STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275121	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sidney Health Center Extended Care	104 14th Ave NW Sidney, MT 59270

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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 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 interview and record review, the facility failed to prevent abuse for 1 (#25) of 6 residents sampled for abuse. The failure resulted in a violation of the resident's right to be free of physical restraint and placed the resident at risk for serious harm. The facility identified the abuse, addressed and corrected the deficient practice before the survey; therefore, it was past non-compliance. Findings include:Review of a facility reported event, submitted to the State Survey Agency on 2/3/25 at 3:40 p.m., showed on 2/2/25 at 1:40 p.m., facility staff held resident #25 down for the purpose of administering an intramuscular medication due to resident #25's behaviors.During an interview on 12/3/25 at 8:35 a.m., staff member A stated that due to the serious nature of the incident, the staff members involved no longer worked at the facility. Staff member A stated a Performance Improvement Project (PIP) had been added to QAPI, including monitoring for further incidents of abuse and restraints. Staff member A stated no further abuse or use of restraints was identified, and the action item had been resolved.Review of the facility's investigation for the reportable incident showed:- The facility investigation substantiated abuse.- Staff interacted with resident #25 in such a way as to have contributed to increased behaviors exhibited by resident #25.- Resident #25 exhibited behaviors that did not rise to the level of posing a risk of immediate harm to herself or others.- Resident #25 was held in a way that restricted her movement while staff administered an injectable (IM) medication.- Staff failed to follow the care plan's behavioral interventions for resident #25.- Staff documented that the medication was administered after 3 interventions failed. Interventions listed were offer food, assess pain, and music. There was no indication that assessing pain resulted in an actual intervention, such as the administration of pain medication. The interventions of offering food and music are not listed in the care plan.- There was no order in the chart to hold resident #25 down during the administration of a medication.Corrective MeasuresReview of a facility document titled, Quality Assurance and Performance Improvement (QAPI) Meeting, dated 2/27/25, showed a Performance Improvement Project (PIP) titled, Abatement Plan (PIP) for 2/2/2025 Event-Abuse by APS had been reviewed and added to the QAPI program.Review of a facility document titled Ad hoc Quality Assurance and Performance Improvement (QAPI) Meeting, dated 3/7/25, showed a QAPI meeting was conducted to review the event and outlined training, education, corrective action, monitoring, and audits put in place.Review of a facility document titled Quality Assurance and Performance Improvement (QAPI) Meeting dated 7/31/25, showed the PIP titled Abatement Plan (PIP) for 2/2/2025 Event-Abuse by APS was resolved 7/31/25.Due to the survey findings and evidence gathered, the facility identified and corrected the deficient practice before the survey.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on Interview and record review, the facility failed to submit a report to the State Survey Agency within the required timeframe for reportable events for 5 (#s 9, 25, 30, 39, and 46) of 10 residents sampled for facility-reported events. Findings include: 1. Review of a facility reported event, dated 11/23/25 at 7:05 p.m., showed resident #9 had an unwitnessed fall with injury. The resident was treated in the ER and released. Resident #9 had a CT scan of her head and pelvis. The results of her CT scan showed a fracture to S5 vertebrae. The facility submitted the initial report to the State Survey Agency on 11/24/25 at 11:05 p.m. The submission was outside the maximum two-hour reporting window for incidents that result in serious bodily injury. During an interview on 12/2/25 at 3:40 p.m., staff member B stated reports to the State Survey Agency should be filed as soon as possible after an incident occurred and within two hours if there was a serious injury. Staff member B stated she did not know why any incident would be reported late. 2. Review of a facility reported event, dated 2/2/25 at 1:40 p.m., showed resident #25 was held down by staff during the administration of a medication. The event resulted in the termination of two staff members for abuse. The facility submitted the initial report to the State Survey Agency on 2/3/25 at 3:40 p.m. This was outside the maximum two-hour reporting window for incidents involving suspicion of abuse or mistreatment. Review of a facility provided document titled, Abuse Investigation-[Resident #25's Name], dated 2/2/25, showed NF4 was notified of the incident on 2/2/25 at 1:48 p.m. Staff member C was notified of the incident on 2/2/25 at 1:59 p.m. An investigation was initiated to determine if there was any abuse, and three staff members were suspended pending investigation. The report to the State Survey Agency did not occur until the following day. During an interview on 12/2/25 at 8:10 a.m., staff member A stated some incidents may have been reported late by NF4. 3. Review of a facility-reported event, dated 10/15/25, showed resident #30 sustained an unwitnessed fall. The facility's investigation included a review of the video surveillance, which showed resident #30 was attempting to move a blanket from a recliner, while holding a cup of coffee, and the resident appeared to have lost her balance and fell. The resident landed on her back. The facility's report of findings for resident #30's fall with injury was due on 10/22/25, but was not submitted until 10/24/25. During an interview on 12/3/25 at 11:35 a.m., staff member B stated the fall was determined to be accidental and not suspicious for abuse. Staff member B stated she did not know why the report of findings was not submitted on time. During an interview on 12/3/25 at 1:22 p.m., staff member A stated staff member B was responsible for the BOUNDS (Montana State Event Reporting System) reporting. Staff member A stated both she and staff member B have access to the reporting system. Staff member A stated she did not know why the investigative report findings were reported late for resident #30. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of a facility reported event, dated 9/25/25 at 6:30 p.m., showed resident #39 was involved in a resident-to-resident altercation where resident #39 was pinched by another resident. The abuse investigation findings were due on 10/2/25. Investigation findings were submitted to the State Survey Agency on 10/3/25. During an interview on 12/2/25 at 3:40 p.m., staff member B stated the facility has been working on improving the investigation processes. 5. Review of a facility-reported event, dated 8/30/25, showed resident #46 sustained an unwitnessed fall with injury. The resident was treated in the ER and released. The facility submitted the initial report to the State Survey Agency on 9/4/25; therefore, the final report to the State Survey Agency was late. During an interview on 12/2/25 at 3:40 p.m., staff member A stated reports were filed as soon as possible after an incident occurs, and staff member A stated she would be responsible for submitting a reportable incident if staff member B was unavailable or on vacation. During an interview on 12/3/25 at 11:35 a.m., staff member B stated she was not in the facility at the time of the incident and did not return to work until 9/3/25, after the resident had passed away. Staff member B stated the report and the findings were submitted on 9/4/25, after she returned to work. Staff member B stated she did not know why the report was not filed for resident #46 timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on Interview and record review, the facility failed to complete a thorough investigation and comprehensive corrective action following facility-reported events for 3 (#s 9, 39, and 46) of 10 residents sampled for facility-reported events. Findings include:During an interview on 12/2/25 at 8:10 a.m., staff member A stated the facility provided all investigation files they had for the requested incidents, which included for #s 9, 39, and 46. Staff member A stated they may not have formal investigation files on some of the incidents due to the previous Interim Director of Nursing not maintaining files for investigations. Staff member A stated that for those events, the only documentation they had was a copy of the submission of the event to the State Survey Agency. 1. Review of a facility reported event, dated 11/23/25 at 7:05 p.m., showed resident #9 had an unwitnessed fall with injury. The resident was treated in the ER and released. Resident #9 had a CT scan of her head and pelvic area. The results of her CT scan showed a fracture of the S5 vertebrae. Due to the resident's fall with significant injury, it was unwitnessed, and the resident was not a reliable reporter, the event met the reporting criteria for an injury of unknown origin. On 12/1/25 at 5:00 p.m., a request was made by the survey team for the investigation on the facility reported event for resident #9, dated 11/23/25, but the facility failed to provide an investigation file. 2. Review of a facility reported event, dated 9/25/25 at 6:30 p.m., showed resident #39 was involved in a resident-to-resident abuse altercation where resident #39 was pinched by another resident. On 12/1/25 at 5:00 p.m., a request was made by the survey team for the investigation for the abuse event involving #39, for the event dated 9/25/25, and the facility failed to provide an investigation file for this incident. 3. Review of a facility-reported event, dated 8/30/25, showed resident #46 sustained an unwitnessed fall with injury. The resident was treated in the ER and released. The facility submitted the report of findings to the State Survey Agency on 9/4/25. During an interview on 12/3/25 at 11:35 a.m., staff member B stated she was not in the facility at the time of the incident with resident #46, and she did not return to work until 9/3/25. Staff member B stated she did not investigate the incident. Review of a facility document, which was untitled and undated, showed, No investigation was conducted for the fall of [Resident #46], the fall occurred on 8/30/25. the DON was not back in the building until 09/03/2025 to do an investigation . [sic] Review of resident #46's nursing progress notes, hospital records, and death certificate validated the resident's death was not related to the fall on 8/30/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update resident care plans based on individual resident needs for 4 (#s 4, 8, 9, and 25) of 19 sampled residents. This deficient practice placed residents at risk for injury, unmet needs, and decline in overall function and health. Findings include:1. Review of resident #4's comprehensive care plan showed an admission date of 4/8/25. The care plan showed the resident was at high risk for falls, and a care plan problem for falls was dated 4/11/25. The care plan included a long-term goal for minimizing the risk of the resident's falls and injuries. The interventions to prevent falls included: Keep call light within reach. Instruct [Resident #4] of safety measures. Fall assessment PRN. Remind [Resident #4] to change positions slowly. An additional intervention was started on 9/11/25, to show resident #4 had a recent fall when she slipped while getting up from the toilet, and the resident had a rib fracture. The staff placed gripper strips in front of the toilet. A review of resident #4's medical record showed there was no fall safety event form completed for the 9/8/25 fall event, and there were no additional interventions added to the resident's fall care plan. The resident's care plan did not include that the resident was taking a high-risk anticoagulant medication, and there was no root cause analysis completed for the fall event since there was no fall event form completed following the fall, as to ensure the interventions on the care plan addressed the direct root cause(s) and contributing factors of that fall. 2. Review of resident #8's fall safety event form, dated 11/3/25, showed resident #8 experienced an unwitnessed fall. The section for the care plan review showed the review did not occur, and there were no interventions added to the care plan following the fall. The evaluation section showed the event was still open, not closed, with no root cause analysis completed for the fall, even though the fall occurred over a month before the survey. Review of resident #8's comprehensive care plan showed an admission date of 6/8/22, and the facility added a problem related to falls on 9/22/25. The care plan's long-term goal was for resident #8 to be free from injury from falls, and for resident #8 to be able to get herself to the edge of the mattress and fall to the floor mattress. The care plan's interventions were to keep resident #8's bed in the lowest position at night, and the floor mattress would be placed beside the bed. An additional intervention on the care plan included that a Hoyer lift was to be used for all transfers. The care plan failed to include interventions for the 11/3/25 fall, either added or deleted, or that the care plan was evaluated by the IDT to show the fall interventions in place after the fall continued to be appropriate. 3. A review of resident #9's event reports, dating from 11/10/25 to 11/27/25, showed resident #9 had four falls, and the resident sustained injuries on the falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident #9's care plan for fall prevention, dated from 6/2/25 to 12/2/25, showed no updates were made to the care plan interventions in response to the root causes of the resident's four falls, which occurred between 11/10/25 to 11/27/25. The last update made to the fall care plan interventions was dated 10/16/25. The facility failed to show that the interventions were evaluated, that the interventions continued to be appropriate, or that new interventions were identified related to the direct root causes of the four falls during that time span. 4. A review of resident #25's event reports, with the date range of 11/1/25 to 11/28/25, showed resident #25 had five falls with injury within that time frame. A review of resident #25's care plan for fall prevention, with the date range of 10/1/25 to 12/3/25, showed there were no updates made to the care plan for fall prevention efforts in response to the five falls that occurred between 11/1/25 to 11/28/25. The last update to the fall care plan interventions was dated 4/21/25. The facility failed to identify and address the direct root causes of the five falls in the fall prevention care plan. During an interview on 12/3/25 at 10:04 a.m., staff member B stated when there was a fall, the nurse on duty would complete a fall report, send a text to staff member B related to the fall, and interventions were implemented to prevent further falls. Although staff member B stated this was the process for falls, this did not occur. During an interview with staff members E and F, on 12/3/25 at 1:35 p.m., staff member E stated she, along with staff member F, split the case load of facility residents. Staff member E stated she would add updates to resident care plans after completing MDS assessments. Staff member E stated she did not know how additional updates to care plans were communicated to direct care staff who worked with the residents. Staff member E stated, right now, care plan intervention updates were, Like puddling through a mud puddle, we are going to get a process together. Staff member E stated resident falls were discussed in their morning meeting, and sometimes it was unclear who was responsible for updating the care plan after a fall. A review of a facility policy titled Fall Prevention Program last revised on 12/31/24, showed: .Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: . 9. When any resident experiences a fall, the facility will: . . e. Review the resident's care plan and update as indicated. [sic]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an effective fall prevention program; failed to follow the established fall policy and failed to identify and address the direct root causes of resident falls with and without major injury. Additionally, the facility did not ensure staff received updated fall-prevention training or education on newly implemented fall prevention interventions. These failures negatively affected 4 (#s 4, 7, 9, and 46) residents out of 5 residents sampled for falls with injuries, to include: - Resident #4 experienced a fall on 9/8/25 and sustained a rib fracture;- Resident #7 experienced multiple falls, with three individual falls on 2/13/25, 6/17/25, and 11/13/25, where she sustained injuries to include head lacerations and bruising. - Resident #9 experienced a fall on 11/23/25, sustaining an S5 sacral fracture and orbital hematoma;- Resident #46 experienced a fall on 8/30/25, sustaining a head laceration. On 12/3/2025 at 4:05 p.m., the facility Administrator and Director of Nursing were notified that an Immediate Jeopardy existed in the area of F689 - Accidents and Hazards, which was identified to be at the severity and scope of K. Upon removal of the immediacy, this was lowered to an H. The facility submitted an acceptable plan to remove the immediacy, which was verified as removed on 12/4/25 at 9:45 a.m., and it was validated that the facility did remove the immediacy as of 12/3/25 at 8:30 p.m. Findings include: 1. Resident #4: Review of resident #4's nursing progress notes, dated 9/8/25 at 4:02 p.m., showed: CNA reported to this nurse, resident was standing up from the toilet and feet slipped and she sat down hard on the toilet, striking left side of lower back on toilet rails. No bruising or swelling noted. Resident reports pain of a dull ache when ambulating or standing. During an interview on 12/3/25 at 8:42 p.m., staff member B stated there was no fall checklist packet completed for resident #4's fall in September. Staff member B stated it had not been considered a fall by staff, so no fall checklist was started. Review of resident #4's electronic medical record showed an admission date of 4/8/25. Resident #4's primary admitting diagnosis showed, Fracture of unspecified part of neck of left femur. Resident #4 had diagnoses including Long term (current use of anticoagulants) and, Chronic atrial fibrillation. Review of resident #4's Minimum Data Set (MDS) with a Quarterly assessment reference date (ARD) of 9/17/25, section J Health Conditions, showed Yes was coded for Has the resident had any fall since admission/entry or reentry or the prior assessment.? The response was marked as 1, showing a fall, and a major Injury occurred, which would include bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma. Review of resident #4's nursing progress notes, dated 9/5/25 at 11:09 p.m., showed: Alert medication charting: Change in Warfarin 5mg to be given Mon & Fri & 7.5 mg to be given Sun, Tue, Wed, Thurs & Sat (for the days in the week). No adverse symptoms observed with this medication change. No abnormal bleeding & or bruising. VS stable. [sic] There were no nursing progress notes to reflect any change of condition or assessments of resident #4's back or upper and lower extremities completed by nurses on 9/8/25, 9/9/25, and 9/10/25, after the 9/8/25 fall event occurred. There were no fall safety event forms completed for the 9/8/25 fall event in the bathroom. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of resident #4's nursing progress notes, dated 9/11/25 at 2:29 p.m., showed: The resident requested an x-ray to her right ribs this morning. Walk-in clinic appt made. CT chest without contrast obtained. Impression: Acute appearing fracture of the right ninth rib posteriorly. No pneumothorax. Multiple healing left-sided rib fractures. 2. Resident #7: During an observation on 12/2/25 at 11:05 a.m., resident #7 was sitting in her recliner in her room. Resident #7 had a nasal cannula on, with tubing connected to an oxygen concentrator. Resident #7's room was dark, and she was resting with her eyes closed. No signs were posted on resident #7's door or wall to reflect that the resident was at an increased risk for falls. During an interview on 12/3/25 at 10:50 a.m., staff member A stated residents who had a history of falls had different interventions implemented and included in their care plans. Staff member A stated the facility had never considered using any kind of fall or bed alarms for residents. Staff member A stated there had been a discussion at one point to use a soft helmet for a resident as a fall safety precaution. Staff member A stated the intervention was never attempted because it was considered a dignity issue. During an interview on 12/3/25 at 11:25 a.m., staff member B stated the current fall prevention protocol meant there would be an update to the resident's care plan reflecting the resident was at increased risk for falls. Staff member B stated there would be alert charting completed on a resident after a fall. The alert charting documentation would be continued for three days after a fall occurred. The alert charting would identify fall outcomes or issues related to it. Review of resident #7's electronic medical record showed she was admitted to the facility on [DATE]. Resident #7 had a total of seven documented falls from the date of her admission through 11/13/25. Resident #7 experienced a witnessed fall and multiple unwitnessed falls. There were two fall risk assessments completed for resident #7; one on 1/2/25 and the other on 12/3/25. Review of resident #7's Minimum Data Set (MDS) with a quarterly assessment reference date of 3/26/25, section C Cognitive Patterns, showed the Staff Assessment for Mental Status reflected resident #7 had problems with short-term memory, which was for seems or appears to recall after 5 minutes, and had problems with her long-term memory, which was for seems or appears to recall long past. Section I, for the resident's Active Diagnoses, showed resident #7 had two neurological conditions: seizure disorder and Traumatic Brain Injury (TBI), which would impact her ability to remember what was instructed to her, such as remembering to use her call light for assistance. Section N, or Medications, showed the resident took high-risk drugs in the categories of anticonvulsants, diuretics, and antibiotics. These drug categories increase the risk for older adults to experience falls and or injuries, due to common side effects. Review of resident #7's fall risk assessment, dated 1/2/25, showed: - Does the resident have a history of falls in last 3 months? with the answer marked as a score of, 4 showing Three or more falls. - Fall Risk Score – Score of 10 or higher represents a high risk for falls, with a total score of 14, and a level of At Risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility reported incident, dated 2/13/25, showed resident #7 was found on the floor in her room with blood coming from her forehead. The report showed the resident was transferred to the ER for evaluation and treatment. A review of resident #7's Progress Notes from her medical record showed on 2/10/25 that she had been refusing to get out of bed for three days. She complained of weakness and stated she was to weak to stand to check her blood pressure checked. The nursing notes did not address her fall precautions or increased risks related to her weakness. The next progress notes occurred on 2/13/25, which is when the resident fell. Review of the facility reported incident findings, submitted to the State Survey Agency on 2/19/25, showed resident #7 was trying to transfer herself from her recliner to a wheelchair and slipped on a small rug. The findings showed that resident #7 was treated for a laceration in the ER. Resident #7's family removed the rug from the floor and agreed to gripper strips on the floor in front of the recliner, as resident #7 refused to wear gripper socks. Review of resident #7's social services progress notes, dated 2/13/25 at 12:07 p.m., showed: Stopped in to see [Resident #7], she had fallen this morning. We had just visited yesterday about waiting for help. She said that it is very hard when you are independent and she does not like having to ask for help. I talked to her about if she has a serious injury she is going to loose her independent due to a fx hip or something, so in the long run she will be more independent if she accepts help and prevents injuries. [Resident #7's] thought process was all over the place she jumped from topic to topic and at times her responses were not related to the current topics. [Resident] does admit she forgets to use call light, she refuses to have signs to remind her. She said her sons have strongly encouraged her to wait for assistance. [sic] Review of resident #7's nursing progress notes, dated 6/17/25 at 5:58 p.m., showed: During attempt to get a weight on [Resident #7]. While the CNA was helping [Resident #7] to stand she lost her grip on [Resident #7]. [Resident #7 lost her balance and fell to the floor hitting her head on the over the bed stand. When I arrived in the room [Resident #7] was laying on her left side with her head near the over the bed stand. Blood noted on the floor and [Resident #7] was asking to get up. [Resident #7] was noted to have a small laceration above her left eye that was bleeding. [Resident #7] was cleaned up since she had blood on her head and face. [Resident #7] is noted to have a small skin tear on her left forearm and an abrasion below her knee cap on her left lower extremity. Neuros started. Sent [Resident #7] to ER for further assessment . [sic] Review of resident #7's fall safety event form, dated 11/13/25, showed: CNA heard a thump and found resident laying on her left side in front of her bed. Resident states the floor was very slippery. Resident did have slipper socks on. Tube feeding running. Resident confused but able to follow direction. 2 lacerations on the forehead were cleaned and dressed. Resident incontinent of BM. She was changed. Abrasion on left knee was cleaned and dressed. DON notified. Called and gave report to ER nurse and CNA transferred resident to ER in wheelchair at 0455 (4:55 a.m.) . [sic] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275121	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sidney Health Center Extended Care	104 14th Ave NW Sidney, MT 59270

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The fall event form showed resident #7's care plan was not reviewed, and the evaluation section marked, N/A: Event still open, failed to reflect a root cause analysis was completed for the event. A review of resident #7's comprehensive care plan showed she had a problem identified for falls. The care plan had interventions carried over from the prior year that were no longer applicable. The care plan did not address her weakness and fall prevention efforts when trying to transfer herself in/out of bed, what staff were to do related to increased monitoring if the resident was confused and could not remember to use the call light, but staff were to reinforce the use of the call light, even though the resident was noted to be confused consistently. An intervention showed staff were to make frequent rounds to establish her routines and times she liked to do things, and if there were patterns, incorporate safety interventions. It did not appear that safety interventions were developed related to this intervention. The resident had a problem of being always incontinent of bowel, but the care plan did not address interventions for staff to use to ensure the resident's incontinence needs were met as it related to fall prevention, such as a scheduled toileting plan, or increased monitoring during times when she frequently had a bowel movement. 3. Resident #9: During an observation on 12/2/25 at 10:30 a.m., there was no information in resident #9's room or on the door to alert staff that resident #9 was a fall risk. During an interview on 12/2/25 at 10:45 a.m., staff member M stated a resident's fall risk was communicated during report, and the resident's name was listed on the CNA assignment sheets. Staff member M stated there was a binder at the nursing station for reviewing the care plan changes. Staff member M stated she had received training on fall prevention, but was uncertain when it occurred. During an interview on 12/2/25 at 10:55 a.m., staff member N stated she was not aware of anything that may be posted in a resident room alerting staff to a resident's fall risk. Staff member N stated they kept track of residents who were a fall risk on the CNA assignment sheets. Staff member N stated if a resident was a fall risk, she would have them with her as much as possible, check on them a lot, and would have other staff watch the resident if staff member N was busy with another resident's care. Staff member N was unable to state specific care planned interventions for any residents she felt were a fall risk. During an interview on 12/3/25 at 10:04 a.m., staff member B stated falls had been identified as an issue and were tracked based on the fall investigation. Staff member B stated she was the staff member responsible for investigating and reviewing falls. Staff member B stated she looked at trends and staffing when the number of resident falls was high. Staff member B stated the facility was in the process of improving the review process for the falls, and she wanted to start a fall review team and implement a fall prevention program, such as a Falling Star Program. Staff member B stated these had not been implemented yet. Staff member B stated that when there was a fall, the nurse on duty completed a fall report, would send a text to staff member B, and interventions would be implemented to prevent further falls. Staff member B stated she did not keep investigation files related to falls; she would just keep her tracking sheets. Staff member B stated, I'm not always good at writing things down. During an interview on 12/3/25 at 10:50 a.m., staff member A stated the facility completed a fall checklist on all falls in the facility to ensure all fall investigation components were completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sidney Health Center Extended Care	104 14th Ave NW Sidney, MT 59270

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with staff members E and F on 12/3/25 at 3:30 p.m., staff member E stated resident falls were discussed in their morning interdisciplinary meeting, and sometimes it was unclear who was responsible for updating the resident's care plan after a fall occurred. Staff member F stated the MDS department tried to update care plans when they noted it had not been completed. Staff member F reported the facility had ongoing issues with fall prevention. Staff member F stated she thought this was due to staff turnover on the management team, especially because there had been a change in the Director of Nursing position. Staff member F stated the facility planned to implement a fall review team, but this had not been implemented yet. Staff member F stated, You just came a month too early. Review of a CNA assignment sheet, updated 11/28/25, showed no documentation to reflect the fall risk for resident #9. Review of a facility reported event, dated 11/23/25 at 7:05 p.m., showed resident #9 had an unwitnessed fall with injury. The resident required treatment in the ER for a fractured S5 vertebrae, pain to the right hip and leg, pain to the left arm, a frontal hematoma, a laceration to the left forearm, one skin tear to her right arm, and one skin tear to her right elbow. The resident was released back to the facility. A review of the Emergency Department Provider Notes, dated 11/23/25, showed: . ED Provider Notes. . Assessment/Plan/Decision Making: . She (resident #9) fell down from a standing position. She (resident #9) had a large frontal hematoma on the left side. A small superficial laceration in left proximal forearm, two small skin tears in right arm. CT scan reported a fracture in Sacrum (S5). She (resident #9) had laceration in left arm repaired with glu. She (resident #9) was given Tylenol for pain. [sic] A review of resident #9's event reports for falls, between the date ranges of 11/10/25 to 11/27/25, showed resident #9 had four falls with injury within that time frame. A review of resident #9's fall care plan, with the date range from 6/2/25 to 12/2/25, showed there was no update to the resident's individualized care plan interventions in response to the falls that occurred between 11/10/25 to 11/27/25. There were no root causes identified within the event reports to be included on the care plan for future fall prevention. The last edit to the fall care plan interventions was dated 10/16/25. 4. Resident #46: Review of a facility-reported event showed resident #46 sustained an unwitnessed fall on 8/30/25, which resulted in a three cm head laceration. Resident #46 was treated in the hospital emergency department and released back to the facility. Resident #46 later passed away at the facility due to an unrelated illness and was not present for the survey. During an observation on 12/2/25 at 8:56 a.m., there were no observed fall precaution signs posted in any resident room or on the resident doors, to show the residents were at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/3/25 at 10:50 a.m., staff member A stated the facility completed a fall checklist on all resident falls that occurred in the facility, to ensure all fall investigation components, were completed. During an interview on 12/3/25 at 11:25 a.m., staff member B stated resident #46's fall was not investigated because resident #46 passed away from an unrelated cause, before staff member B returned to work, and therefore the fall did not need to be investigated. Staff member B stated there was no root cause analysis completed for resident #46's fall with injury, and the IDT did not review the fall. Review of resident #46's nursing progress notes showed resident #46 returned to the facility on 8/30/25 at 2:02 p.m. The resident passed away on 9/1/25 at 1:49 a.m. Review of a staff education, titled Post Fall Procedures, showed: . A comprehensive post fall management plan should include, but is not limited to: . Revise plan of care and/or facility practices to reduce likelihood of another fall. [sic] Review of a facility policy titled Fall Prevention Program, revised on 12/31/24, showed: .Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: . 7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. . 9. When any resident experiences a fall, the facility will:. . e. Review the resident's care plan and update as indicated. f. document all assessments and actions. [sic] Review of the facility policy titled, Fall Risk Assessment, revised 12/31/24, showed: .It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents . 1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. 2. The risk assessment will contain the following components: a. Identify environmental hazards and individual risks, including the need for supervision b. Evaluate and analyze hazards and risks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident. 5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.