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

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 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. 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 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: - . 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.