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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Crest Nursing Home | 3131 Amherst Ave<br>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.

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to ensure a Director of Nursing (DON) worked full-time (defined by CMS as 40 hours or more per week) as the Director of Nursing. This failure increased the risk of negative outcomes for all residents. Findings include:During an interview on 5/4/26 at 12:30 p.m., staff member A stated the facility employed a full-time Director of Nursing and did not have any nurse staffing waivers in place.During an interview on 5/7/26 at 10:20 a.m., staff member B stated she is the infection preventionist and also the DON. Staff member B stated she dedicated 20 hours per week to infection control and the rest of her time to director of nursing responsibilities. During an interview on 5/7/26 at 11:40 a.m., staff member A stated staff member B could complete all her DON duties and infection control duties within a 40-hour work week due to the size of the facility and the low census. Staff member A stated staff member B never went into overtime. Staff member A stated they had always combined DON and infection control duties. Review of a letter provided by the facility with a date of 5/8/26, showed: If the DON requirement is only 35 hours, and if she spends 20 hours a week on Infection Prevention, that leaves 15 hours fully dedicated to other things. [sic]Review of the facility's Facility Assessment with a revision date of 2/11/26, showed: .Facility Resident Population: 1.1 Number of residents as of date of facility assessments completion: 44 .Administrative nurses: Infection control - tracking and trending, employee health, outbreak management Regulatory requirements Employee Health Quality Assurance/performance Improvement, Staffing and supply control including cost management MDS and quality measure information, five star ratings Pharmacy recommendations and consultant reports MD communications and Medical director communications Nurse Practice Act Resident's rights Fire safety Abuse identification, prevention and reporting Customer service .3.2 Position: .Other nursing personnel (e.g., those with administrative duties), MDS/CP RN, Director of Nursing. [sic]The facility assessment showed only two administrative nurses covering the facility's administrative nursing responsibilities.Review of a facility document titled Job Title: Director of Nursing Services, undated, showed: Summary: Responsible for the administration of the health care facility to maintain standards of resident care, and advises Department Heads, and the Administrator in matters related to nursing service by performing the following duties personally or through subordinate supervisors.Essential Duties and Responsibilities include the following. Establishes and implements an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. [sic] The job description did not show the Director of Nursing position was a dual position and the DON would also be required to fulfill the Infection Preventionist role. |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to revise a care plan to include interventions that were effective in monitoring the bed rails for a resident's ongoing use of the rails, for 1 (#43) of 15 sampled residents. This failure caused the staff to provide inconsistent reasoning for the use of the bed rails. Findings include:During an observation on 5/6/26 at 10:03 a.m., resident #43 was observed in bed with upper and lower bed rails in place. Both upper and lower bed rails had open areas for potential entrapment of arms, and there was space between the upper and lower bed rails which could have the potential for entrapment of a limb.During an interview on 5/6/26 at 10:17 a.m., staff member F stated all four rails were to be up while resident #43 was in bed. Staff member F stated the bed rails help with repositioning. Staff member F stated there was always someone in the resident's room during repositioning. During an interview on 5/6/26 at 1:36 p.m., staff member C stated bed rails were part of the MDS assessment, and interventions should be on the care plan. Staff member C stated bed rails should be reassessed when there is a change in condition, general nursing assessment, and should be a part of the quarterly assessment.During an interview on 5/7/26 at 8:35 a.m., staff member H stated staff member G was responsible for assessing the need for upper bed rails. Staff member H stated staff member G would add bed rails and interventions into the care plan.During an interview on 5/7/26 at 10:14 a.m., staff member B stated the bed rails should be assessed every quarter and as needed. Staff member B stated the interventions should be reviewed and revised at least quarterly. Staff member B stated the care plan showed the staff was to observe to ensure the bed rails were up.Review of resident #43's care plan, dated 11/24/25, showed the potential for sleep pattern disturbance, with difficulty falling asleep and early morning awakening. Interventions included the use of rails on the bed, . to decrease the resident fall with increased agitation.Review of resident #43's care plan, dated 1/3/26, showed potential for disruptive interaction, aggression, and/or agitation. Interventions include . use side rails on the bed to decrease falls to the floor with agitation.Review of resident #43's care plan, dated 1/28/26, showed potential for trauma and falls with injury. Interventions included, . use side rails on bed to decrease risk of fall to floor with agitation. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>Based on observation, interview, and record review, the facility failed to ensure bed rails were assessed for entrapment, assessed for other alternatives, failed to ensure the bed rails had a documented medical rationale for the use of the bed rails, and failed to have a physician-signed order for the bed rails for 1 (#43) of 15 sampled residents. The failure placed the resident at risk for entrapment or injury from the use of bed rails. Findings include:During an observation on 5/5/26 at 4:30 p.m., resident #43 was lying in bed with full upper and lower bed rails on both sides of the bed.During an observation on 5/6/26 at 10:03 a.m., resident #43 was observed in bed. He was sleeping with his head tilted to the right with the head of the bed elevated. There were open areas on the upper and lower rails potentially creating a risk for entrapment. There was space between the upper and lower rails, potentially creating a risk for entrapment.During an interview on 5/6/26 at 10:17 a.m., staff member F stated resident #43 was to have all four rails up while in bed. Staff member F stated resident #43 was evaluated by physical therapy. Staff member F stated there was always someone in the room during repositioning. Staff member F stated the resident could possibly reposition himself. Staff member F stated the nurse signed with the POA on the consent form for only the upper bed rails.During an interview on 5/6/26 at 4:59 p.m., staff member B stated resident #43 suffered from a traumatic brain injury which caused aggressive behavior and was not easily redirected. Staff member B stated the rails on the resident's bed were to keep him from falling off the bed. Staff member B stated the goal was to get the resident stronger through physical therapy so he could go home.During an interview on 5/7/26 at 7:49 a.m., staff member B stated the resident used the rails for repositioning.During an interview on 5/7/26 at 8:35 a.m., staff member G stated she was the one who had done the assessment for resident #43's upper bed rails. Staff member G stated nursing completed the assessment for the lower bed rails. Staff member G stated she signed consent with resident #43's family member for the upper rails.During an interview on 5/7/26 at 10:14 a.m., staff member B stated the bed rails should be assessed every quarter and/or as needed. Staff member B stated all staff members should check the bed rails on every round. Staff member B stated nursing completed the lower rail assessment and they conferred with physical therapy. Staff member B stated there should be a physician order for the use of the bed rails. Staff member B stated resident #43 was impulsive and kicked his legs a lot which caused a risk for falls. Staff member B stated the bed rails were for safety reasons.The facility failed to consistently identify a reason for the use of the bed rails and failed to ensure staff were aware of a documented reason for the bed rails. Review of resident #43's care plan, with a current date of 1/28/26 for the bed rails showed the facility documented inconsistent reasons for the bed rails.Review of resident #43's bed rail consent forms showed one was signed by the DON and the resident's family member on 10/29/25 for the lower rails, and one was signed by physical therapy and the POA on 10/31/25 for the upper rails. The consent form, dated 10/29/25, showed the indication for lower rail use was, for TBI, impulsive, agitation, request of family. The consent form, dated 10/31/25, showed the indication for upper rail use was, for ^ (increased) bed mobility. [sic] Resident #43's care plan, dated 11/24/25, 1/3/26, and 1/28/26, failed to show alternative interventions for the rationale to continue the use of the bed rails.Review of resident #43's bed rail assessment, dated 10/30/25, showed the rails were for . assistance with bed mobility, to prevent rolling and falling out of bed, and for comfort and security. Plan . device appropriate, obtain consent and obtain order. Review of resident #43's care plan showed: . -11/24/25 Problem; Potential for sleep pattern disturbance and difficulty sleeping with early awakening.Use side rails on bed to decrease risk of fall with increased agitation.-1/3/26 Problem; Potential for disruptive interaction, aggression and/or agitation.Use side rails on bed to decrease resident falling to the floor with agitation.-1/28/26 Problem; Potential for trauma and falls with injury.Use side rails on bed to<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | decrease risk of fall to floor with agitation.The facility failed to provide a signed physician order for the bed rails, failed to complete an assessment for potential entrapment, failed to document a rationale for the use of the bed rails, and failed to document alternatives used prior to use of bed rails. |

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| F 0801<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on interview and record review, the facility failed to ensure the director of food and nutrition services met the education qualifications required by CMS for a food service director and failed to employ a full time Dietician, which increased the risk of negative outcomes to residents receiving food from the dietary department. Findings include:During an interview on 5/5/26 at 3:09 p.m., staff member E stated she did not have a dietary manager certification. Staff member E stated she had not enrolled or completed an approved dietary manager certification course. Staff member E stated the dietician came to the facility once every two weeks to evaluate the residents. Staff member E stated she would call the dietician if she had questions or concerns. During an interview on 5/6/26 at 1:22 p.m., staff member A stated that staff member E had not completed a dietary manager certification course but had five years of experience in dietary management before being hired in 2024. Staff member A stated she had been under the impression that staff member E's prior experience was enough to meet the CMS requirement for dietary managers. Staff member A stated the dietician visited the facility twice a month, and the facility has a remote dietician who assisted with menus and other dietary duties. Staff member A stated the facility did not employ an onsite full-time dietician.Review of staff member E's education provided by the facility showed staff member E had completed continuing education hours in multiple different areas but failed to show staff member E had completed a certified dietary manager course. Review of a facility document titled Job Title: Food Service Manager showed: .Qualifications Requirements: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Certificates, licenses, registrations: Successful completion or current enrollment in a course approved by American Dietetic Association. [sic] |