

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Glendive Medical Center N H		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Prospect Dr Glendive, MT 59330	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to report allegations of resident abuse to the State Survey Agency within 24 hours of the incident for 2 (#s 13 and 34) of 15 sampled residents. Findings include: Review of the facility reported incident dated 9/11/24 at 8:40 a.m., showed a resident representative reported to social services resident #13's roommate (resident #34) had been making resident #13 feel uncomfortable by rubbing resident #13's thigh and groin area. The allegation of resident-to-resident abuse was not reported to the State Survey Agency until 9/11/24. During an interview on 9/11/25 at 8:10 a.m., staff member D stated she received a call from resident #13's representative on 9/11/24 requesting a potential room change for resident #13. Staff member D stated the residents representative stated resident #13 had felt uncomfortable with her roommate (resident #34) due to unwanted touching of resident #13's leg. Staff member D stated it was then reported to the State Survey Agency on 9/11/24. Staff member D stated during the facility's investigation it was found resident #13 reported the unwanted touching by resident #34 to a nurse on 9/8/24. Staff member D stated she did not know why the facility reported incident was not reported to the State Survey Agency within 24 hours from the event which occurred on 9/8/24. During an interview on 9/11/25 at 10:35 a.m., staff member B and E were present. Staff member B stated the incident involving residents #13 and 34 on 9/8/24 was not reported to the State Survey Agency within 24 hours because the nurse failed to report the incident to administration. Staff member B stated social services spoke to resident #13's representative on 9/11/24 at which time she was first made aware of the incident which occurred on 9/8/24. Staff member B stated the facility then reported the incident to the State Survey Agency on 9/11/24. Review of resident #13's nursing progress note dated 9/8/24 at 5:00 p.m., showed resident #13 stated to the nurse her roommate (resident #34) rubbed her leg and asked the nurse to talk to her (resident #34). Resident #13 then came down the hallway an hour later and reported to the nurse in a low tone of voice her roommate (resident #34) had touched her leg again. Review of the facility's policy titled, Resident Abuse, last revision dated 2/14/25, showed: . SUBJECT: RESIDENT ABUSE it will be the responsibility of any department head receiving the complaint of alleged abuse, corporate punishment, involuntary seclusion, neglect, mistreatment, misappropriation or resident property, or exploitation to inform the administrator or designee immediately. REPORTING 1. Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property or reasonable suspicion of a crime against a resident or an individual receiving care from the facility will be immediately reported. Collective reporting may occur, which means, that a staff member will report it to SS, DON, ADON or Administrator and those individuals will notify the state, however, it is the covered individuals responsibility to follow up and assure the suspect or known abuse/crime was reported timely. [sic]</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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>Based on interview and record review, the facility failed to complete a Significant Change minimum data assessment within fourteen days after the facility identified a major decline in 1 (#6) of 15 sampled residents. The decline had the potential to impact the resident's physical and health status. Findings include: Review of resident #6's nursing note, dated 6/28/25 at 4:04 p.m., showed resident #6 was diagnosed with a non-displaced tibial plateau fracture. The resident was to wear a knee immobilizer and was non-weight bearing for two to three months. Review of resident #6's MDS, with an assessment reference date of 5/8/25, showed the resident needed partial to moderate assistance with performing oral care, getting herself on and off the toilet, showering, removing her footwear, personal hygiene, toilet transfer, transfer from bed to chair, and moving from a sitting to a standing position. Comparing the minimum data assessment with an assessment reference date of 7/17/25, showed the resident had declined and needed substantial to maximum assistance. During an interview on 9/11/25 at 9:30 a.m., staff member C said she had been completing the minimum data assessments for about one year. Staff member C said she had been trying to educate herself with online training. Staff member C said she had not completed all the training yet. Staff member C said she now knows that you have two weeks to set the assessment reference date for a resident who had a significant change in condition. Staff member C said the Significant Change minimum data set assessment reference date was not set on time, and the minimum data assessment was late.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review, the facility failed to ensure social services were provided to assist 2 (#s 19 and 26) of 15 sampled residents with emotional and psychosocial support following allegations of abuse. The deficient practice had the potential to cause emotional distress for the residents. 1. Review of a facility reported event, submitted to the State Survey Agency, on 10/4/24, showed resident #19 was spoken to harshly by a staff member. Review of resident #19's medical record progress notes, dated 10/4/24 through 10/25/25, failed to show any allegations of abuse, and there was no follow-up to the alleged incident of a staff member talking harshly to resident #19. There were not social service notes to determine if the resident had any negative outcomes from the event or if the resident was comfortable with care provided by the staff member. 2. Review of resident #19's nurse's note, dated 10/6/24 at 4:40 a.m., showed the resident was picking frequently at the skin on her face and chest, causing open areas. The behavior was difficult to direct. There were no social service notes to show what was done for resident #19's psychosocial health and to help identify the cause of the behavior or if it was in relation to the recent allegation of staff to resident abuse. 3. Review of the facility reported incident, submitted to the State Survey Agency, on 12/18/24, showed resident #26 was handled roughly during a transfer. No progress notes were found or provided showing social services followed up with the resident after the allegation where she was treated roughly. During an interview on 9/10/25 at 9:10 a.m., staff member E said there should be a note documenting the residents had been followed by social services after an allegation of abuse. Staff member E said she would expect a social services note to identify how the residents were doing. Staff member E said she had heard the staff discussing how the residents were doing but would guarantee there probably isn't a note. During an interview on 9/10/25 at 9:15 a.m., staff member D said she followed up with resident #26 after her rough treatment. Staff member D said she should have completed a psychosocial assessment after an allegation of abuse. Staff member D said a note should be documented in the medical record showing how the resident was doing following the event.</p>