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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement an effective infection prevention and control program, including failure to ensure Enhanced Barrier Precautions (EBP) were implemented for 2 (#s 1 and 4) of 13 sampled residents; and failed to implement a system for the ongoing surveillance, identification, and prevention of infections for all residents. The failures placed residents at risk for developing and transmitting infections. Findings include: Enhanced Barrier Precautions: 1. During an interview on 4/8/26 at 11:52 a.m., staff member J stated resident #1 had an open pressure wound on her left heel and coccyx area. Staff member J stated she was not aware enhanced barrier precautions should be used when providing care for resident #1 due to the pressure ulcers. During an interview on 4/8/26 at 12:10 p.m., staff member K stated she usually works on the Keys unit and was not aware of any residents on enhanced barrier precautions. Staff member K stated resident #1 had two pressure wounds, one on her left heel and one on her coccyx area. Staff member K stated she was not aware she needed to use enhanced barrier precautions when providing care to resident #1. Review of resident #1's physician's order, dated 4/1/26, showed an order for a dressing change to the resident's right heel with a diagnosis of a pressure ulcer of the left heel, which was documented as Unstageable, for the severity. The second order showed a dressing change to the resident's coccyx area, with a diagnosis of pressure ulcer of the sacral region, which was documented as a Stage II for severity. 2. During an observation and interview on 4/6/26 at 2:33 p.m., resident #4 was observed in his room with heel protector boots on over bilateral foot dressings. Resident #4 stated he was unaware that he was on enhanced barrier precautions, which would require a gown and gloves for high-contact care. Resident #4 stated staff only wore gloves when changing his foot dressings or when helping him with personal care. During an interview on 4/8/26 at 11:45 a.m., staff member C stated there were no residents in the facility who were currently on enhanced barrier precautions. Staff member C did not know when enhanced barrier precautions should be used for a resident. During an interview on 4/8/26 at 3:02 p.m., staff member H stated the facility did not have anyone on enhanced barrier precautions at that time. During an interview on 4/8/26 at 3:45 p.m., staff member C stated she changed all wound dressings in the facility weekly and completed a wound assessment. Staff member C stated she had not been wearing a gown (for adhering to enhanced barrier precautions) when changing wound dressings and (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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated, I guess I should be. During an interview on 4/9/26 at 8:00 a.m., staff member L stated they would wear personal protective equipment (PPE) whenever there was a sign (for infection control precautions) posted on the resident's door, and there currently were no signs posted on any rooms to reflect the need for PPE to be used. When interviewed, staff member L was unable to differentiate between the different types of infection control precautions or when they would be used. Staff member L stated, We haven't had anyone on precautions since the Norovirus outbreak. During an interview on 4/9/26 at 8:25 a.m., staff member M stated, We would only wear (a) gown and gloves (for enhanced barrier precautions) if we emptied a catheter bag. We don't wear a (protective) gown if we are doing personal care. In the shower, we just wear the shower apron, so we don't get wet. A request for documentation of staff education provided on enhanced barrier precautions was made on 4/9/26. No documentation was provided by the end of the survey. Review of a facility policy titled Enhanced Barrier Precautions, revised 3/1/26, showed: .1. a. All staff receive training on Enhanced Barrier Precautions upon hire and at least annually and are expected to comply with all designated precautions . 2. b. An order for Enhanced Barrier Precautions will be obtained for residents with any of the following: . I. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices, even if the resident is not known to be infected or colonized with an MDRO. 3. a. Personal protective equipment (PPE) for Enhanced Barrier Precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include: a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or useh. Wound care: any skin opening requiring a dressing. [sic] Infection Prevention and Control Program: During an interview on 4/9/26 at 9:13 a.m., staff member B stated she started in November 2025 and was responsible for the infection prevention and control program. Staff member B stated, I am still learning. I haven't finished the infection preventionist course yet. Staff member B stated that infections and pathogens were not being tracked or mapped within the facility. Staff member B stated the facility had a significant Norovirus outbreak in February of 2026 that was reported to the health department; however, the information was not added to the infection control logbook. Review of a facility document titled Infection Control Log book, undated, showed a monthly report generated from the facility's electronic health record system; however, infections listed included (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	non-specific diagnoses such as UTI unspecified, history of UTI, and respiratory infection unspecified, and the information lacked infection surveillance and or any analysis of infections. The logbook did not show any information pertaining to the Norovirus outbreak, and the infection summary report for February 2026 showed no gastrointestinal infections. Review of a facility document titled Infection Surveillance, revised February 2026, showed, Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the designated infection preventionist was qualified by education, training, or experience to oversee the infection prevention and control program for the facility. The failure placed all residents at increased risk for the development and transmission of infections. Findings include:During an interview on 4/8/26 at 1:33 p.m., staff member A stated staff member B started in her role at the facility on 11/4/25, and had been taking the CDC Infection Preventionist certification training, but was only up to module eight because she was busy filling in on the floor as needed and had not had time to complete the training. During an interview on 4/9/26 at 9:13 a.m., staff member B stated she started in November 2025 and was responsible for the facility's infection prevention and control program. Staff member B stated, I am still learning . I haven't finished the infection preventionist course yet. Staff member B explained that some of the information she was learning was new to her. Review of a facility document titled Infection Surveillance, revised February 2026, showed: The infection preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility .Review of CDC's Nursing Home Infection Preventionist training, located online at https://www.cdc.gov/long-term-care-facilities/hcp/training/index.html and accessed on 4/13/26, showed the Infection Preventionist course contained 23 required modules and the course completion time was approximately 20 hours.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan, which included the minimum necessary instructions needed to provide effective and person-centered care of a resident for 1 (#2) of 13 sampled residents. Findings include:During an interview on 4/9/26 at 8:56 a.m., staff member B stated nursing was responsible for starting baseline care plans for residents on admission. Staff member B stated that the baseline care plan should include the health information necessary to care for a resident properly. Staff member B stated the facility used a software program to develop the baseline care plans, and facility staff were not able to include all the information related to a resident's care due to limitations with the program. Staff member B stated she would need to research options available for the completion of a thorough baseline care plan. Review of resident #2's physician progress note, dated 3/8/26, showed the resident was to be admitted to the facility on [DATE] and continue using the following medications:- Lantus insulin 60 units subcutaneous nightly,- Levothyroxine 75 mcg by mouth daily,- Lithium 300 mg by mouth twice daily,- Melatonin 3 mg by mouth nightly,- Olanzapine 10 mg by mouth nightly,- Olanzapine 5 mg by mouth daily,- Pioglitazone 30 mg by mouth daily and,- Rosuvastatin 5 mg by mouth daily.Review of resident #2's document titled, Baseline Care Plan, dated 3/9/26, did not include a problem, goals, or interventions for medication management.Review of the facility document titled Baseline Care Plan, with a revision date of 9/29/25, showed: . Policy Explanation and Compliance Guidelines:I. The baseline care plan will:a. Be developed within 48 hours of a resident's admission.b. Include the minimum healthcare information necessary to properly care for a resident, including, but not limited to:. II. Physician orders.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise a care plan to reflect a resident's current care needs for 1 (#1) of 13 sampled residents. Findings include:During an observation on 4/7/26 at 12:30 p.m., resident #1 was sitting in her wheelchair at the dining table. The resident was noted to have heel protectors on her feet.During an interview on 4/8/26 at 11:44 a.m., staff member C stated resident #1 had a pressure wound on her left heel. Staff member C stated resident care plans were updated weekly, and she was not sure why resident #1's care plan had not been revised for the pressure wound. Review of resident #1's physician progress note, dated 4/3/26, showed resident #1 had an Unstageable pressure ulcer on the left heel, as well as a Stage II pressure ulcer on her coccyx.Review of resident #1's current care plan, reviewed on 4/8/26, did not reflect that the resident had developed pressure wounds on her left heel and coccyx area, or the use of heel protectors.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure nursing staff documented wound care, wound status, and dressing changes in accordance with professional standards of practice for 1 (#4) of 3 residents sampled for wounds. The failure placed the resident at increased risk for ineffective wound healing, undetected changes in condition, and infection. Findings include:During an observation on 4/6/26 at 2:33 p.m., resident #4 was observed in his room with heel protector boots in place over bilateral foot wound dressings.During an interview on 4/7/26 at 4:02 p.m., staff member H stated he only documented wound treatments or dressing changes .if the wound looked a lot better or a lot worse.During an interview on 4/8/26 at 3:30 p.m., staff member C stated she or staff member B was responsible for completing weekly wound assessments, including wound measurements, evaluation, the wound deterioration or healing, and physician notifications, if needed. Staff member C stated the nursing staff was responsible for monitoring wound dressings and completing dressing changes according to a physician's order. Staff member C stated wound care was documented as completed on the medication administration record (MAR); however, nursing staff were expected to document a wound dressing and status in the resident's medical record progress notes, every shift, and at the time of the wound dressing change. Staff member C stated she was confident wound care was being completed as ordered, as reflected in the medication administration record (MAR); however, documentation of wound dressing observations and wound care was not consistently documented as completed in the nursing progress notes.Review of resident #4's physician orders, dated 3/31/26, showed: Right ankle wound: Change dressing every 3 days. Monitor every shift. Change dressing as needed if saturated.Stage 2 pressure injury to right heel: Change dressing every 3 days. Monitor every shift. Change as needed if saturated.Top of foot wound: Change dressing every 3 days. Monitor every shift. Change dressing as needed if saturated. [sic]Review of resident #4's nursing progress notes from 4/1/26 to 4/8/26 showed one comprehensive wound assessment documented by staff member C on 4/2/26. There were two additional nursing progress note entries during this period, which included: 4/2/26 at 2:45 p.m., . Dressing change done by ADON and is charted, and 4/5/26 at 6:49 p.m., The pt. had his dressings changed with improvement noted to his bilat lower extremities. [sic] Resident #4's nursing progress notes showed a total of two entries referencing the resident's wounds over seven days, during which 14 opportunities existed to document the wounds or wound dressing statuses. Review of a professional wound management resource located online at https://www.woundsource.com/blog/documentation-in-wound-care, accessed on 4/13/26, showed, Clinicians must provide adequate and accurate documentation of all relevant wound characteristics, interventions, and responses.Review of a facility document titled Documentation in Medical Record, revised February 2026, showed: Policy Explanation and Compliance Guidelines: . 1. Licensed staff . shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program, including monitoring of antibiotic use within the facility. The failure placed residents at increased risk for inappropriate antibiotic use, adverse drug reactions, and development of antibiotic-resistant organisms. Findings include:During an interview on 4/9/26 at 9:13 a.m., staff member B stated she started in November 2025 and was responsible for the infection prevention and control program, including oversight of antibiotic use. Staff member B stated providers were good about obtaining cultures and changing or discontinuing antibiotics based on culture and sensitivity reports; however, she was not currently tracking the information. Staff member B stated, I am just learning. It makes perfect sense to track the pathogens and antibiotics, and I will start tracking and monitoring them now.Review of a facility document titled Infection Control Log Book, undated, showed monthly reports generated from the facility's electronic health record system of antibiotics in use; however, infections listed included non-specific entries such as UTI unspecified, history of UTI, and respiratory infection unspecified. The logbook contained no identified pathogen or culture and sensitivity information for prescribed antibiotics, and antibiotic use was not being meaningfully tracked or analyzed to support appropriate prescribing.Review of a facility document titled Antibiotic Stewardship Program, revised February 2026, showed: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . 11. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to:- a. Action plans and/or work plans associated with the program.- b. Assessment forms.- c. Antibiotic use protocols/algorithms.- d. Data collection forms for antibiotic use, process, and outcome measures.- e. Antibiotic stewardship meeting minutes.- f. Feedback reports.- g. Records related to education of physicians, staff, residents, and families.- h. Annual reports . [sic]

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete multiple comprehensive Minimum Data Set (MDS) assessments for the resident's Pre-admission Screening and Resident Review (PASRR), for 1 (#12) of 13 sampled residents. Findings include:During an interview on 4/8/26 at 12:22 p.m., staff member F stated resident #12's PASRR Level One was completed on 1/3/23, and a PASRR Level Two was completed on 1/27/23. Staff member F stated that when she completed section A of the resident's MDS submission on 1/21/25 and 1/12/26, she overlooked adding PASRR information because the system pre-populated the resident's demographic information.Review of resident #12's electronic medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of Anxiety, Depression, Schizoaffective Disorder, and Cerebral Palsy. A Level One PASRR was completed on 1/3/23, and the resident qualified for a Level Two screening, which was completed on 1/27/23, with recommended services received on 2/1/23. Staff member F stated resident #12 did not have any disruption in service due to the incorrect coding on the resident's comprehensive assessments submitted on 1/21/25 and 1/12/26.Review of resident #12's MDS assessment dated [DATE] and 1/12/26, with an Assessment Reference Date of 1/6/25 and 1/5/26, section A, showed the facility documented the resident was not considered to have serious mental illness and or intellectual disability or a related condition, using the State PASRR evaluation process, due to how the MDS was coded.