STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275070	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Memorial Nursing Home	440 W Laurel Ave Plentywood, MT 59254

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40068 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopements resulting in a fall with injury for 1 (#1) out of 1 sampled resident. Findings include: Review of a facility incident for resident #1 dated, 5/29/24 showed, .Resident (#1) eloped from the facility. Resident fell out of w/c in the street outside the building and received injuries to his head. Facility was not aware resident had eloped from the building . Incident Description: Resident was attempting to get onto elevator prior to elopement .Staff that were downstairs outside came up the stairs and informed us that one of our residents were downstairs. Staff down immediately to assist. Resident had fallen out of his wheelchair into the street .Noted bleeding and hematoma to his R upper eyebrow. Superficial rash to hairline .On call provider to unit to assess resident . Findings .The resident went down the elevator to door B4 and exited out as another person entered the building. The resident fell out of their chair in the road next to the curb. A right-side facial injury was noted, laceration above the eye, abrasion on the hairline and bruising .Resident had been outside earlier with staff due to restlessness and wanted to go to the garage .Can be a 1:1 situation at times .Restlessness interventions: Quotes on wander guard system, Risk and Maintenance will gather information. Rounding on the residents and offering the patio, also offer recliner more if they are restless. A new wander guard was placed in the wheelchair .[sic] Review of the document Office/Clinical Notes after resident #1's fall dated, 5/29/24 showed, .History of Present Illness .patient with a fall outside from his wheelchair. He did partially catch himself but landed downward with one side of his face (right side) making contact with the ground. Patent reports he did not lose consciousness. He feels shaken up but fine .sustained a right-sided upper facial contusion .Skin abrasion was noted but no need for sutures or staples . During an observation and interview on 6/11/24 at 10:45 a.m., resident #1 was in his wheelchair ambulating independently on the unit. Resident #1 stated he was from Medicine Lake and his wife visited him frequently. He stated he liked to go outside. Resident #1 had a healed abrasion above his right eye. (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 - Few	During an interview on 6/11/24 at 11:02 a.m., Staff member D stated resident #1 has eloped multiple times from the facility prior to the elopement on 5/29/24 but would elope to the hospital, which was connected by a set of doors. Staff member D stated he was very restless and had periods of confusion. Staff member D stated resident #1 had owned a bar and often wanted to leave and have a beer. Staff member D stated resident #1 was very observant and learned how to turn off the chirper on the door leading to the hospital. Staff member D stated his wheelchair has a roam alert band attached to it, and sometimes the roam alert system did not work correctly. The facility was looking into getting a new system. Staff member D stated the staff try to engage resident #1 in activities, but he usually was not interested. He liked to watch TV and would sit in a recliner for a bit. During an interview on 6/11/24 at 11:25 a.m., staff member B stated, each internal hallway door, including the doors to the hospital have a chirper on the door. Staff member B stated the chirper made a loud noise when the door was opened. This chirper could be turned off with a key. Staff member B stated the key to the chirper was always left in the key slot so anyone could turn it off. Staff member B stated the external door, which was also the main door to the building had a Roam Alert System staff member B stated it was a delayed egress system that would initiate if a resident had a wander guard bracelet on. The door would lock for 15 seconds, then open. This allowed staff members to stop residents with the wander guard on or before they exit the facility. Staff member B stated resident #1 was admitted to the facility almost a year ago with a broken neck. Since then, he had been rehabilitated and was mobile. Staff member B stated he has periods of confusion and becomes restless. Staff member B stated resident #1 had a friend in the hospital a few months ago and he would be taken over to visit. Staff member B stated she believed that is what started the elopements. Resident #1 learned how to turn off the chirper on the door by turning the key to the off position. Then on 5/29/24 he eloped down the elevator and out the main door to the parking lot and fell . Staff member B stated it was hard to create interventions because he was unpredictable, fast, and intermittently confused. Staff member B stated the facility did not know how to evaluate his confusion because it would come and go. Staff member B stated he was able to get to the main door before the wander guard system had time to initiate and lock. Staff member B stated the facility did not foresee resident #1 eloping out of the building until he did so on 5/29/24. Review of resident #1's Admission Elopement Risk assessment dated , 8/17/23 showed, he was at risk of elopement. Review of resident #1's Roam Alert Sensor assessment dated , 2/22/24 showed, the roam alert sensor was placed on 8/22/23. During an interview on 6/11/24 at 12:10 p.m., staff member C stated, I watched back the video and he (resident #1) got in the elevator with a visitor and went down the elevator and caught the main door right before it was going to latch and exited the building. Staff member C stated 5/29/24 was a Wednesday and the VA is open that day so there was a lot of visitors in and out of the building. Staff member C stated she thought resident #1 exited the building when staff members were pre-occupied. Staff member C stated the Roam Alert System did alarm, but staff get used to hearing the alarm and do not react. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 12:50 p.m., staff member B stated, right before the elopement on 5/29/24 resident #1 tried to get out of the facility multiple times. Staff member B stated she took him outside before the elopement because he was restless. Staff member B stated after taking him outside, she caught him three times trying to go down the elevator. Staff member B stated it would have been beneficial to have more supervision for resident #1 knowing he was restless and was actively attempting to elope. A Review of Nursing Progress for resident #1 dated, 5/31/24 showed, Elopement on 5/29/24 14:15 the resident went down the elevator to door B4 and exited out as another person entered the building .Residents had been outside earlier with staff due to restlessness and wanted to go to the garage .During the (staff job titles) were doing checks of the wander guard since the resident was attempting to get out. Can be a 1:1 situation at times. .1245 - Resident has been restless, roaming the halls, attempting to get on the elevator .We went downstairs to look for his garage, we went outside. Resident saw his garage was not there. He seemed content .1330 staff tried to redirect him to another activity without success .resident continues to be restless and up and down the halls. Staff on unit are aware he is very active and mobile and to keep an eye on his as much as possible Resident attempting to make his way on the elevator x3 even after staff try and redirect. Two of the incidents he was witnessed by the staff, but the roam alert system did not engage .New roam alert monitor received from purchasing. Checked and put on wheelchair .1415 Staff that were downstairs outside came up the stairs and informed us that one of our residents were downstairs . [sic] Review of a facility reported incident for resident #1 dated, 6/6/24 showed, Hospital called to notify nursing home that resident was in the Atrium by the stairwell-hospital. Resident brought back to nursing home by hospital staff. Resident stated he got out the north doors and that the alarm did not go off .Resident is a poor historian and wasnt able to state what he was doing/wanting. He has fluctuating confusion and isn't always able to express needs/wants. No injuries were sustained. No medical treatment was needed. Immediate interventions included: calling (staff job title) to check on roam alert system . Review of the after action meeting documentation dated, 6/10/24 for resident #1's elopement on 6/6/24 showed, .Risk is currently looking at 2 companies we currently use in the facility for updated wander guard system for the nursing home .Resident had exited out the same door on 5/29/24 and a letter was sent to the spouse explaining out capabilities and concerns with their ability to find a way to exit the building. They have not brought their concerns back, that was sent on 6/3/24 . (staff names) express concern with the 1:1 needed and what additional intervention. Intervention: When the resident gets agitated and wants to leave set up the TV or iPad with old sports games. Set up a mini bar so they can serve drinks. It is important to contact (name of staff) that there may be a need for just a 1:1 staff with resident at this time . During an interview on 6/11/24 at 2:50 p.m. staff member B stated the facility did not have a protocol for what 1:1 supervision was. Staff member B stated it is the discretion of the nurse on shift. Staff member B stated the facility should have a protocol for what 1:1 supervision was. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's current care plan showed, .Elopement on 5/29/24 14:15 the resident went down the elevator and exited out as another person entered the building .Can be a 1:1 situation at times .Interventions: Quotes on wander guard system, .risk management will gather information, rounding on residents and offering the patio, also off recliner more even if they are restless, a new wander guard was placed in the wheelchair Elopement 6/6/24 resident eloped down the elevator and though door B4 .Staff educating resident to ask for help if he wants to go outside. Resident verbalizes understanding but he does not always remember that you told him. Will continue to educate throughout the day. Resident often is looking for a beer or trying to get out to go to the bar .Orders placed: resident may have 2 non-alcoholic beers a day after lunch. [sic] Review of the facility's policy and procedure titled, Elopement with a revision date of, 6/28/23 showed, . Definitions: Elopement - occurs when a patient/resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Elopement can be purposeful or accidental .Policy: It is the policy of (Name of Hospital Association) to provide a safe environment for our wandering patient/residents and to reduce the risk of elopement.