STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275079	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wibaux County Nursing Home	712 Wibaux St S Wibaux, MT 59353

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility staff failed to protect 1 (#1) of 8 residents sampled for neglect of care by the staff when safe lifting practices were not employed during resident transfers with a mechanical lift, and the facility policies were not followed. Findings include:During an interview on [DATE] at 2:01 p.m., NF1 said, “I had been a [position title] for seven years, and I never used mechanical lifts by myself before coming here. I knew I should have a second person to assist because I was trained and have always had two people for lifts. NF1 said she was trained at this facility by CNAs and was told that this facility only used one person to transfer residents with a mechanical lift. During an interview on [DATE] at 2:00 p.m., staff member H said the staff have been completing mechanical lifts without a second person in attendance. Staff member H said this had been going on for over a year and was probably longer. During an interview on [DATE] at 2:33 p.m., staff member C said that when the census went down, the administration and the board made the facility decrease the staff hours. Staff member C said this caused a change in the staffing level, and then there was one certified nurse assistant in the front (assigned to care outside of the dementia unit), and one certified nurse assistant on the secured dementia unit. Staff member C said the staff could not always find two staff members to help during that time. Staff member C said she could not remember the exact time, but said it was between March and July of 2025. Review of resident #1's care plan, dated [DATE], showed that resident #1 was totally dependent upon two staff members for transferring her from surface to surface. The care plan directed the staff to use a Hoyer mechanical lift and two staff members we directed to assist during the lift. Review of resident #1's nursing note, dated [DATE] at 6:44 p.m., showed resident #1 was seen lying on her right side, with the right side of her face on the floor, and a large amount of blood was observed on the floor around the resident. The certified nurse assistant reported the resident fell from the Hoyer (full body) mechanical lift. Emergency medical services were on the scene at approximately 6:15 p.m. Resident #1 was transported to a local hospital for further assessment and care. Review of the hospital emergency department report, dated [DATE] at 1:01 a.m., showed the resident sustained: -Subdural hematoma, acute. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-C2 cervical fracture - Fall in her home (the facility) -Forehead laceration. Review of resident #1's Montana Certificate of Death, dated [DATE], showed resident #1 died on [DATE] at 6:10 a.m., which was three days after the fall with significant injuries. The Montana certificate of death listed the causes of death as: - a subdural hematoma - fall from a Hoyer lift.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews and record review the facility failed to ensure services were provided according to professional standards related to safe use of mechanical lifts for 1 (#1) of 8 sampled residents. Review of resident #1's care plan, dated 8/5/22, showed that resident #1 was totally dependent upon two staff members for transferring her from surface to surface. The care plan directed the staff to use a Hoyer fully body mechanical lift. During an interview on 9/22/25 at 2:01 p.m., NF1 had not used a mechanical lift by themself before working at the facility, and stated, I knew I should have a second person because I was trained and have always had two people for lifts. During an interview on 9/22/25 at 2:32 p.m., staff member H said she was taught to use two people when using a mechanical lift to transfer people. Staff member H said she had used the lift by herself. Staff member H said she was aware that only using one person for transferring residents with a mechanical lift was not the right way to provide the care. Staff member H said it upset her when the staffing was changed to having only one CNA in each hall. Staff member H said the residents had to get taken care of, so We had to do what we could to get the residents taken care of, and that included using the mechanical lifts by ourselves. During an interview on 9/23/25 at 10:39 a.m., staff member L said he had training on the lifts in the past. Staff member L said he had been using lifts for a long time, so he knows how to use them. Staff member L said it was never 100% for getting two staff to help. Staff member L said most of the time he had two staff doing the lifts, but sometimes the facility is short-staffed and two staff are not always available.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, a facility staff member failed to transfer a resident properly while using a mechanical lift and ensure that two staff members were assisting. The resident fell from the lift and sustained a fracture, a head injury, and passed away at the hospital. Documentation reflected that the fall contributed to the resident's death, for 1 (#1) of 7 sampled residents. Findings include: On [DATE] at 11:35 a.m., the facility Administrator, Assistant Administrator/Business Office Manager, and the Director of Nursing were notified of an Immediate Jeopardy (IJ) situation, which involved resident #1 related to a fall with major injuries. The IJ pertained to F689 - Free of Accident Hazards/Supervision/Devices. The Severity and Scope of the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy, lowered to G.On [DATE] at 11:40 a.m., the facility provided an acceptable plan to remove the immediacy for the residents residing in the facility who are at continued risk of harm due to the failed practices related to mechanical lift use. The surveyor verified the removal of immediacy onsite through the use of observations, interviews, and record reviews, on [DATE]. Review of resident #1's care plan, dated [DATE], showed the resident #1 needed total assistance when transferring from surface to surface. The care plan directed the staff to use a Hoyer (full body mechanical) lift with two staff members. Review of resident #1's nursing note, dated [DATE] at 6:44 p.m., showed resident #1 was seen lying on her right side, with the right side of her face on the floor, and a large amount of blood was observed on the floor around the resident. The certified nurse assistant reported the resident fell from the Hoyer (full body) mechanical lift. Emergency medical services were on the scene at approximately 6:15 p.m. Resident #1 was transported to a local hospital for further assessment and care. Review of the hospital emergency department report, dated [DATE] at 1:01 a.m., showed the resident sustained:-Subdural hematoma, acute-C2 cervical fracture.-Fall in her home (the facility).-Forehead laceration. Review of resident #1's Montana Certificate of Death, dated [DATE], showed resident #1 died on [DATE] at 6:10 a.m., which was three days after the fall with significant injuries. The Montana certificate of death listed the causes of death as:- a subdural hematoma- fall from a Hoyer lift. During an interview on [DATE] at 2:01 p.m., NF1 said she had been working at the facility for about a month before resident #1's fall. NF1 said she did not receive orientation on the mechanical lifts and their use of them and did not complete a return demonstration to verify her knowledge for the use of the mechanical lifts. NF1 said the CNA who trained her to the facility told her to use the mechanical lifts by herself, as this was the practice at this facility. NFI said she had been working as a caregiver for over seven years, and she knew there should be two staff when using lifts, although this did not occur at the time of resident #1's fall. NF1 said she was transferring resident #1 at the end of her shift, and she was tired. NF1 said she was transferring resident #1 from her chair to the bed, and the resident fell out of the lift during the transfer. NF1 said she did not know exactly how the resident #1 fell out of the lift, and said she was not sure how one strap became unhooked from the sling, but the other three straps were still connected to the lift. NF1 said she informed management that the CNAs were using the mechanical lifts alone, training new staff on that practice, and were not using the required two people.During an interview on [DATE] at 2:32 p.m., staff member H said she responded to resident #1's room to assist with patient care after #1's fall from the lift. Staff member H said the front left sling strap was not hooked on the bar of the mechanical lift. Staff member H said that when she had used the mechanical lifts in the past, she had caught the straps popping off the hooks many times. Staff member H said she had been using the lifts independently for a long time at the facility.During an interview on [DATE] at 3:02 p.m., staff member S said he saw resident #1 in the hospital the second day she was there. Staff member S said resident #1 had a subdural hematoma and fractures of the Cervical spine at level C1-C2. Staff member S said the fractures of C1-C2 were unstable, but there was no spinal cord involvement and no spinal cord dissection. Staff member S said he did not complete the death certificate, but the cause of death would likely be from subdural hematoma, closed head injury, and concussion. Staff member S said the cause of death was definitely related to the fall from the lift.During an interview on [DATE] at 2:17 p.m., staff member E said she watched the hallway camera video of the fall which occurred on [DATE] at approximately 6:00 p.m. Staff member E said she saw NF1 stick her head out of the door (of #1's room). Staff member E, and another staff member went into resident #1's room, and she could see one of the shoulder straps was not connected to the lift. During an interview on [DATE] at 2:40 p.m. staff member E said she was the nurse on duty at the time resident #1 fell and was injured. Staff member E

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure licensed nurses and certified nurse assistants received training on the procedure and safety requirements for using mechanical lifts for fifteen (D, E, F, G, H, I, J, K, L, M, N, P, Q, R, NF1) of sixteen sampled staff members. The deficient practice increased the risk of harm for the seven residents in the facility still utilizing a mechanical lift. The facility reported a census of 30. Findings include: During an interview on 9/22/25 at 2:01 p.m., NF1 said she started her job at the facility about a month ago. NF1 said the Director of Nursing did not complete any training with her prior to working directly with residents. NF1 said upon hire she signed some paperwork and then trained directly with a certified nurse assistant during orientation. NF1 said during orientation the CNAs who trained her said a resident who required the use of a mechanical lift did not require two staff to assist, and NF1 could perform the task independently. NF1 said the other certified nurse assistants said they also complete the lift transfers independently. During an interview on 9/22/25 at 2:32 p.m., staff member H said she did not receive training or complete a competencies evaluation related to mechanical lifts and their use of them for transferring residents, prior to 9/11/25, which was after resident #1 fell from the mechanical lift and sustained major injuries. Staff member H said her last mechanical lift competency was completed years ago, which was when she completed her state exam for the certification. During an interview on 9/22/25 at 2:55 p.m., staff member C said nursing staff competencies related to mechanical lift education were completed in May 2025, which was when nursing staff were required to perform a return demonstration of the mechanical lift use.Review of staff education, specifically related to mechanical lifts and their use, showed only staff member O received the mechanical lift training on 5/30/25. Staff member C provided one mechanical lift competency form for staff member O. Staff member C could not produce any more mechanical lift competency training documents for the rest of the licensed or certified nursing staff, and or the two management staff, who retained their CNA certification. Review of resident #1's nursing progress note, dated 9/10/25 at 6:44 p.m., showed, . Upon arrival to the room, resident seen lying on her right side with right side of face on floor and large amount of blood noted on the floor around the resident. CNA reported resident fell from the hoyer lift in a staff witnessed fall. [sic]

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews and record review the facility failed to ensure the facility was administered in a manner that allowed resident #1 to be provide individualized care related to mechanical lifts and falls and failed to promote the well-being and prevent physical harm, pain and death for 1 (#1) of 10 sampled residents. Findings include: Review of resident #1's care plan dated 8/5/22 showed the resident #1 needed total assistance when transferring from surface to surface. The care plan directed the staff to use a Hoyer lift with two staff members. The care plan failed to identify the size sling to be used for resident #1. Review of resident #1's nurses note dated 9/10/25 at 6:44 p.m., showed resident #1 was seen lying on her right side with the right side of her face on the floor and a large amount of blood noted on the floor around the resident. The certified nurse assistant reported the resident fell from the Hoyer lift. Emergency medical services were on the scene at approximately 6:15. Resident #1 was transported to a local hospital. During an interview 9/23/25 at 2:40 p.m., staff member F said she was the nurse on duty at the time resident #1 fell and was injured. Staff member F said she could tell resident #1 was hurt. Staff member F said the certified nurse assistant transferred resident #1 by herself. Staff member F said some of the certified nurse assistants told her staff member C was aware the certified nurse assistants were doing independent lifts and staff member C allowed the staff to transfer residents using the mechanical lifts by themselves with no help. During an interview of 9/22/25 at 2:01 p.m., NF1 said she was trained and oriented by the other certified nurse assistants. NF1 said the other certified nurse assistants trained her to only have one staff member present during the mechanical lift transfers. During an interview on 9/22/25 at 2:48 p.m., staff member D said the certified nurse aides use the mechanical lifts independently. Staff member D said the management was aware the lifts were being used by one person, and the policy was not being followed. During an interview on 9/23/25 at 2:00 p.m. staff member H said the staff have been doing mechanical lifts without a second person in attendance. Staff member H said the practice of not having two staff member help with lifts had been going on for over a year and probably longer.During an interview on 9/23/25 at 2:33 p.m., staff member C said when the census went down, the administration and the board made the facility decrease staff hours. Staff member C said this caused a change in the staffing level to include one certified nurse assistant in the front and one certified nurse assistant on the locked dementia unit. Staff member C said the staff could not always find two staff to help during that time. Staff member C said she could not remember the exact time and said between March and July of 2025.