STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275122	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Nursing Home	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect a vulnerable resident from non-consensual sexual contact by a resident #22, who had a with a history of sexually inappropriate behaviors, for 1 (#1); and failed to monitor physical and psychosocial harm for 1 (#18) after an incident of abuse by resident #43, of 5 residents sampled for abuse by another resident. This failure resulted in resident #1 having her breast groped and bruising to resident #18's head and neck. Findings include:1. Review of a facility-reported event submitted to the State Survey Agency on 7/22/25, showed resident #22 was observed with one hand holding up resident #1's shirt while holding her breast with his other hand. During an observation and interview on 5/5/26 at 1:22 p.m., resident #22 was standing alone in the sitting room staring at the TV. Resident #22 stated he . touched someone's breast, and I am not allowed to do that. I have been good now. During a telephone interview on 5/5/26 at 1:40 p.m., NF1 stated he observed resident #22 lift resident #1's shirt with one hand while holding resident #1's breast with the other hand. NF1 stated when resident #22 saw him, he quickly removed his hand, and NF1 immediately removed resident #1 from the area. NF1 stated, He (resident #22) definitely knew his behavior was wrong. During an interview on 5/5/26 at 2:12 p.m., staff member A stated resident #1 was unaware of the incident, and no post-event psychosocial assessments were completed because she believed they were unnecessary, as the resident did not remember the incident. Staff member A stated if resident #1 showed behavior changes, it would have been documented in the nursing progress notes. Staff member A stated she was more worried about resident #22 than resident #1 after the incident. Staff member A stated resident #22 was issued a formal discharge; however, the resident remained in the facility due to placement challenges. Staff member A stated the facility immediately implemented interventions to prevent a future sexual incident, including escorting resident #22 to common areas and ensuring a six-foot distance from female residents. During an interview on 5/6/26 at 2:08 p.m., staff member H stated, [Resident #1] passed away in September last year. She was usually just pleasantly confused. Staff member H also stated resident #22 had a history of sexually inappropriate behavior toward female residents, which included long periods of stability where staff had no concerns, followed by periods of sexually inappropriate behavior. Staff member H stated since the 7/22/25 incident, nursing staff had been documenting inappropriate behavior for resident #22 once per shift, and CNAs were monitoring the resident's location once per hour. Staff member H stated no additional incidents had occurred. Staff member H stated she did not recall if any new interventions were implemented for resident #1 after the 7/22/25 incident. (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Nursing Home	3131 Amherst Ave Butte, MT 59701

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/7/26 at 1:13 p.m., NF2 stated after the 7/22/25 incident, resident #22's physician adjusted the resident's risperidone (antipsychotic) dose and added estradiol (estrogen) to reduce sexual behaviors. NF2 stated resident #22 had been on estradiol a couple of different times over the last couple of years for similar instances. Review of resident #1's Quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 7/18/25, showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of an incident report for resident #1 dated 7/22/25 showed special care remarks included, . redirect away from male resident [resident #22 initials] to at least six feet. Review of resident #1's electronic health record (EHR) did not show documentation of psychosocial evaluations related to sexual abuse. The EHR also did not show documentation of follow-up nursing progress notes, new tasks or interventions, or care plan updates pertaining to the 7/22/25 sexual abuse incident. Review of resident #22's quarterly MDS assessment, with an assessment reference date of 4/28/25, showed a Brief Interview for Mental Status score of 15, indicating intact cognition. Review of resident #22's physician progress note dated 4/2/25 showed the following diagnoses: paranoid schizophrenia, sleep disturbance, hypersexuality, and dementia without behavioral disturbance. Review of a facility social services note dated 7/23/25 at 3:37 p.m., showed, . I have contacted the police and they will be coming to serve him (resident #22) a ticket this afternoon and that we will need to issue him a discharge notice and try to get him transferred to another facility that is willing to provide this level of supervision ongoing, as we will not be able to provide it ongoing. [sic] Review of the facility's investigative documentation provided on 5/5/26 for the 7/22/25 sexual abuse incident showed staff and residents were asked whether they had witnessed a resident attempt to touch another resident inappropriately within the prior two weeks. The facility's investigative documentation also included a document titled 5 day follow up 7/25/25, which showed, Interviewed other residents and staff if they have ever seen anyone inappropriately touching or been touched by anyone in the facility and none had. 2. During an interview on 5/6/26 at 10:24 a.m., staff member F stated if resident #43 was tired, he would yell leave me alone. Staff member F stated the resident would reach out aggressively to staff when they were doing cares in pairs. Staff member F stated the resident was able to move his arms and legs. Staff member F stated the resident used to sit in the assisted dining room but eats in his room now because he hit other residents. During an observation on 5/6/26 at 12:45 p.m., resident #43 was seated in a wheelchair eating the afternoon meal in his room. At 12:46 p.m., staff member B entered the resident's room and assisted the resident with eating. During an interview on 5/6/26 at 1:36 p.m., resident #18 stated, . [abuse incident] has been a while ago. He (resident #43) doesn't eat in the dining room. He (resident #43) hit me as hard as he could. It hurt. He (resident #43) does that. He punches people . randomly. They stopped him (resident #43) from (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coming to the dining room. I don't have any more concerns. I feel safe. During an interview on 5/6/26 at 5:13 p.m., staff member B stated the facility followed up with resident #18. Staff member B stated resident #18 had not remembered the incident or it had not bothered him. Review of a facility reported incident, submitted to the State Survey Agency on 1/3/26, showed resident #43 was in the assisted part of the main dining room eating the morning meal. While staff had their back to him, resident #43 was able to move his wheelchair with one leg over to where resident #18 was seated and hit him in the neck and head. Resident #43 was removed from the dining room, away from other residents. Resident #43 had become agitated. Resident #43's care plan was updated to reflect the resident was to eat in his room if agitated or the activity room away from others if he was pleasant. Resident #18's care plan was updated to reflect the resident was to be seated away from resident #43. Resident #18's skin was checked for injuries and neurological checks were completed. Resident #18 had not shown any marks related to the incident. Review of the investigative findings, dated 1/8/26, showed resident #43's care plan was updated with interventions to eat in his room or the activity room depending on his mood and if there are other residents around. The resident was to have supervision during meals. He was also to be kept at least six feet away from other residents. The physician reviewed and made changes to the residents' medications. Review of a document, no title, dated 1/3/26, by staff member A showed three residents were interviewed regarding the incident and all three said they had never seen anyone kicked or hit prior to this incident. All three residents felt safe in the facility and had no concerns. The facility did not interview any other residents regarding abuse. Review of a facility document titled Continuing Education Record-Group, dated 1/3/26, showed education was completed for all staff on abuse and the reporting policy on 1/3/26 or before their next shift. Review of nursing progress notes dated 1/3/26, showed resident #18 was assessed with no abnormal physical findings. Review of resident #18's nursing progress notes for follow up after the incident, showed the following dates were documented as follow up to the incident 1/6/26, 1/8/26 and 1/9/26. On 1/6/26 there was a bruise on the back of the resident's neck which measured 6.3 cm X 5.2 cm. The facility had not documented daily physical and psychosocial assessments. There was one interview in which resident #18 stated he was doing fine. Review of a facility policy titled Resident Safety Abuse Policy, revised 2/22, showed: Providing a safe environment is one of the most basic and essential duties of the facility . Residents have the right to be free from abuse by anyone . Sexual abuse is non-consensual sexual contact of any type with a resident .