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	04/22/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect from sexual abuse 1 (#13) by resident #4; and failed to protect from physical abuse 1 (#5) by resident #8 of 12 sampled residents. Findings include:1. Sexual AbuseReview of the facility investigation for the incident reported to the State Survey Agency on 1/26/26, showed resident #4 was found by staff with his hand down resident #13's brief in a common area. Resident #13 did not have capacity to consent. The facility investigation did not show other residents were interviewed or assessed for potential to be affected by similar sexual abuse incidents.During an interview on 4/21/26 at 4:22 p.m., staff member A stated the incident between residents #13 and #4 was reported to the wrong facility type license as they were unaware, they had an adult day care service license as well as the skilled nursing facility license. Staff member A stated the two residents were assessed and many interventions were put in place, but for the investigation no other residents were present, so no others were asked or assessed for potential similar incidents.During an interview on 4/22/26 at 12:26 p.m., NF2 stated he was notified when the incident happened and was told it was resident #13 and the perpetrator, and no other incidents have happened. He understood the interventions in place.During an interview on 4/22/26 at 3:04 p.m., staff member K stated he was the one who walked into the common area where he found resident #4 with his hand to his wrist inside the brief of resident #13. Resident #4 put his hands up when staff member K told him to stop. Staff member K stated he called the nurse to come, and the residents were immediately separated. Staff member K stated resident #4 was under constant supervision since the incident, and resident #13 had no change in her behavior.2. Physical AbuseReview of a facility incident reported to the State Survey Agency on 2/2/26 showed resident #8 was upset at his wife, resident #5, for being tired at dinner together in the dining room. He proceeded to shake her head to wake her. Staff intervened and took resident #5 to the nurses' station as she was agitated by the event, and resident #8 went back to their shared room. Resident #8 returned to the nurses' station with a spray bottle filled with water, and after staff asked him to give them the spray bottle, he continued and sprayed resident #5 in the face with the water until staff could remove the bottle from resident #8.During an observation on 4/21/26 at 7:56 a.m., resident #8 went into his room, which had the nameplates for resident #5 and resident #8. The belongings of both residents were in the room.During an interview on 4/21/26 at 4:22 p.m., staff member A stated the facility self-reported the incident of spouses due to resident #8 shaking resident #5's head and spraying her in the face with a water spray bottle to wake her up to eat dinner. Staff member A stated resident #5 was always out in the common areas.During an interview on 4/22/26 at 11:41 a.m., NF1 stated she was notified of the incident between resident #8 and #5. NF1 stated resident #8 was just being ?old school' and was just trying to get resident #5 to do what he thought was needed. NF1 stated it was the history of their relationship as spouses. NF1 stated that, for the most part, the two residents were kept away from each other when up, and resident #5 slept in a recliner by the nurses' station most of the time.During an interview on 4/22/26 at 2:49 p.m., staff member K stated resident #5 was rarely in her room, only when resident #8, her husband, was not. Staff member K stated resident #5 spent her time in her wheelchair and slept in a recliner by the nurse's station or common room, 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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ate at an assisted table away from resident #8 due to behaviors between the two.Review of resident #5's Care Plan, last updated on 4/9/26, showed she was not to be in the room when resident #8 was in the room unless they both wanted to be there during the day. The door had to be open, and staff had to intervene if yelling was occurring due to an incident of resident #8 shaking her head and using a spray bottle on 2/2/26.