

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 07/30/2025
NAME OF PROVIDER OR SUPPLIER Sheridan Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, interview, and record review, the facility failed to establish a grievance policy which included information on how to file a grievance anonymously for 2 (#s 19 and 20) of 21 sampled residents; and failed to post the grievance officer's address and phone number in a prominent location. This deficient practice affected all who have the right to file a grievance anonymously and who to contact if they wish to file a grievance. Findings include: During an interview on 7/29/25 at 9:21 a.m., resident #20 said he did not know anything about how to file a grievance or the grievance process. He did not know there was a process to file a grievance anonymously. Resident #20 said he had not seen a grievance form or a place to deposit the form.</p> <p>During an observation on 7/30/25 at 9:56 a.m., there was no information posted identifying who the grievance officer was and the required contact information for the grievance officer.</p> <p>During an interview on 7/30/25 at 11:44 a.m., resident #19 stated she had not filled out a complaint or grievance before. Resident #19 stated she did not know where to find grievance or complaint forms or how to drop forms off for staff to review. Resident #19 stated if there was an issue with something, she would let a nurse know. Resident #19 stated she would ask a nursing staff member for a complaint form if she had a big concern to address that she could not tell someone about verbally.</p> <p>During an interview on 7/30/25 at 12:18 p.m., staff member G stated she had been in her new position for about a month. Staff member G stated she was the grievance officer and would handle resident grievances and complaints. Staff member G stated she had not had to fill out a grievance form for a resident yet. Staff member G stated if residents had a concern or complaint, the staff member would take care of the issue and it was discussed verbally, without documenting it. Staff member G stated the staff member notified of the concern would then notify the specific department for the area of concern, for it to be addressed right away. Staff member G stated the staff member who was originally made aware of the issue would discuss the incident with the resident and family, to see if they were fine with how the concern was resolved, before filling out an official complaint form.</p> <p>During an interview on 7/30/25 at 2:00 p.m., staff member B stated when a resident wanted to submit a grievance anonymously, it was the same process as submitting a written grievance. Staff member B stated the person wanting to submit a grievance would have to ask a staff member for the grievance form, which was contained in an electronic form that had to be printed off for the resident.</p> <p>During an interview on 7/30/25 at 3:18 p.m., staff member F stated she was the grievance officer for the facility. Staff member F confirmed there was no posting in the facility that noted her as the grievance officer or her required contact information.</p> <p>(continued on next page)</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and interview on 7/30/25 at 4:04 p.m., staff member D stated the wooden box on the nurses' station counter was where residents could put forms into for staff to review. Staff member D stated, "See the box here, this shows 'Suggestions' on the front, not complaints or grievances." Staff member D stated the box had been used for placing grievance forms in the past. Staff member D stated a staff member had changed it, and had not returned it to being used as a locked grievance or complaint drop box.</p> <p>Review of the facility's policy titled, "Patient Complaints and Grievances," last revised 3/13/25, lacked information on how to submit a grievance anonymously.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on interview and record review, the facility failed to identify a resident's past history of trauma and failed to identify triggers to avoid re-traumatization for 1 (#5) of 21 sampled residents. Findings include: Review of resident #5's electronic health record showed the resident was seen for the treatment of chronic post-traumatic stress disorder, by NF4. Review of the NF4 provider notes for resident #5 showed the following: -1/30/24, . 1. Chronic post-traumatic stress disorder - Recent medication changes have actualized and been effective . - 4/8/24, .2. Chronic post-traumatic stress disorder - Will increase the venlafaxine by double from 75 mg to 150 mg. - 5/6/24, .2. Chronic post-traumatic stress disorder - She was either in a dissociative state today or acutely confused. Regardless she still having quite a bit of depression. Will increase the venlafaxine from 150 mg daily to 225 mg, [sic] - 8/20/24, .2. Chronic post-traumatic stress disorder, F43.12 Post-traumatic stress disorder, chronic. - 12/11/24, .2. Chronic post-traumatic stress disorder, F43.12 Post-traumatic stress disorder, chronic . During an interview on 7/30/25 at 3:43 p.m., when an interview was being conducted on resident #5's history of post-traumatic stress disorder, NF3 stated resident #5 was in a physically and verbally abusive marriage, had experienced the loss of her son in a tragic accident, and was left in the hospital by her parents for a period of time when she was diagnosed with Polio. NF3 stated resident #5 did have times when past feelings were triggered, such as stating her ex-husband was at the facility or that she saw him out the window, and he's trying to get her. NF3 stated resident #5's post-traumatic stress disorder diagnosis had been discussed with staff, but not lately, because the staff had changed. Review of resident #5's comprehensive care plan lacked the identification of the post-traumatic stress disorder. The care plan lacked the identification of identified triggers or interventions for these in an attempt to avoid re-traumatization. Review of resident #5's Quarterly MDS assessment, dated 5/8/25, showed, . Section I - Active Diagnoses .Psychiatric/Mood Disorder .I6100. Post Traumatic Stress Disorder (PTSD) was not checked. A request was made for resident #5's trauma informed care assessment for the diagnosis of PTSD, on 7/30/25 at 1:45 p.m. No information was provided by the end of the survey. During an interview on 7/30/25 at 5:15 p.m., staff member E stated resident #5 had a diagnosis of PTSD when it was brought to her attention. Staff member E stated there wasn't a process to ensure diagnoses were communicated to staff from specialized providers. A request was made for resident #5's social history and social assessment, on 7/30/25 at 5:36 p.m., no information was provided by the end of survey.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on interview and record review, the facility failed to promptly refer a resident with lost partial dentures to dental services for 1 (#11) of 21 sampled residents. The deficient practice caused the resident to go without his partial denture, and the resident had experienced a weight loss. Findings include: During an interview on 7/30/25 at 12:46 p.m., NF1 stated when she came to pick up resident #11 for a home visit on the Christmas holiday, he was not wearing his upper partial dentures. NF1 stated she was informed by staff when she came to pick up resident #11 that his upper partial dentures were missing. NF1 stated the partial dentures were never found, and the facility had not offered to refer the resident to dental services for the missing partial dentures or to replace them. NF1 stated she, and her family, were disappointed that the partial dentures were missing because they planned to take a family photo, and the loss of dentures would compromise how resident #11 looked in the family photo. NF1 stated resident #11 was on a pureed diet, and he didn't like the pureed texture. NF1 stated resident #11 had lost weight. Review of resident #11's EHR showed a progress note, dated 12/25/24, where a facility licensed nurse documented, Resident OOF with wife and son at 1000 (10:00 a.m). He will possibly stay overnight. They will see how it goes. Residents partial are also missing at this time. Room and bathroom searched and message sent to staff of missing item. [sic] Review of a facility document titled Resident Weight Report, dated July 15, 2025, showed resident #11 had experienced a 15% weight loss in six months. Review of resident #11's comprehensive care plan showed: . Cognitive - Communication Resident has cognitive loss r/t Alzheimer's disease, impaired ability to make needs known, . BIMs: 3/2025: unable to perform. BIMs: 6/2025: unable to perform due to severe cognitive loss. A request was made for documentation related to resident #11's missing partial on 7/30/25 at 5:36 p.m. There was no documentation provided before the end of the survey. During an interview on 7/30/25 at 5:51 p. m., staff member B stated the staff did not even know resident #11's partial was missing. Review of the facility's policy titled Dental Services, last revised 12/12/2023, showed: . Procedure: . III. Denture Care: . B. The facility's responsibility will be determined in accordance with the facility policy and CMS regulations. The facility is responsible for the loss or damage of dentures: 1. If [Facility Name] is responsible for breaking or losing the dentures. 2. If the patient/resident is not competent or suffers from dementia, the patient/resident cannot be held responsible, and the facility is responsible.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to maintain documentation of the Medical Director's (or Designee's) attendance and participation for Quality Assurance and Performance Improvement (QAPI) meetings, which were at a minimum, required to be completed quarterly. The Medical Director had involvement in the oversight of the care and services, and ensuring services met professional standards for care, and provided oversight for the review and approval of policies and procedures. This failure could affect all residents. Findings include: During a record review of the facility QAPI binder, on 7/30/25 at 4:18 p.m., one document for April 2025 was found in which a medical provider attended the scheduled facility QAPI meeting. Review of documents with meeting dates from September 2024 to March 2025, and May 2025 to July 2025, did not show a medical provider or director in attendance at the QAPI meetings, although attendance was required. During an interview on 7/30/25 at 4:33 p.m., staff member B and staff member D stated they were filling in to answer QAPI-related questions for staff member L. Staff member B stated staff member L would lead the QAPI meetings for the facility. Staff member B stated QAPI meetings were held monthly, except for the months of July and December. Staff member B stated staff member C had a medical provider attend QAPI meetings as a designee at times. Staff member B stated staff member C also attended QAPI meetings through video conferencing. Staff member B stated the facility did not have sign-in sheets to show the staff members attending QAPI meetings and said it might be a good idea to have them in place. Staff member B stated staff member L kept track of attendance by writing the names of the staff attending in the attendance section of the QAPI meeting minutes. Staff member B stated staff member C attended monthly medical provider meetings, where issues discussed in QAPI could be reviewed. During an interview on 7/30/25 at 5:23 p.m., staff member C stated he started his role at the facility in January 2025. Staff member C stated that the previous staff member in his position informed him of the requirement for attending regularly scheduled QAPI meetings. Staff member C stated he usually attended QAPI meetings via video conferencing calls. Staff member C stated that the last QAPI meeting he attended for the facility was in May 2025. Staff member C stated he might have been off to the side, or off camera, during a video conference for a QAPI meeting, and with a different medical provider as the designee attending in April 2025. Review of a facility policy titled, [Facility Name] Quality Assurance Performance Improvement (QAPI) Plan, last revised 7/24/2024, showed: . Guidelines for Leadership . V. The Nursing Home Quality Assurance Assessment (NHQAA) committee will consist of the Medical Director . and others if deemed necessary. The team will meet at least quarterly; and at times with the Quality Committee Meeting. The DON or Quality Director will lead the meeting and report on performance improvements, areas of focus, and other pertinent information. A request was made on 7/30/25 at 5:36 p.m. for the QAPI sign-in attendance documentation to verify the medical director or designee's attendance at the required meetings, from July 2024 to the date of the survey, but no documents were received before the end of the survey.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility staff failed to uphold proper infection prevention and control practices during medication administration for 3 (#s 2, 22, and 27) of 4 residents receiving medication. Findings include: During an observation on 7/29/25 at 3:52 p.m., staff member Q prepared medications for resident #27, and failed to perform hand hygiene prior to handling the medications for the administration to resident #27. One of the two medications to be given to #27 was dropped onto the surface of the cart by a staff member Q, and then picked up with a plastic spoon. The medication was placed in the medication cup. Staff member Q failed to perform hand hygiene before administering the medications to resident #27, and the surface of the medication cart was not observed to be sanitized prior to the medication preparation. During an observation on 7/30/25 at 7:23 a.m., staff member Q administered medication to resident #22, but failed to perform hand hygiene prior to handling medications for the resident and administering them. During an observation on 7/30/25 at 7:43 a.m., staff member Q entered resident #2's room, then left the room and returned to administer the medications. During that time, staff member Q was observed touching the counter at the nurses' station, resident #2's call light, resident #2's water cup, and resident #2's hand before administering the medications, or after. Staff member Q failed to perform hand hygiene before administering medications to resident #2. During an interview on 7/30/25 at 7:50 a.m., staff member Q stated hand hygiene should occur before and after resident contact. During an interview on 7/30/25 at 10:17 a.m., staff member D stated that she reviewed the facility's huddle trainings, which showed no training information specific to infection prevention during medication administration. A review of the facility's policy, Nursing Home Medication Administration, last revised 6/11/2025, showed: .II. Preparing Medications and Administering Medications: A. Wash hands. [sic] A review of the facility's policy, Hand Hygiene, last revised 4/17/2024, showed: .Definitions: .Hand Hygiene:- Cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). Procedure: I. Key Moments to perform Hand hygiene: .C. Before and after any direct contact with a patient's intact skin. E. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. H. Before and after glove use. [sic]</p>		