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	04/23/2026

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility had a policy, but failed to implement a process to ensure food safety, including checking food expiration dates and monitoring refrigerator temperatures of resident personal refrigerators for 3 (#s 4, 14, and 51) of 34 sampled and supplemental residents. Findings include:During an observation on 4/20/26 at 2:48 p.m., resident #4's personal refrigerator did not have a temperature gauge on the inside of the refrigerator or a temperature log to record the temperature. On the inside of the refrigerator, there was a cup of cauliflower and carrots wrapped in a bag in the back of the refrigerator that had a noticeable odor when the refrigerator door was opened. There was no date on the vegetables. There was also no date on the [NAME] syrup. During a follow up interview on 4/20/26 at 4:12 p.m., resident #4 stated she checked her own fridge for spoiled food. She stated staff did check the temperature, but would not use a thermometer.During an observation and interview on 4/20/26 at 2:58 p.m., resident #14 stated no staff members checked her refrigerator for temperature or for spoiled food. There was no temperature log located in resident #14's room.During an observation on 4/20/26 at 3:00 p.m., resident #51 had a personal refrigerator with no temperature log or temperature gauge. Inside of resident #51's refrigerator there were three Crustable sandwiches individually packaged, but all located in a Ziploc bag with the date of 3-4 written on the bag.During an interview on 4/22/26 at 8:20 a.m., staff member M stated nursing staff was not responsible for checking the residents' personal refrigerators.During an interview on 4/22/26 at 9:01 a.m., staff member C stated the facility was noncompliant with personal refrigerator temperatures and have started a Performance Improvement Plan.Review of a facility policy, titled Resident Refrigerators, dated 4/11/25, showed: . A thermometer shall remain in the refrigerator. staff shall clean the refrigerator weekly and discard any foods that are out of compliance .

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

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	04/23/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to provide notification to a physician regarding a resident's severe weight loss, resulting in a lack of physician assessment and involvement, which did not allow the physician the opportunity to recommend or implement interventions for 1 (#3) of 16 sampled residents. Findings include:Review of resident #3's weight record showed a severe weight loss of 9.73% from the resident's admission date of 3/10/26 to 4/21/26. The resident's weight on admission was 182 pounds and declined to 164.3 pounds.During an interview on 4/21/26 at 3:56 p.m., staff member G stated she had been following resident #3 closely since admission. Staff member G stated she had been making ongoing changes to accommodate the resident's nutritional needs and did not notify the medical provider of the resident's weight loss but would do so today (4/21/26).During an interview on 4/23/26 at 10:28 a.m., staff member B stated the dietician is responsible for reporting a resident's weight loss to the medical provider. Staff member B stated resident #3's weight loss was not reported to the medical provider until 4/21/26.Review of resident #3's EHR showed no documentation that the physician was notified or involved in resident #3's weight loss until 4/21/26.Review of a facility Document titled Weight Monitoring, not dated, showed: . 7. Documentation:The Physician should be informed of a significant change in weight.

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	04/23/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete an Annual and Significant Change in Status Minimum Data Set (MDS) assessment for a resident's pre-admission screening and resident review (PASARR), for 2 (#s 7 and 11) of 34 sampled and supplemental residents. Findings include:During an interview on 4/23/26 at 8:54 a.m., staff member F stated resident #7's PASARR Level One was completed on 1/15/24, and PASARR Level Two was completed on 1/22/24. Staff member F stated that when she completed section A of resident #7's MDS submission on 12/29/25, she did not think to look at the resident's PASARR information because the system pre-populated the resident's demographic information. Staff member F stated the same thing occurred with resident #11's Significant Change in Status assessment, which was completed on 3/18/26. Staff member F stated, I will need to start double-checking section A of the MDS assessment. Staff member F stated resident #7 and #11 did not have any disruption in service due to the incorrect coding on the residents' MDS assessments submitted on 12/29/25 for resident #7 and 3/18/26 for resident #11.1. Review of resident #7's electronic medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of Major Depressive Disorder and Schizoaffective Disorder. A Level One PASARR was completed on 1/15/24, and the resident qualified for a Level Two screening, which was completed on 1/22/24 with recommended service for resident #7.Review of resident #7's Annual MDS assessment dated [DATE], with an Assessment Reference Date of 12/10/25, section A, showed the facility documented the resident was not considered by the state Level Two PASARR process to have serious mental illness and or intellectual disability or a related condition by answering no.2. Review of resident 11's electronic medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of Bipolar Disorder, Schizophrenia, and Post Traumatic Stress Disorder. A Level One PASRR was completed on 3/11/24, and the resident qualified for a Level Two screening, which was completed on 4/2/24 with recommended service for resident #11.Review of resident #11's Significant Change in Status MDS assessment dated [DATE], with an Assessment Reference Date of 3/8/26, section A, showed the facility documented the resident was not considered by the state Level Two PASARR process to have serious mental illness and or intellectual disability or a related condition by answering no.

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	04/23/2026

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly obtain a new PASARR (Preadmission Screening and Resident Review) Level One screen, upon re-admission from the hospital for a resident who had a significant change in mental status, for 1 (#68) of 16 sampled residents. Findings include:A review of a facility document in resident #68's EHR showed a request for a PASARR Level One review, dated 11/4/22.A review of a progress note for resident #68 in the facility's EHR, dated 4/8/26 at 10:35 a.m., showed, [Resident #68] reported to charge nurse and to myself that she had awakened hearing voices and that she was frightened. She reported that the voices were repeating ?Knife, knife, and kill, kill, kill.' [Resident #68] verbalized being afraid that she may act on the hallucinations . [sic]A review of a progress note for resident #68 in the facility's EHR, dated 4/8/26 at 10:45 a.m., showed, . This writer sat with [Resident #68] until EMS arrived to transport [Resident #68] to the Emergency Department for evaluation. [sic]A review of a telemedicine consult for resident #68, with a creation time of 4/9/26 10:28 a.m., for a Hospital Emergency Department encounter on 4/8/26, showed: Psychiatry Follow-up Evaluation .Summary[AGE] year old female with history of Bipolar II disorder, fetal alcohol syndrome, PTSD present in ED for evaluation of AH that started yesterday morning.Working Diagnoses .Severe depressed bipolar II disorder with psychotic features. [sic]A review of resident #68's diagnoses in the facility's EHR, showed, Altered Mental Status, Unspecified . 3/20/26. The date of the diagnosis was almost three and half years since the last Level One PASARR was completed for resident #68. A review of a facility document in resident #68's EHR showed a new request for a PASARR Level One review, dated 4/22/26.During an interview on 4/23/26 at 9:55 a.m., staff member C stated a new PASARR Level One review should have been requested when there was a new psychiatric or mental health diagnosis. Staff member C further stated a new PASARR Level One should be requested for a resident in the instance of like if we sent them out for psych clearance.A review of a facility policy titled, Resident Assessment-Coordination with PASARR Program, with a copyright date of 2025, showed, Policy:This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.Policy Explanation and Compliance Guidelines:1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screeninga. PASARR Level I - initial pre-screening that is completed prior to admission . [sic]

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	04/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise resident care plans to reflect the Provider Orders for Life Sustaining Treatment (POLST) status for 2 (#s 50 and 74) of 34 sampled and supplemental residents. Findings include:During an interview on [DATE] at 8:21 a.m., staff member J stated resident care plans were updated weekly by the interdisciplinary team. Staff member J stated the nurse can also update the resident's care plan if an immediate update was necessary. Staff member J stated she was not sure why resident #50 and #74's care plan did not reflect their code status.1. Review of resident #50's POLST dated [DATE] showed, section A No CPR.During a review of resident #50's care plan on [DATE], the following entries were documented: Focus: [Resident #50] has an advance Directive as evidenced by: Full codeGoal [Resident #50's] wishes will be honoredIntervention: Will review POLST every 3 months, and upon [Resident #50's] request, to ensure wishes are being followed .2. Review of resident #74's POLST dated [DATE], showed, section A, Do not Attempt Resuscitation (DNR).Review of resident #74's care plan revised on [DATE], showed: Focus: Advance Directive as evidenced by: Full code .Goal: Wishes will be honored through next review date .Intervention: Full Code. Will review POLST every 3 months, and upon [Resident #74's] request, to ensure wishes are being followed .Review of a facility Document titled, Care Plan Revisions Upon Status Change, revised [DATE], showed: Policy:The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.Policy Explanation and Compliance Guidelines:. d. The care plan will be updated with the new or modified interventions.

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	04/23/2026

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review, the facility failed to ensure a physician personally conducted an initial comprehensive visit within the first 30 days after admission for 1 (#3) of 16 sampled residents. The failure increased the risk of missed resident care needs. Findings include:During an interview on 4/22/26 at 3:00 p.m., staff member A stated resident #3 was seen by a physician assistant at the facility on 4/21/26. Staff member A stated there was 10-day slippage for provider visits and the visit on 4/21/26 would meet the deadline for resident #3's 30-day physician visit. Staff member A stated the facility had contracted with a new physician; however, the physician's state license was still pending.During an interview on 4/23/26 at 10:28 a.m., staff member B stated she thought resident #3 was seen by the provider the week of 4/8/26. Staff member B stated she would look for the physician's note.Review of resident #3's hospital discharge noted dated 3/10/26, showed resident #3 had several chronic medical conditions which would require monitoring and medical management, including insulin dependent diabetes, atrial fibrillation on anti-coagulation therapy, congestive heart failure, chronic obstructive pulmonary disease on nasal oxygen, land left leg hematoma with progressive skin changes.Review of resident #3's progress notes from 3/10/26 to 4/23/26, showed no physician visit note that resident #3 was seen by a medical doctor at the facility.A request was made on 4/23/26 for a physician visit note for resident #3. No documentation was received from the facility by the end of the survey.Review of a facility Document titled, Physician Visits and Physician Delegation, revised 1/1/26 showed: Policy:It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents.2. The physician should:a. See resident within 30 days of initial admission to the facility .

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	04/23/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure there was not a 5% or greater medication error rate. The observed medication error rate was 10.34% for 2 (#s 13 and 38) of 34 sampled and supplemental residents. Findings include:1. During an observation and interview on 4/21/26 at 8:15 a.m., staff member K prepared the medications for resident #38 (amlodipine, clopidogrel, aspirin, multivitamin, norco, Senna Plus, and pantoprazole). The pantoprazole administration time shown on the MAR was 7:00 a.m. and was shown to be late. Staff member K stated the pantoprazole should have been given before resident #38 ate breakfast for the medication to have the best efficacy. Staff member K stated they often had to give this medication at the same time as the other medications (at 8:00 a.m.) if staff member K was running late on morning tasks. Staff member K stated resident #38 was currently in the dining room. Staff member K also put one tablet of Senna Plus in the medication cup and then continued to prepare the norco (hydrocodone/acetaminophen). The surveyor asked staff member K why two tablets of Senna Plus was not going to be administered, and staff member K stated, Oh yup, and added an additional Senna Plus tablet to the medication cup.Review of resident #38's EHR showed the physician orders: Senna Plus . Give 2 tablets .2. During an observation and interview on 4/21/26 at 9:50 a.m., staff member L prepared the medications for resident #13 (vitamin b complex, folic acid, coenzyme Q10, vitamin b12, potassium chloride powder, lorazepam, and magnesium oxide). Before pouring out the 400 mg magnesium oxide tablet, staff member L stated the MAR did not match the medication bottle. Staff member L showed the surveyor that the physician order was 420 mg of magnesium oxide (on the MAR), but showed the magnesium oxide medication label was 400 mg. When asked how long the incorrect dose had been given to resident #13, staff member L stated paused and stated, for a while. Staff member L then administered the magnesium oxide to resident #13.

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	04/23/2026

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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the designated infection preventionist had completed specialized training in infection prevention. The failure placed residents at risk for inconsistent infection prevention and control practices due to the lack of specialized training for the infection preventionist. Findings include:During an interview on 4/21/26 at 9:50 a.m., staff member C stated staff member D was the facility's infection preventionist. Staff member C stated staff member D had completed infection preventionist coursework in 2021 but was unable to retrieve a certificate of completion from the CDC (Centers for Disease Control and Prevention) website.During an interview on 4/22/26 at 11:45 a.m., staff member D stated she worked in infection control since approximately 2019 and completed the first 12 (of 23) modules in the CDC infection preventionist training between 2020 and 2021, but did not complete the training and did not have an infection preventionist certification.Review of a facility policy titled Infection Prevention and Control Program, revised January 2026, showed: The infection preventionist is responsible for oversight of the program, including infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of infectious diseases.Review of an online article from the Centers for Disease Control and Prevention titled, Infection Prevention Training for Long-Term Care, located at https://www.cdc.gov/longtermcare/training.html, and accessed on 4/22/26, showed: .nursing homes are required to have a designated infection preventionist who has received specialized training in infection prevention and control.