

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>275121                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>12/04/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Sidney Health Center Extended Care                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>104 14th Ave NW<br>Sidney, MT 59270 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                  |                                                 |
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| F 0689<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Some               | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 &amp; Fri &amp; 7.5 mg to be given Sun, Tue, Wed, Thurs &amp; (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Sat (for the days in the week). No adverse symptoms observed with this medication change. No abnormal bleeding &amp; or bruising. VS stable. [sic]</p> <p>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.</p> <p>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.</p> <p>2. Resident #7:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.<br/>(continued on next page)</p> |                                                                                  |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of resident #7's fall risk assessment, dated 1/2/25, showed:</p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Fall Risk Score &amp;ndash; Score of 10 or higher represents a high risk for falls, with a total score of 14, and a level of At Risk.</li> </ul> <p>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.</p> <p>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 too 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.</p> <p>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.</p> <p>Review of resident #7's social services progress notes, dated 2/13/25 at 12:07 p.m., showed:</p> <p>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 lose 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]</p> <p>Review of resident #7's nursing progress notes, dated 6/17/25 at 5:58 p.m., showed:</p> <p>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]</p> <p>Review of resident #7's fall safety event form, dated 11/13/25, showed:</p> <p>CNA heard a thump and found resident laying on her left side in front of her bed. Resident states the (continued on next page)</p> |                                                                                  |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>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]</p> <p>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.</p> <p>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.</p> <p>3. Resident #9:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 (continued on next page)</p> |                                                                                  |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>would just keep her tracking sheets. Staff member B stated, I'm not always good at writing things down.</p> <p>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.</p> <p>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.</p> <p>Review of a CNA assignment sheet, updated 11/28/25, showed no documentation to reflect the fall risk for resident #9.</p> <p>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.</p> <p>A review of the Emergency Department Provider Notes, dated 11/23/25, showed:</p> <p>. ED Provider Notes.</p> <p>. Assessment/Plan/Decision Making:</p> <p>. 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]</p> <p>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.</p> <p>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.</p> <p>4. Resident #46:</p> <p>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 (continued on next page)</p> |                                                                                  |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of a staff education, titled Post Fall Procedures, showed:</p> <p>. 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]</p> <p>Review of a facility policy titled Fall Prevention Program, revised on 12/31/24, showed:</p> <p>.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.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>. 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.</p> <p>. 9. When any resident experiences a fall, the facility will:.</p> <p>. e. Review the resident's care plan and update as indicated.</p> <p>f. document all assessments and actions. [sic]</p> <p>Review of the facility policy titled, Fall Risk Assessment, revised 12/31/24, showed:</p> <p>.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 .</p> <p>1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified.<br/>(continued on next page)</p> |                                                                                  |                                                 |

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| F 0689<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Some               | 2. The risk assessment will contain the following components:<br><br>a. Identify environmental hazards and individual risks, including the need for supervision<br>b. Evaluate and analyze hazards and risks.<br><br>4. The At Risk for Falls care plan will include interventions, including adequate supervision,<br>consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk<br>of an accident.<br><br>5. Monitor the effectiveness of the care plan interventions, and modify the interventions as<br>necessary, in accordance with current standards of practice. |                                                                                  |                                                 |

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| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was held at safe temperatures in the steam table<sup>1</sup>. The failure placed all residents who are served food from the steam table at risk for foodborne illness. Findings include: During an initial observation of the facility's dining room on 12/1/25 at 5:45 p.m., staff member G was observed in the dining room talking with a resident who was seated at a table. A steam table was observed, which contained trays with stuffed peppers, chicken strips, and soup. All trays were uncovered, and the lids were set off to the side of the steam table. During an observation and interview on 12/1/25 at 5:50 p.m., with staff member A, staff member G was prompted to check the holding temperatures of all foods in the steam table. Staff member G checked the temperature of one stuffed pepper on the top layer and reported the temperature at 127 degrees (Fahrenheit). Staff member G checked the chicken strips last and reported a temperature of 131 degrees (Fahrenheit). Staff member G stated that the recommended intervention if food was not held at warm enough temperatures would be to place the lids on the food trays. Staff member G did not place a lid on the trays of food in the steam table after identifying and reporting the low temperatures. During an interview on 12/2/25 at 2:40 p.m., while discussing the food service observations on 12/1/25, staff member A stated staff member G did not cover the food on the steam table after identifying the low temperatures. Two telephone interview attempts were made to staff member O regarding food service operations on 12/3/25 and 12/4/25. No return calls were received by the end of the survey period. <sup>1</sup>Review of the State Food Safety Resource website, showed, . Anytime the temperature of TCS (Time/temperature Control for Safety) food falls between 41-135 F, the number of pathogens in the food start growing quickly. The longer food stays in the temperature danger zone, the more dangerous it becomes. Hot holding temperatures should stay above 135 F It's an important part of your job as a food handler to keep held food out of the temperature danger zone. Check food warmers, steam tables, and hot holding units regularly to make sure hot TCS foods are being held at 135 F or hotter. The information may be located at: <a href="https://www.statefoodsafety.com/Resources/Resources/holding-time-and-temperature-log; 2025">https://www.statefoodsafety.com/Resources/Resources/holding-time-and-temperature-log; 2025</a>.</p> |                                                                                  |                                                 |

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| F 0868<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to ensure the Medical Director participated in the Quality Assurance and Performance Improvement meetings, in order to meet the minimum requirements for the meeting attendees and frequency. This failure could affect any resident when or if a care system was effectively addressed or corrected for a deficient practice. Refer to F689 Accidents and Hazards, with an Immediate Jeopardy cited related to falls; F880, Infection Control; F883 Influenza Vaccines; and F887 Covid-19 vaccines, all system failures related to direct care. Findings include: During an interview on 12/3/25 at 8:31 a.m., staff member A stated that sign-in attendance sheets were not used to track attendees who participated in the QAPI meetings. Attendance was noted on the meeting minutes with the word present listed by the names of the attendees who were at each meeting. Staff member A stated the Medical Director was a member of the QAPI team but did not attend meetings regularly. Staff member A stated the medical director was provided with the meeting minutes and updated regarding significant action items being followed in QAPI. During an interview on 12/3/25 at 12:07 p.m., staff member D stated he did not physically attend QAPI meetings, but he planned to start. Staff member D stated he was provided updates from QAPI meetings via the meeting notes. Staff member D stated he was not aware whether the QAPI committee had identified resident falls as a concern, or if the facility created a performance improvement plan in an effort to decrease the number of falls residents were experiencing. During an interview on 12/3/25 at 12:07 p.m., staff member A stated she was not sure the last time staff member D attended the facility's QAPI meeting but said she thought it had been a couple of years. Review of a facility provided document titled QAPI Facility Plan dated July 31, 2025, showed, . The core members are the Medical Director or his/her designee. [sic] Review of a facility provided document, titled [Facility Name] Quality Assessment Program, which was undated, showed: . B. The Quality Assessment Committee membership includes: 1. Medical Director. [sic] Review of the facility-provided documents titled Quality Assurance and Performance Improvement (QAPI) Meeting dated May 22, 2025; July 31, 2025; and October 23, 2025, showed staff member D was not marked as present for any of the meetings.</p> |                                                                                  |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>275121                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                         | (X3) DATE SURVEY<br>COMPLETED<br><br>12/04/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Sidney Health Center Extended Care                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>104 14th Ave NW<br>Sidney, MT 59270 |                                                 |
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| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | Provide and implement an infection prevention and control program.<br><br>Based on interview and record review, the facility failed to maintain adequate infection surveillance and documentation within the facility over a four-month period for the early identification and monitoring of infections and safe infection control practices. This failure increased the risk for all residents in the facility and staff, related to the transmission and prevention of infectious agents. Findings include: During an interview on 12/3/25 at 10:27 a.m., staff member A stated she was unable to locate infection surveillance logs for the period of February 2025 through June 2025. Staff member A stated she only had line lists for a norovirus and a COVID outbreak that were tracked earlier in 2025. During an interview on 12/3/25 at 2:41 p.m., staff member R stated she had started in the position in July 2025. Staff member R stated in September 2025 that she had updated many of the program components to bring the facility back into compliance with the Federal regulations. Staff member R stated she did not know how the facility was tracking infections before starting her role. Staff member R stated that staff member A would have to provide information for infection surveillance logs before July 2025. Review of a facility document titled INFECTION PREVENTION AND CONTROL PROGRAM FY 2026, not dated, showed: . Surveillance, including process and outcome surveillance, will include monitoring, data analysis documentation, and communicable diseases reporting (as required by State and Federal law and regulation). Surveillance activities will be conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations. A request was made on 12/4/25 at 9:54 a.m. for the facility infection control surveillance logs for any facility infections from February through June 2025. No documentation was provided before the end of the survey. |                                                                                  |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |                                                                                  |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> |                                                                                  |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Respond appropriately to all alleged violations.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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]</p> <p>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.</p> |                                                                                  |                                                 |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>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:</p> <p>Keep call light within reach.</p> <p>Instruct [Resident #4] of safety measures.</p> <p>Fall assessment PRN.</p> <p>Remind [Resident #4] to change positions slowly.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A review of resident #9's care plan for fall prevention, dated from 6/2/25 to 12/2/25, showed no<br/>(continued on next page)</p> |                                                                                  |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>275121                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                         | (X3) DATE SURVEY<br>COMPLETED<br><br>12/04/2025 |
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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                  |                                                 |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A review of a facility policy titled Fall Prevention Program last revised on 12/31/24, showed:</p> <p>.Policy:</p> <p>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.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>. 9. When any resident experiences a fall, the facility will: .</p> <p>. e. Review the resident's care plan and update as indicated. [sic]</p> |                                                                                  |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>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 Measures Review 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.</p> |                                                                                  |                                                 |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on interview and record review, the facility failed to ensure adequate documentation was completed and maintained for the education provided to the resident or their responsible party, related to the risks and benefits of the seasonal influenza vaccination, for 3 (#s 6, 7, and 13) of 5 residents sampled for vaccinations. Findings include: During an interview on 12/3/25 at 2:41 p.m., staff member R stated she had administered vaccinations to facility residents for seasonal influenza and COVID vaccinations. Staff member R stated there was a section in the electronic medical record for a resident's vaccination administration information to include education on the risks and benefits provided to residents or their responsible parties. Staff member R stated she needed to go back into the resident medical records to update that section to indicate the education was provided to the resident or responsible party. Staff member R stated there were a few other nurses who administered vaccinations, but she administered most of the seasonal vaccinations. Review of a facility document, untitled and undated, included a table of residents who consented or declined to receive influenza and COVID vaccinations in October 2025. Resident #s 6, 7, and 13 declined the influenza vaccination in October 2025. Review of resident #s 6, 7, and 13's vaccination records did not show documentation of education provided explaining the risks and benefits of the influenza vaccination to the resident or their responsible party. Review of a facility document titled Influenza and Pneumococcal Immunizations, revised 1/21, showed: . PURPOSE: To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza, and pneumococcal pneumonia. PROCEDURE: 1. Before offering the influenza immunization, and/or the pneumococcal immunization, each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of these immunizations. 2. Documentation of this education will be placed in the resident's medical record.</p> |                                                                                  |                                                 |

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| F 0887<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on interview and record review, the facility failed to ensure documentation was completed and maintained to show education was provided to the resident or their representative related to the risks and benefits of the COVID-19 vaccination, for 4 (#s 6, 7, 13, and 14) of 5 residents sampled for vaccinations. Findings include: During an interview on 12/3/25 at 2:41 p.m., staff member R stated she had administered Covid-19 vaccinations to facility residents. Staff member R stated there was a section in the electronic medical record for a resident's vaccination administration information to include education provided to the resident or their representative on the risks and benefits of the vaccine. Staff member R stated she needed to go back into the resident records to update that section showing the education was provided. Review of a facility document, that was untitled and undated, included a table of residents who consented or declined to receive the COVID-19 vaccination in October 2025. Resident #s 6, 7, 13, and 14 declined to receive COVID-19 vaccination in October 2025. A review of residents #6, 7, 13, and 14's vaccination records did not show documentation of the education on the risks and benefits provided prior to the COVID-19 vaccination being given or offered to the resident or responsible party. Review of a facility document titled Infection Prevention and Control Program, effective date 9/24, showed: . 8. COVID-19 Immunization: c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine.</p> |                                                                                  |                                                 |