

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Powder River Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N Trautman 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>48268</p> <p>Based on interview and record review, the facility failed to accurately document an event sent to the State Survey Agency regarding a resident-sustained facial burn and the resident had pain, due to the application of a heat pack, and failed to provide accurate documentation of the facility's investigative findings, for 1 (#9) of 16 sampled residents. Findings include:</p> <p>During an interview on 3/11/25 at 10:12 a.m., resident #9 reported he had received a burn to his left cheek and ear, approximately five or six months ago, from a heat pack applied for a toothache.</p> <p>During a phone interview on 3/11/25 at 4:15 p.m., NF6 stated he received a complaint from resident #9 pertaining to receiving a burn. NF6 stated he saw the facial burn approximately one week after the incident. At the time of his visit, NF6 stated, There was no blistering remaining, but the entire cheek, from top of the ear to the left jawline, was quite red, inflamed, and was reported by [Resident #9] to be painful.</p> <p>During a phone interview on 3/12/25 at 1:15 p.m., NF5 stated resident #9's left face was red and blistered from the hairline above the ear to the jawline. NF5 stated, His (Resident #9's) face was so red, blistered, and sore looking, that I thought maybe he had shingles, until they (staff) told me what happened.</p> <p>Review of a Facility-Reported event, submitted to the State Survey Agency on 7/2/25, showed resident #9 sustained a . red area on residents left upper cheek and ear . We did not have to do any medical treatment to the area. [sic]</p> <p>Review of the facility's report of findings, submitted to the State Survey Agency on 7/3/25 showed, No need for treatment as there were only a couple small blisters less than 2mm in size on one ear.</p> <p>Review of resident #9's nursing progress notes, dated 7/2/25, showed, . the entire area from the left jaw to above his ear was red. Blisters noted from left cheek to left jaw line.</p> <p>Review of resident #9's electronic medical record, dated 7/2/25, showed a verbal order was requested by nursing for aloe vera topical cream for the burn.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #9's nursing progress notes, dated 7/5/25, showed, .Cheek and upper neck are swollen and hot to the touch with more blistering than noted yesterday. Aloe applied to burn and surrounding areas. Ice pack applied for 10 minutes to help with swelling. Resident stated, 'My jaw feels swollen and puffy. It kind of hurts a little too.' Contacted DON to have someone look at the area.</p> <p>Review of resident #9's physician progress notes, dated 7/8/25, showed . 1. Burn of second degree of head, face, and neck, unspecified site, initial encounter - T20.20XA (Primary) . Notes: Will monitor skin closely. I question the start of impetigo to some of the burn, but will see how he responds to the oral antibiotic I am giving him for the oral infection. Will recheck patient on Wednesday. RN staff can continue topical aloe vera. [sic]</p> <p>Review of the facility policy titled, Incident Reporting, dated 8/26/24, showed, Procedure for Filing an Initial Report . 10. The extent of any injuries: and . the outcome of your investigation.</p>

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48268</p> <p>Based on interview and record review, the facility failed to ensure staff were performing cares within their scope of practice; failed to ensure sufficient supervision; and failed to ensure nursing staff performed adequate pain assessment and ongoing monitoring for the application of a heat pack for 1 (#9) of 16 sampled residents. The facility's failures resulted in the development of a partial thickness facial burn for one resident and increased the risk of serious injuries for any resident in need of heat pack application. Findings include:</p> <p>During an interview on 3/11/25 at 10:12 a.m., resident #9 reported he received a burn to his left face approximately five or six months ago when he reported a toothache.</p> <p>During an interview on 3/12/25 at 1:45 p.m., staff member D stated, We don't use hot packs here at all. There was an incident with one in the past.</p> <p>During an interview on 3/12/25 at 2:40 p.m. regarding the 7/1/25 burn incident reported by resident #9, staff member A stated, The CNA went back to physical therapy without permission and got a heat pack from the hydrocollator. As an OT (occupational therapist), I have had to have specialized modality training on how to use a hydrocollator heat pack. Those packs can get up to 165 degrees (Fahrenheit) or so. That was a bad deal.</p> <p>During a telephone interview on 3/12/25 at 3:28 p.m., staff member G stated the CNA staff did occasionally use heat packs, as needed. She had been shown how to access and use the hydrocollator, located in the physical therapy department. Staff member G was unable to recall who trained her on the use of the hydrocollator. Staff member G stated on the day of the injury, she notified staff member H of resident #9's request for a heat pack for his dental pain, and she would get one from the physical therapy department. Staff member H stated Okay. Staff member G obtained the heat pack from physical therapy, and applied it to resident #9's face. Staff member G stated she then became busy and did not get back to remove the pack until 30-40 minutes later. Staff member G did not know if staff member H had assessed or monitored the resident before, during, or after the heat application. Staff member G stated when she removed the heat pack, resident #9's face was reddened, and reported the redness to staff member H. Staff member G stated she thought the redness would go away after the removal of the pack. The following morning, staff member G noted there was blistering on resident #9's face. Staff member G stated she knew the burn was from the heat pack application the day prior and reported it to the nurse on duty. Staff member G stated the staff were no longer allowed to use heat packs in the facility because of resident #9's burn injury.</p> <p>An interview attempt with staff member H was made by phone on 3/12/25 at 3:18 p.m. No return call from staff member H was received by the end of the survey period.</p> <p>During an interview on 3/12/25 at 4:00 p.m., staff member C stated the heat pack policy was being updated to show only therapy can use the hydrocollator, but it had not yet been updated, due to administrative staff changes. Staff member C stated all staff were educated by email and instructed to no longer apply heat packs to any resident.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #9's nursing progress notes, dated 7/1/25, showed, . No c/o mouth/gum pain. No request for prn medication. There were no additional notes on this date to show the assessment, application of heat, monitoring, or follow-up.</p> <p>Review of resident #9's nursing progress notes, dated 7/2/25, showed, . NOC nurse reported to this RN at 0600 (6:00 a.m.) that resident had blisters on the left side of his cheek from a heat pack that was put on his face to help with oral pain. Heat pack was on too long and resident has developed blistering. Assessment of site Revealed the entire area from the left jaw to above his ear was red. Blisters noted from left cheek to left jaw line. All intact. Resident did allow this RN to place a cool compress on the left side of his face for pain and swelling. Will pass this onto the night nurse and DON. [sic]</p> <p>Review of a facility document, titled, Policy: Hydrocollator and Moist Heat Pack Usage, with an effective date of 3/8/23, showed, Only PT, OT, or CHARGE NURSE are permitted to utilize hydrocollator and/or MHPs . [sic]</p>