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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to label, date, and store food in a manner to maintain food safety and prevent foodborne illness by failing to ensure all open items were dated. This deficient practice had the potential to affect all residents who ate at the facility. Findings include:During an observation and interview on 4/21/26 at 7:40 a.m., the initial kitchen walkthrough showed the following items were stored on the open shelving to the right of the grill and stovetop. The containers were opened for use, and not marked with the date they were opened:- large plastic bottle of cooking oil, capped,- large plastic bottle of butter-flavored oil, capped,- large container of parsley flakes, capped,- large container of dry, chopped onions,- round container of Quaker oats, capped- box of Malt-O-Meal hot breakfast cereal,- box of instant mashed potatoes,- large container of ground ginger, capped- large container of ground coriander, capped, and- large container of whole sesame seeds, capped.Staff member H stated she had been the kitchen manager for 12 years. Staff member H stated she tried to get the staff to date items when they were opened. Staff member H stated it was hard to get and keep good workers. Staff member H stated she was aware that the staff did not date food items when they were opened.During an interview on 4/22/26 at 2:00 p.m., staff member H stated she did not have a lot of storage space, so she felt she went through food items quickly enough to be safe. Staff member H stated she periodically checked food items for an open date. Staff member H stated that all staff were responsible for dating food items, and the facility had never had an outbreak of a foodborne illness due to food items being used beyond a safe use-by date.

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	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 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure the accuracy of MDS assessments for 2 (#s 1 and 7) of 12 sampled residents. Resident #1 had a history of pneumonia and resident #7 had limited range of motion to her left arm and shoulder. These were not accurately shown in the resident's MDS assessments. The deficient practice had the potential to affect resident care as the resident's current status was inaccurately documented. Findings include: 1. During an observation on 4/21/26 at 12.41 p.m., resident #1 was seated in the dining room eating lunch. The resident showed no shortness of breath, no cough, or any other respiratory symptoms. The resident was not using oxygen.Review of resident #1's Quarterly MDS assessment, with an ARD of 2/27/26, showed an active diagnosis of pneumonia. Review of resident #1's EHR, accessed on 4/21/26 and 4/22/26, failed to show any treatment, medication, or provider notes related to a pneumonia diagnosis during the past six months.Review of resident #1's diagnoses list in the EHR, accessed on 4/21/26, showed the resident had a history of pneumonia in 2022.During an interview on 4/22/26 at 11:41 a.m., staff member B stated the MDS system auto-populated diagnoses from the EHR to Section I. Active Diagnoses. Staff member B stated that the nurse completing the MDS remotely should have manually corrected the diagnosis list to show no current diagnosis of pneumonia. Staff member B stated she did not review the MDS for accuracy before it was submitted.2. During an observation and interview on 4/21/26 at 10:59 a.m., resident #7 was unable to lift her left arm above her shoulder.Review of resident #7's admission MDS assessment, with an ARD of 3/17/26, showed the resident had no limited range of motion.During an interview on 4/22/26 at 11:41 a.m., staff member B stated the nurse who had been doing MDS assessments for some time had left the facility. Staff member B stated the facility had hired a nurse to remotely complete the MDS assessments while she and another staff member completed MDS assessment training. Staff member B was not able to say why the remote nurse completed the range of motion information incorrectly. Staff member B stated resident #7 had been at the facility in 2022, and those assessments showed no limited range of motion.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure direct care staff were aware of a resident's wandering behaviors and the need to increase monitoring when the weather warmed up for 1 (#6) of 12 sampled residents. This deficient practice increased the risk the resident would leave the facility unaccompanied. Findings include: Review of resident #6's dementia care plan, initiated on 4/7/21, showed the resident had memory problems due to her dementia. An intervention, initiated on 7/2/25, showed, Sometimes I attempt to go outside on my own repeatedly so a wander guard bracelet was put on my walker to alert staff .and also have history of going outside alone to try to check the bird feeders . [sic]During an observation on 4/22/26 at 8:00 a.m., resident #6 was seated in the dining room eating breakfast. When the resident had finished eating, she used her wheeled walker to ambulate back to her room.During an interview on 4/22/26 at 8:10 a.m., staff member F stated she had worked at the facility for several years. When asked about resident #6's wandering behaviors, staff member F stated resident #6 was not a wander risk and did not have a wander guard on her person or her walker. Staff member F did not remember resident #6 having any wandering or elopements in the past.During an interview on 4/22/26 at 9:56 a.m., staff member E was asked about resident #6's wandering behaviors. Staff member E stated resident #6 was not a wanderer. She stated the resident had occasional confusion but did not try to leave the facility.During an interview on 4/22/26 at 11:56 a.m., staff member B stated resident #6 went outside when the weather was nice. Staff member B stated the activities department provided bird seed for resident #6 to use when she wanted to fill the bird feeders. Staff member B stated the activities staff accompanied resident #6 outside to fill the bird feeders. Staff member B was not able to explain why the care plan did not include these warm weather outings and why some staff were unaware of resident #6's wander risk.Review of the facility's policy titled, Elopements and Wandering Residents, dated 8/26/24, showed, Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering . c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.