview on 4/9/25 at 1:41 p.m., staff member F stated resident #54's door should be open so the staff could see him. Staff member F stated she did not know why the door was closed. During an interview on 4/9/25 at 1:45 p.m., staff member I stated the CNAs should have ensured resident #54's door was open for safety. Staff member I stated resident #54 had eloped twice as far as she was aware. During an observation on 4/9/25 at 2:45 p.m., resident #54 was exiting his room carrying clothes, entered another resident's room, who was not in the room, and placed the items on the dresser. Resident #54 went over to the bed, moved the bedding around and exited the room. Resident #54 then entered another resident's room. Resident #54 exited the room and went back to his room. Resident #54 then exited his room and entered resident #56's room, moving items around on the chair and then going over to the bed and touching resident #56's leg. Resident #56 was sleeping and resident #54 started to exit as staff entered and found resident #54, redirecting him back to his room. Review of a Facility Reported Incident, dated 8/26/25, reflected, . [Resident #54] was found outside, across the street by van driver and was escorted back to the facility safely and without incident.It was found that [Resident #54] had removed the window and the screen from his private room and exited the facility by the window. [sic] Review of resident #54's EHR Nurse Progress Note, dated 3/16/25, reflected, nurse alerted by housekeeping that resident was seen outside another resident room walking on the sidewalk. housekeeping and CNA went outside front door to encourage resident to come back inside. resident was standing in parking area near main front entrance when approached. resident redirected and assisted to room, toileted and given snacks. resident continues to actively exit seek after redirection. [sic] During an interview on 4/9/25 at 11:30 a.m., staff member M stated resident #54 pulled the full window out on 8/26/25 and set it inside his room. Staff member M stated resident #54 eloped straight out the window and was a very smart man with construction work in his background. Staff member M stated resident #54 was on 15-minute checks and there was nothing to prevent him from going out a window in another resident's room. Review of resident #54's EHR attached Visual checks reflected no visual check sheets for 4/4/25 through 4/6/25. Visual Checks sheet dated 4/9/25 reflected missing checks from 12:30 p.m. to 2:00 p.m. Review of resident #54's active Nursing Care Plan, revision date 3/20/25, reflected: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- . resident #54 was at risk for injury related to wandering. Interventions for this focus included 15-minute to 1:1 checks for safety and elopement risk (revised on 3/17/25). - DX of UNSPECIFIED DEMENTIA, MILD, W/AGITATION, is an elopement risk/wanderer as evidenced by impaired orientation and impaired safety awareness, decision making, and judgement(i.e., changes in behavior to include wandering, throwing away clothing, wandering into other residents rooms etc.), dining room wandering with tendencies of grabbing food off plates and grazing, undressing tendencies in public areas, urination elimination in inappropriate places, and inappropriate communication/language towards others. (revised on 3/20/25). Interventions included: Monitor for psychosocial changes, new or increase in behaviors and or agitation. 30-minute checks, 1:1 engagement/supervision. [sic] Review of the facility's policy, Elopements, dated Qrt 3, 2018, did not reflect what the process would be after the incident report was filed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49554 Based on observation, interview, and record review, the facility failed to ensure staff were educated on policies and procedures for the use of personal protective equipment, for a resident on enhanced barrier precautions, for 1 (#57) of 16 sampled residents for enhanced barrier precautions. This deficient practice increased the risk of infection for all residents related to staff not adhering to proper EBPs. Findings include: During an observation and interview on 4/7/25 at 10:22 a.m., staff member P was exiting a resident's room with trash. A sign was on the door reflecting the resident was on EBP precautions. Staff member P stated she did not know what EBP stood for or what the precautions were for the resident. Staff member P stated she was in orientation, but she was currently working the floor by herself. Staff member P stated her trainer went to lunch. During an interview on 4/9/25 at 11:24 a.m., staff member Q stated, I don't know what EBP is . I think Enhanced Barrier Precautions are used when someone has an infection or C-Diff; we (staff) would then wear a gown and gloves when we go into the residents' room. We should also use PPE if the resident has pneumonia or some other illness. During an interview on 4/9/25 at 3:27 p.m., staff member C stated the facility tried to highlight Enhanced Barrier Precautions at their annual skills fair and upon hire. Staff member C stated, I know EBP is an ongoing issue with staff. During an observation on 4/10/25 at 7:49 a.m., two unidentified staff were observed assisting resident #57 to get up from his bed. Neither of the unidentified staff were wearing PPE while assisting resident #57. There was an Enhanced Barrier Precaution sign on #57's door and PPE hanging on the back of the door. During an interview on 4/10/25 at 8:35 a.m., staff member F stated, We (staff) should wear PPE when doing catheter care and peri-care if the resident is on Enhanced Barrier Precautions. I think we are supposed to wear gowns while doing baths as well, but they get all wet, and it makes us feel like we need a shower. The gowns don't work well when doing showers . Wow, we must use PPE for all those areas of care? Review of resident #57's care plan showed: Focus: Enhanced barrier precautions r/t an indwelling medical device. Interventions: [NAME] gown and gloves during high-contact personal care activities, Enhanced Barrier Precautions . Review of a facility document titled Enhanced Barrier Precautions, dated August 2022, showed: .1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply . 3. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. Changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) . 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required . [sic] 48261