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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>275087 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>12/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Powder River Manor |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>104 N Trautman<br>Broadus, MT 59317 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41652</p> <p>Based on interview and record review, the facility failed to ensure all allegations of neglect by staff were reported to the administrator and State Survey Agency within the required timelines for 2 (#s 1 and 4) of 7 sampled residents. Findings include:</p> <p>During an interview on 12/30/24 at 12:39 p.m., staff member B stated she had witnessed staff member H pushing resident #4 down the hall towards his room. Staff member B stated the resident was sitting on a bath chair and wrapped in a blanket. Staff member B stated staff member H took resident #4 into his room and left him there. Staff member B stated resident #4 began, hollering and yelling for help. Staff member B stated she witnessed staff member G go into the resident's room. Staff member B stated she did not remember how much time elapsed between when staff member H left resident #4 in his room and when staff member G entered the resident's room to help him.</p> <p>During an interview on 12/30/24 at 6:28 p.m., staff member G stated she was working with staff member H on a day shift. Staff member G stated staff member H had given resident #4 a bath and was returning him to his room. Staff member H put resident #4 in his room and left him sitting in a bath chair wrapped up in a blanket. Staff member G stated she heard resident #4 yelling for help, and when she entered the resident's room, she observed resident #4 sitting in the middle of his room, without a call light or any way to summon help. Staff member G stated she asked staff member H why she left the resident alone in his room without a call light. Staff member H stated another CNA was supposed to have gone in and helped him. Staff member G stated she followed the chain of command and reported the incident to staff member I. Staff member G stated she expected staff member I to investigate the incident.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 12/31/24 at 7:55 a.m., staff member J stated she remembered a day when staff member G gave resident #4 a bath and then left him in his room unattended. Staff member J stated the resident was sitting in a bath chair wrapped in a blanket and had no call light within his reach. Staff member J stated she did not know how much time had passed before resident #4 began yelling for help. Staff member J stated she saw staff member I walking in the hallway when the resident began yelling for help. When asked if she had witnessed any other incidents of possible neglect of care involving staff member H, staff member J stated she had followed staff member H on a day shift. Staff member J stated when she did 2:00 p.m. rounds, she found resident #1, who had been taken care of by staff member H from 6:30 a.m. to 2:00 p.m., in a heavily saturated brief which also contained a large bowel movement. Staff member J stated the brief was an overnight brief. Staff member J stated the BM had dried to his skin. Staff member J stated she followed the chain of command and reported the incident to the nurse on duty.</p> <p>During an interview on 12/31/24 at 9:15 a.m., staff member G stated she had assisted staff member J with caring for resident #1. Staff member G stated she found the resident in an overnight brief which was very, very wet. Staff member G stated the overnight briefs were used during the night because they were more absorbent than the regular briefs. Staff member G stated she followed the chain of command and reported the incident to staff member I and was told, Other people do that.</p> <p>During an interview on 12/31/24 at 10:10 a.m., staff members A and K stated when direct care staff came to them regarding complaints about staff member H, they referred them back to staff member I. Staff member I told staff member A she would take care of it. Staff member A stated she trusted staff member I to deal with the issues. Staff member A stated she began to become concerned with staff member I's job performance when the complaints involving staff member H continued and other staff were refusing to work with staff member H. Staff member A stated she was not aware of the incidents of possible neglect with resident #1 and resident #4 until they were identified during the survey. Staff member A stated staff member H and staff member I were very close friends, and she (staff member A) believed nothing was ever done because of the friendship. Staff member A stated the incidents with the two residents should have been reported and investigated as possible neglect. When asked what, if anything, had been done regarding the complaints associated with staff member H, staff member A stated she decided it was best not to renew staff member H's contract. Staff member A stated staff member H had not worked since before Christmas. When asked if staff member I had kept any notes or records related to the incidents involving resident care, staff member A stated they were not able to find any helpful documentation after staff member I left the facility in late October of 2024.</p> <p>Review of the facility policy titled, Abuse prevention, investigation, and reporting of resident abuse, dated 2/7/23, showed, All allegations of resident abuse (neglect) will be investigated and reported to the proper authorities. The policy also showed, . All suspected incidents of abuse (and neglect) shall be reported . An incident report shall be forwarded to the Administrator . In any case in which the facility's administrator does not respond to reports from its employees of suspected abuse or neglect, those employees who have knowledge of possible abuse or neglect are required to report this information directly to DPHHS .</p> <p>Staff members H and I were no longer employed by the facility and were not available to interview.</p> |  |  |