STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	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 ensure a resident was free from abuse and neglect of care needs for 1 (#1) of 3 sampled residents. The deficient practice resulted in the resident feeling worthless, anxious, confused, and feeling like she was being punished. Findings include: Review of a Facility-Reported Incident, dated 3/7/26, showed resident #1 reported she was forced to remain in a recliner in the day lounge rather than in her bed. The resident also stated she was denied water upon request and did not have access to a call light or any other way to summon help if needed. The report also showed that the resident repeatedly expressed feeling as if she was being punished for something.During an interview on 4/8/26 at 8:28 a.m., staff member H stated she was assigned to care for resident #1 on the day shift on 3/7/26. Staff member H stated resident #1 was in a recliner in the day lounge when she came on shift on the morning of 3/7/26. Staff member H stated resident #1 was sitting in a recliner, which was unusual for her. The staff member stated that resident #1 was usually in her bed when the day shift started. Staff member H stated while receiving a report from staff member M, staff member M stated, She (resident #1) doesn't get any water because she would need to get up. This comment was made in front of several staff members (H, J, M, and N) and resident #1. Staff member H stated she did not see any water near the resident in the day lounge. Staff member H stated she and staff member J assisted resident #1 to her room to get her settled into her bed for a while before breakfast. Staff member H stated that resident #1 said her call light had not been answered during the night. Staff member H stated the resident repeatedly thanked the staff for anything they did for her, and the resident seemed more anxious than usual.During an interview on 4/8/26 at 3:45 p.m., staff member J stated that when she came on shift on the morning of 3/7/26, resident #1 was seated in a recliner in the day lounge. While assisting resident #1 from the day lounge to her room, accompanied by staff member H, staff member J described the resident as distraught. She stated the resident said, I don't know why I was treated that way, and repeatedly thanked the staff for helping her and was worried about it (the treatment she received overnight on 3/7/26) happening again. Staff member J stated that resident #1 needed frequent reassurance that it would not happen again.During an interview on 4/9/26 at 7:50 a.m., resident #1 stated she remembered the incident that occurred on 3/7/26. Resident #1 stated the treatment she received during the night shift (from 3/6/26 at 6:00 p.m. to 3/7/26 to 6:00 a.m.) made her feel like she, . was not worth anything .they wouldn't bring me any water .I don't understand why they were treating me that way.Review of resident #1's Facility Reported Event investigative file, dated 3/7/26, showed the following interviews and written statements:- Resident #1, in her transcribed interview, stated, They would not give me any water to drink. Because I get up to many times and I also could not have my call light. They kept me out in that awful room in a chair that was not comfortable. [sic]- Staff member J reported, in her written statement, an allegation of abuse on 3/7/26 which involved resident #1 and staff member M. Staff member J's written statement, dated 3/7/26, showed resident #1 reported she had been told, . not to call for help and had an awful night . did not understand why this happend [sic] to her. (confusion) The resident also kept repeating why she was being punished. - Staff member H reported, in her written statement, that she received a hand-off report from staff (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 Sheridan Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 440 W Laurel Ave Plentywood, MT 59254	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	members M and N, who were sitting on either side of resident #1. During the report, resident #1 requested water, and staff member M told her no because she would have to use the bathroom again. Staff member H reported that staff members M and N laughed in front of resident #1. While assisting resident #1 from the day lounge to her room, assisted by staff member J, the resident told them her . night was terrible, and she was told, . could not use her call light or have an ice pack.- Staff member I reported, via an email statement, she was told (by staff member J) the resident claimed she was told not to use her call light, was refused an ice pack, and was refused water overnight. Staff member I then reported the abuse allegation involving resident #1 to staff member B.- Staff member M, in her transcribed interview, reported she had to redirect resident #1 to use her call light before getting up, rather than after she had finished. Staff member M stated that resident #1 also made a statement about being punished, and staff member M told the resident she did not want the resident to fall. Staff member M stated that resident #1 got up from her bed three times without using her call light until she was finished in the bathroom.- Staff member M, in her written statement dated 3/6/26 (incorrect, should have been dated 3/7/26), showed that after the second time resident #1 got up to the bathroom without using her call light, staff member M stated the resident's emergency bathroom light went off. Staff member M stated the resident was not listening to reason, and she brought resident #1 out to the day lounge just to keep an eye on her.Review of the abuse meeting notes, dated 3/12/26, showed staff members A, B, C, S, and T were in attendance. The following concerns were identified:- Resident (#1) was placed in a recliner in a common area to be watched more closely. The resident asked to return to bed. This was dismissed.- An overbed table was placed across the resident to keep her in the recliner. This could not be corroborated by staff present in the facility.-The resident's walker was moved farther away, limiting mobility.- Resident #1 reported feeling punished.The group determined the incident represented abuse, and it was reported to the State Survey Agency.Review of the facility policy titled Abuse, dated 8/7/25, showed, Purpose: . Each resident/patient has the right to be free from abuse, .and it is the facility's responsibility to prevent not only abuse, but also those practices and omissions, neglect, .that if left unchecked, lead to abuse. Residents/patients must not be subjected to abuse by anyone, including, but not limited to facility staff .

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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 interview and record review, the facility staff failed to use a gait belt when ambulating a resident, resulting in a minor injury, which was a skin tear with tendon exposure to the left fourth digit, requiring only nursing treatment for 1 (#4); and failed to evaluate and modify Interventions to prevent future falls for 3 (#s 2, 4, and 5) of 3 residents sampled for falls. These deficient practices contributed to continued falls for the residents and increased the risk of potential injuries. Findings Include:1. Review of a Facility-Reported Incident, dated 11/4/25, showed resident #4 fell while ambulating with staff member K. Resident #4 was using a rolling walker and was wearing supplemental oxygen. Staff member K turned her back on the resident, and the resident lost her balance, falling backward onto her bottom. The report showed the resident hit her left arm and hand on the door jam and sustained a minor injury, which was a skin tear with tendon exposure on her left fourth finger. The resident was not wearing a gait belt. A dressing was applied by the nurse, and no further medical care was required.Review of a list of resident falls between 10/1/25 and 4/6/26 showed resident #4 sustained unwitnessed falls on 1/17/26, 2/3/26, 2/12/26, and 2/19/26, and a near miss on 11/29/25.Review of resident# 4's nursing progress note, dated 11/29/25, showed the resident was ambulating in the hallway still wearing her oxygen (which was still connected to the concentrator in her room. The resident tripped on the tubing and tipped towards the wall. The note showed a CNA was able to catch her before she fell.During an interview on 4/8/26 at 9:12 a.m., staff member K stated resident #4 always had staff with her when she was walking. Staff member K stated that she always uses a gait belt during resident transfers or walking. Staff member K could not explain why resident #4 was not wearing a gait belt on 11/4/25. Staff member K stated she was behind the resident and turned around to answer a question. While having her back to resident #4, the resident lost her balance and fell backward onto her bottom.During an interview on 4/8/26 at 3:40 p.m., staff member J stated the CNAs were expected to use gait belts for all residents who required assistance with transfers or ambulation. Staff member J said she could not think of a circumstance that would justify not using a gait belt, and every resident had their own gait belt.Review of the Facility's policy titled, Mechanical Lift & Transfer Procedures of Patients/Residents, dated 10/1/25, showed a gait belt was to be used when staff assistance was needed to get a resident out of a chair or bed, when transferring from a wheelchair to the toilet, and to provide support when ambulating. The procedure for using a gait belt included, . E. Properly grasp belt and/or handles of belt for effective use.J. Holding onto the belt and standing a few steps behind the patient/resident, assist patient/resident when walking.2. Resident #2During an interview on 4/8/26 at 12:15 p.m., staff member S stated the MDS nurse was primarily responsible for updating resident care plans.During an interview on 4/8/26 at 1:15 p.m., staff member F stated she was responsible for updating care plans when necessary. When asked how the IDT evaluated the effectiveness of fall interventions, staff member F stated she did not routinely attend the weekly fall meetings. But she believed the post-fall documentation included interventions in place at the time of the fall and any new interventions implemented after a fall. She stated the initial fall incident note was revised to include daily resident status notes for five days after the fall, and any information on causes and new interventions determined by the fall team. Staff member F stated she had not been updating the fall care plans.Review of the Fall Meeting Notes, dated between 10/16/25 and 2/23/26, showed the following for resident #2:- Unwitnessed fall on 10/27/25 at 8:00 p.m. while walking in her room and tripped over her own feet, no injuries, cause was unsafe balance gate, new interventions of checking all shoes are safe and reminding the resident to use her walker even when in her room.- Unwitnessed fall on 11/28/25 at 8:50 a.m., found on the bathroom floor, trying to put on another brief, no injuries, cause was dehydration, seen in ED for new onset of confusion, dietician recommended increasing water intake and decreasing soda intake.- Unwitnessed fall on 12/23/25 at 10:45 p.m., missed her recliner (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when trying to sit down and landed on her bottom, skin tear on her left arm requiring band aid, cause was documented as, Increase in weakness, confusion. New medication Primidone 50mg qhs, four-wheel walker not used in the room. Documented interventions were, Possibility to a 2-wheel walker, and possibility of room change. When resident is up in the room queue to be using the walker, pare down the room. Nursing to remind her to make sure that the chair is behind her. [sic]- Unwitnessed fall on 1/10/26 at 5:45 a.m., found on the bathroom floor, cause was documented as, Sepsi(s) onset, alter mental status, [sic] Interventions were documented as, When tremors are getting bad and all of sudden falling asleep, report to the provider. Will need to stand by assist and gait belt. - Unwitnessed fall on 1/11/26 at 9:15 a.m., found on the floor in another resident's room, reported she tripped and fell on the floor, cause documented as, Unsteady and in a different room and having tremors. Interventions documented as, When tremors are getting bad and all of sudden falling asleep, report to the provider. Will need to stand by assist and gait belt.- Unwitnessed fall on 1/24/26 at 8:30 p.m., found on the floor in her room, cause documented as, Patient has had increased weakness and confusion since last hospitalization. Interventions were documented as, OT to reassess-may recommended trial switching to FWW instead of 4WW for more stability. Keep encouraging patient to call for assist with all transfers. Discuss room move closer to desk for more supervision.- Unwitnessed fall on 2/23/26 at 8:00 p.m., found on the floor of her room, the resident stated her walker hit the edge of the door frame. The cause was documented as the resident was unsteady, and interventions were documented as, If up walking in the hall during the evening staff to walk with her.- Unwitnessed fall on 2/26/26 at 8:00 p.m., found on the floor of her room. The cause was documented as, Forgets to use the call light after using the restroom. Interventions were, Staff need to check in on the resident after taking to the bathroom to assist afterwards.Review of resident #2's Fall Care Plan, dated 4/7/26, showed the addition of the intervention to use a gait belt. No other care plan changes were documented between 11/26/25 and 4/7/26.3. During an interview on 4/8/26 at 10:35 a.m., staff member L stated it was the expectation that gait belts would be used for all assisted transfers and ambulation. Staff member L stated that each resident should have their own gait belt.Review of resident #5's Fall Risk Assessment, dated 10/13/25, showed the resident was at a high risk for falls.Review of the Fall Meeting Notes, dated between 10/16/25 and 2/23/26, showed the following for resident #5:- Unwitnessed fall on 10/13/25 at 11:05 p.m., found on the bathroom floor. The cause was documented as, More Parkinson activity where he freezes, wheelchair may not have been locked. Interventions were documented as, Make sure to round every hour to check on the resident.- Unwitnessed fall on 11/4/25 at 9:55 p.m., found on the floor next to his bed. The cause was documented as Resident does not call for staff. Interventions were documented as, Find out where the wheelchair is being located, making sure that every time we leave his room that the wheelchair is locked and nearby.-An Unwitnessed fall on 2/11/26 at 00:15 a.m., the resident was found on the floor between his recliner and his bed. The cause was documented as, Resident does not want to call for assistance. Interventions were documented as, Resident is resistant to walker and asking for help. Attempt a toileting schedule. A visualization to assist as needed.Resident #5 sustained unwitnessed falls on 1/24/26 and 1/25/26. The Fall Meeting notes failed to show any details or discussion of these falls.Review of resident #5's Fall Care Plan, dated 11/6/25 and 1/29/26, failed to show any changes in the care plan.Review of the facility's policy titled, Fall Prevention, dated 2/4/25, showed the purpose was . to promote proactive health-care practices for patient/resident care planning which minimize the risk for falls. The policy also showed, . IV. Every attempt will be made to safely support the patient/resident's rights for independence and self-determination by creatively activating the least restrictive methods for fall prevention that are effective. The procedure was, . Nursing staff will be informed of each patient/resident's risk level and initiated care plan interventions.Interventions may be added to the care plan to prevent further falls.During an interview on 4/8/26 at 2:42 p.m., staff member C stated she had not been updating the care plans after the weekly fall meeting.