STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275087	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powder River Manor	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)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure readily available results of surveys completed by the State Survey Agency were located in a publicly accessible area. This failure would affect any person wishing to view the survey results. Findings include:During an observation on 9/8/25 at 1:18 p.m., the facility had a wall-mounted file holder viewable upon entrance into the facility's building, located on the wall of the common area TV room. The holder had a label with the words printed on it, SURVEY RESULTS. The holder did not have any binder or documents to view.During an observation on 9/10/25 at 8:22 a.m., the facility did not have any binder or documents to view in the same entry area wall-mounted file holder.During an interview on 9/10/25 at 10:12 a.m. staff member D stated she did not realize the binder with results from surveys was not available in the file holder. Staff member D stated she would check to see where it might be. During an interview on 9/10/25 at 10:51 a.m. staff member D stated she did not know why the binder had not been available in the file holder. Staff member D stated it could have been pulled to the nurses station for something and just not returned. Staff member D stated, It's one of those things, just in walking by it every day, you forget to think of that being there or not.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a completed POLST form with physician signature was readily accessible in the hard chart and the electronic medical record for 1 (#5) of 5 sampled residents. Findings include:During a record review of resident #5's POLST, dated [DATE], showed No CPR and selective treatment was selected, and the form was filled by the resident's responsible party. The form was not signed by resident #5's responsible party. The form was not signed by the provider, it was without a date, and there was not a printed name of the provider.During an interview on [DATE] at 11:23 a.m., staff member F stated admission forms, including POLST forms, were reviewed by staff member F, the resident or responsible party, and or family member. Staff member F stated some forms were given to the resident or responsible party to fill out ahead of time, before entering the facility. Staff member F stated she was not sure why resident #5's POLST had not been completed and filled out with the responsible party signature, provider signature, and date.Review of a facility policy titled, Advance Directives, revised [DATE], showed: . The facility defines the following in accordance with current OBRA definitions and guidelines:. a. Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. h. Physician Orders for Life-Sustaining Treatment (or POLST) . form - a form designed to improve patient care by creating a portable medical order form that records patients treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency .Review of a document provided by the facility, Directions for Health Care Professionals, revised [DATE], showed: Completing POLST . Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant. Patient (or legal decision-maker, if patient unable to make medical decisions) must sign to be valid.