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	04/09/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of neglect was reported to the State Survey Agency within the required timeframe for 1 (#13); failed to ensure allegations of abuse by staff were reported to the administrator and State Survey Agency within the required timeframe for 3 (#s 12, 19, and 25) of 6 residents sampled for abuse and neglect reporting. The failures placed the residents at risk for continued abuse or neglect and delayed investigation and intervention by the State Survey Agency. Findings include:1. Review of a facility-reported event, submitted to the State Survey Agency on 3/20/26, showed an event involving resident #13 that occurred on 3/17/26 during the night shift and involved a lack of hygiene care and a lack of monitoring following episodes of vomiting. During an interview on 4/7/26 at 10:51 a.m., staff member A stated the event with resident #13 was identified on the morning of 3/18/26 after review of video surveillance. Staff member A stated the facility reported the concerns to the travel staffing agency and terminated the contracts of the involved staff on 3/18/26. Staff member A stated the facility did not report the event to the State Survey Agency until 3/27/26, after being notified that the involved staff had been reported to their respective regulatory boards. Staff member A stated, That's when we realized we should have reported it to the state. 2. Review of a facility-reported event, submitted to the State Survey Agency on 3/10/26, showed on 3/9/26 resident #19 was allegedly pushed by a facility staff member, resulting in the resident falling to the ground. The event was not reported to the State Survey Agency until 3/10/26; after a facility staff member failed to report the event immediately to the nurse. During an interview on 4/8/26 10:01 a.m., NF7 stated that on 3/9/26, while providing care to resident #19, the resident became aggressive. NF7 stated she was trying to keep her distance from resident #19, and as she put her hand out, it contacted the resident's left shoulder, causing the resident to lose his balance, which resulted in NF7 assisting the resident #19 to the ground in the sitting position. NF7 stated she did not report the event to the nurse. NF7 stated that at the time the event occurred, she did not feel it was reportable, but after she spoke to staff member A, she realized she should have reported the event to the nurse immediately after it occurred. During an interview on 4/8/26 at 2:29 p.m., NF2 stated on 3/9/26 that she had witnessed the event between NF7 and resident #19. NF2 stated she did not report the event to the nurse until the following day (3/10/26) because she was trying to process what had happened. NF2 stated she should have reported the event to the nurse immediately after it occurred. 3. Review of a facility-reported event, submitted to the State Survey Agency on 3/13/26, showed an allegation that on 3/10/26, residents #12 and #25 were verbally abused by a facility staff member. (continued on next page)

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

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	275079	A. Building B. Wing	04/09/2026

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Wibaux County Nursing Home	712 Wibaux St S Wibaux, MT 59353

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The alleged event was not reported to the State Survey Agency until 3/13/26, after a facility staff member failed to report the event immediately to the nurse on 3/10/26. During an interview on 4/8/26 at 2:35 p.m., NF2 stated on 3/10/26 she had worked with NF7 helping prepare resident #12 for a bath. NF2 stated resident #12 displayed behaviors prior to her bath. NF2 stated NF7 made a remark with the resident present in her room, stating, Maybe a cold shower would cool you (resident #12) off. NF2 stated on the same day (3/10/26) NF7 also told resident #25 to sit down and be quiet when the resident was entering the dining area. NF2 stated she did not report the events involving resident #12 until 3/12/26. NF2 stated she should have reported the events to the nurse immediately after they occurred. Review of a facility document titled Abuse, Neglect, and Exploitation, with a revision date of January 2026, showed: . VII. Reporting/Response A. [Facility Name] will have written procedures that include: 1. Reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide necessary care and services to maintain a resident's quality of life for personal dignity, comfort, and safety for 1 (#13) of 13 sampled residents. The failure resulted in the resident remaining in vomit-soiled conditions for an extended period of time. The resident refused care and was periodically checked on by staff, but did not receive the level of care or assessment necessary related to her emesis episodes or risks related to them. Findings include: Review of a facility-reported event submitted to the State Survey Agency on 3/20/26 showed NF8 and NF9 failed to provide hygiene care and failed to assist resident #13 from a recliner following episodes of vomiting. Resident #13 was periodically checked on by staff but did not receive an appropriate assessment or care related to her vomiting episodes. During an observation on 4/8/26 at 7:35 a.m., resident #13 was observed with no skin breakdown. Resident #13 kept her eyes closed and was verbally and physically aggressive to staff during repositioning for skin observation.Review of a facility document titled [Resident #13] camera footage timeline, dated 3/17/26, showed resident #13 vomited at 6:45 p.m. and 7:51 p.m. The document showed no hygiene care was provided following these episodes. The document showed resident #13 was checked on periodically throughout the early evening, and restless and coughing until 8:48 p.m.; however, NF8 did not check on the resident again until 10:51 p.m. The document showed no physical assessment, monitoring, or interventions were implemented despite the resident's condition, except placement of a towel and a shirt change shortly before shift change.Review of resident #13's nursing progress notes dated 2/1/26 to 3/31/26 showed the resident had a history of aggressive behaviors and language, which at times made it difficult for staff to provide care.Review of resident #13's nursing progress notes dated 3/18/26 at 2:30 a.m. showed no documentation of physical assessment or increased monitoring following vomiting episodes.During an interview on 4/7/26 at 10:51 a.m., staff member A stated NF8 and NF9 were travel staff assigned to resident #13 on the night shift of 3/17/26. Staff member A stated video surveillance was reviewed after concerns were identified and reported on the morning of 3/18/26.