

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Crest Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 Amherst Ave 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41951</p> <p>Based on interview and record review, the facility failed to ensure licensed nursing staff adhered to accepted standards of practice by only administering oxygen within the parameters of provider's orders for 3 (#s 4, 5, and 6) of 3 sampled residents prescribed supplemental oxygen. Findings include:</p> <p>1. Resident # 5</p> <p>Review of resident #5's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date: 03/12/2024 RESPIRATORY TREATMENT: Oxygen 1lpm via NC to maintain SpO2 >90% for hypoxemia.at bedtime NOC noc O2 Sat: AM am O2 Sat: PM pm O2 Sat. [sic]</p> <p>- All occurrences for resident #5, from 9/2024 through 3/20/25, showed professional nursing staff documented the oxygen levels delivered exceeded the prescribed one liter per minute.</p> <p>- September 2024 showed 14 occurrences out of 89 entries,</p> <p>- October 2024 showed 45 occurrences out of 90 entries,</p> <p>- November 2024 showed 42 occurrences out of 88 entries,</p> <p>- December 2024 showed 55 occurrences out of 91 entries,</p> <p>- January 2025 showed 21 occurrences out of 86 entries,</p> <p>- February 2025 showed 24 occurrences out of 77 entries, and</p> <p>- March 2025 showed 46 occurrences out of 53 entries.</p> <p>Review of resident #5's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- . Entry Date: 3/20/25 RESPIRATORY TREATMENT: Oxygen 1lpm via NC to maintain SpO2>90% for hypoxemia continuous to keep oxygen sats at 90% equal to or greater NOC noc O2 Sat: AM am O2 Sat: PM pm O2 Sat . [sic]</p> <p>- 3/20/25 through 3/24/25, showed six occurrences out of 13 entries for resident #5, in which oxygen documented as delivered exceeded the prescribed one liter per minute.</p> <p>2. Resident #6</p> <p>Review of resident #6's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date: 03/25/2024 RESPIRATORY TREATMENT: Apply oxygenO2 Saturation 2L continuous (per nasal cannula) to keep O2 sat > or equal to 90 % AM PM NOC noc O2 Sat: am O2 Sat: pm O2 Sat. [sic]</p> <p>- All occurrences for resident #6, from 10/1/24 through 11/22/24, showed professional nursing staff documented the oxygen levels delivered exceeded the prescribed two liters per minute.</p> <p>- October 2024 showed 31 occurrences out of 91 entries, and</p> <p>- November 2024 (through 11/22/24) showed 16 occurrences out of 61 entries.</p> <p>Review of resident #6's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date: 11/22/2024 RESPIRATORY TREATMENT: Apply oxygen O2 Saturation 2L continuous (per nasal cannula) r/t heart failure to keep O2 sat > or equal to 90 % AM PM NOC noc O2 Sat: am O2 Sat: pm O2 Sat. [sic]</p> <p>- All occurrences for resident #6, from 11/23/24 through 1/31/25, showed professional nursing staff documented the oxygen levels delivered exceeded the prescribed two liters per minute.</p> <p>- November 2024 (11/23/24 - 11/30/24) showed one occurrence out of 23 entries,</p> <p>- December 2024 showed five occurrences out of 86 entries, and</p> <p>- January 2025, showed two occurrences out of 88 entries.</p> <p>3. Resident #4</p> <p>Review of resident #4's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date: 02/02/2024 RESPIRATORY TREATMENT: evaluate continued oxygen need at night : Administer oxygen 1-2lpm via NC at night to maintain Spo2 equal or greater than 90%. for Resp Failure with hypoxiaNOC noc O2 Sat: first date: 02/02/2024 May titrate to room if SpO2 90% or greater on room air. [sic]</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- All occurrences for resident #4, from 11/1/24 through 1/31/25, showed professional nursing staff documented the oxygen levels delivered exceeded the prescribed maximum of two liters per minute.</p> <p>- November 2024 had eight occurrences out of 30 entries,</p> <p>- December 2024 had 21 occurrences out of 31 entries, and</p> <p>- January 2025 had two occurrences out of 26 entries.</p> <p>Review of resident #4's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date 12/20/2024 RESPIRATORY TREATMENT: Portable O2 tank 1L - 2L nasal cannula when outside the room. Related to Respiratory failure. noc O2 Sat: am O2 Sat: pm O2 Sat. [sic]</p> <p>- 12/20/24 through 12/31/24 had seven occurrences out of 33 entries, showed professional nursing staff documented the oxygen levels delivered exceeded the prescribed maximum of two liters per minute.</p> <p>During an interview on 3/25/25 at 10:28 a.m., staff member D stated nursing was the only discipline allowed to change oxygen levels on the residents' oxygen concentrators or portable tanks. She stated a nurse would need new provider orders to change a resident's oxygen rate of flow, if it was outside the existing order parameters. Staff member D stated oxygen was considered a drug.</p> <p>During an interview on 3/25/25 at 10:38 a.m., staff member G stated a nurse needed provider's orders to change the rate of flow for a resident's oxygen.</p> <p>During an interview on 3/25/25 at 1:10 p.m., staff member A stated nurses were to always follow the provider's orders for the delivery rate of oxygen.</p> <p>Review of the facility document titled, Oxygen - Appropriate Use, Management and Storage, last revised 1/25, showed:</p> <p>- . 1. Oxygen Orders:</p> <p>- a. Treat oxygen as a medication. As with any drug, continuously monitor the dosage or concentration of oxygen and routinely check the provider's orders to verify that the patient is receiving the prescribed oxygen concentration.</p> <p>- . 2. Oxygen Management:</p> <p>- . b. The licensed nurses MUST follow a physician order for oxygen delivery.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>41951</p> <p>Based on observation, interview, and record review, the facility failed to ensure a portable oxygen tank was replaced when the metered volume was empty, with the resident's oxygen saturation at 86%, for 1 (#6); and failed to ensure licensed nursing staff documented provider notification, nursing assessments, and/or nursing interventions of resident's oxygen saturation levels below the parameters set forth in written orders of 90% for 2 (#s 5 and 6) of 3 sampled residents receiving supplemental oxygen. Findings include:</p> <p>1. Resident #6</p> <p>During an observation on 3/24/25 at 11:17 a.m., resident #6 was seated in her wheelchair, in the hallway, outside of her room. Resident #6 had a portable oxygen tank attached to her chair, which showed the pressure gauge needle at approximately 1,500 psi.</p> <p>During an interview on 3/24/25 at 12:33 p.m., staff member D stated all staff were responsible for checking the oxygen levels on the resident's portable oxygen tanks. Staff member D stated, regarding the pressure gauge of the oxygen tanks, when the needle on the gauge was in the red, the tank needed to be replaced. She stated if the needle on the oxygen tank was close to the red area, she would make a mental note to continue to check the gauge constantly. Staff member D stated if the needle on the gauge was really close to the red area and she was afraid the tank would run out, she would just go ahead and change out the oxygen tank.</p> <p>During an interview on 3/24/25 at 12:51 p.m., NF1 stated he had seen resident #6's portable oxygen tank empty (with the needle of the gauge in the red) several times. NF1 stated he was very worried about resident #6's oxygen levels, with readings as low as 74%, and the facility not changing out her portable oxygen tank when it was empty. NF1 stated he had taken his concerns to the administration of the facility.</p> <p>During an observation on 3/25/25 at 8:00 a.m., resident #6 was seated in the dining room for breakfast. Resident #6's portable oxygen tank needle read approximately 1,000 psi on the gauge.</p> <p>During an interview on 3/25/25 at 8:28 a.m., staff member C stated the staff check the oxygen levels on the resident's portable tanks constantly.</p> <p>During an observation on 3/25/25 at 10:00 a.m., staff member A was changing out residents' portable oxygen tanks in the common/activity area of the facility.</p> <p>During an observation on 3/25/25 at 10:10 a.m., resident #6's portable oxygen tank's needle was at the bottom of the red area, on empty. Staff member C was asked about the empty tank and stated they (staff) would change the tank. Staff member C used the pulse oximeter to read resident #6's oxygen level, which was 86%.</p> <p>Review of resident #6's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- . Entry Date: 11/22/2024 RESPIRATORY TREATMENT: Apply oxygen O2 Saturation 2L continuous (per nasal Cannula) r/t heart failure to keep O2 sat > or equal to 90 % AM PM NOC noc O2 Sat: am O2 Sat: pm O2 Sat. [sic]</p> <p>- All occurrences and omissions for resident #6, from 11/1/24 through 3/24/25, showed oxygen readings were below 90% or not documented in the record, without any provider notification or documentation of further interventions.</p> <p>- November 2024 showed one occurrence out of 23 entries,</p> <p>- February 2025 showed three occurrences out of 76 entries, and</p> <p>-March (3-1-25 through 3-24-25), showed three occurrences and 20 omissions out of 72 possible entries.</p> <p>Review of resident #6's EHR document, titled Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date 03/25/2024 NURSING ORDER: Check O2 Concentrator or Portable Tank to ensure turned on and at 2L NC AM PM NOC first date: 02/25/2024. [sic]</p> <p>- All omissions for resident #6, from 10/1/24 through 3/24/25, showed no documentation to ensure the oxygen was turned on and set at two liters per minute.</p> <p>- October 2024 showed one omission.</p> <p>- November 2024 showed two omissions,</p> <p>- December 2024 showed six omissions,</p> <p>- January 2025 showed four omissions,</p> <p>- February 2025 showed four omissions, and</p> <p>- As of 3/24/25, March 2025 showed nine omissions.</p> <p>2. Resident #5</p> <p>During an observation on 3/24/25 at 11:33 a.m., resident #5 was seated in the dining room. Resident #5 was receiving supplemental oxygen, via nasal cannula, from a portable oxygen tank.</p> <p>Review of resident #5's EHR document titled, Treatment Administration Record (Summary Report), printed 3/25/25, showed the following order and documentation:</p> <p>- . Entry Date: 03/12/2024 RESPIRATORY TREATMENT: Oxygen 1lpm via NC to maintain SpO2 >90% for hypoxemia.at bedtime NOC noc O2 Sat: AM am O2 Sat: PM pm O2 Sat. [sic]</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- All occurrences for resident #5 for September 2024 through January 2025, showed licensed nursing staff failed to document any provider notification, nursing assessments, and/or nursing interventions of resident's oxygen saturation levels when they fell below 90%.</p> <p>- September 2024 showed five occurrences out of 89 entries,</p> <p>- October 2024 showed six occurrences out of 90 entries,</p> <p>- November 2024 showed 15 occurrences out of 88 entries,</p> <p>- December 2024 showed seven occurrences out of 91 entries, and</p> <p>- January 2025 showed seven occurrences out of 86 entries.</p> <p>During an interview on 3/25/25 at 10:25 a.m., staff member F stated she checked the resident's vital signs, including oxygen levels. She stated if a resident had a oxygen level below 90%, she would report the reading to the nurse.</p> <p>During an interview on 3/25/25 at 10:28 a.m., staff member D stated CNAs checked resident's vital signs. She stated if any part of the vital signs were outside of the resident's normal, the CNAs would report to the nurse. Staff member D stated if the resident's oxygen level readings were below 90%, then an assessment would be completed, notification to the provider, and what interventions were performed, all documented in the resident's record.</p> <p>During an interview on 3/25/25 at 10:38 a.m., staff member G stated resident's portable oxygen tanks were checked each shift to make sure oxygen levels were correct. Staff member G stated we (staff) periodically check tank oxygen levels and some residents will tell staff when their oxygen is empty. Staff member G stated nurses and CNAs checked vital signs. She stated a CNA would report to their nurse if a resident's oxygen level was below 90%. Staff member G stated if a resident's oxygen level was below 90%, she would check to see why the oxygen was low and would call the provider for further interventions. Staff member G stated she would chart on the resident's oxygen levels exception in their record.</p> <p>During an interview on 3/25/25 at 12:28 p.m., staff member A stated CNAs did vitals, which was written on the CNA sheet, which was part of the care plan. Staff member A stated if vitals were outside of the normal, the CNA would report to the nurse. She stated the nurse would then further assess the resident and the provider would be notified of changes in the oxygen levels. Staff member A stated the vitals, assessment completed, notification to the provider, and any interventions should be documented in the resident's record.</p>		