

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Sweet Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Airport Rd Chinook, MT 59523	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652</p> <p>Based on observation, interview, and record review, the facility failed to ensure a vulnerable resident was free from physical abuse by another resident for 2 (#s 29 and 30) of 19 sampled residents and supplemental residents. Resident #30 was struck on two separate occasions by resident #29. Findings include:</p> <p>During an observation on 12/4/24 at 10:13 a.m., resident #30 was wandering throughout the facility, including going behind the nursing station. Resident #30 mumbled nonsensical words to herself, while ambulating alone, in the hallways. The resident was also wandering around the activity room during story time. Resident #30 would not sit down in the activity room or listen to the story being read.</p> <p>Review of a Facility-Reported Incident, dated 10/17/24, submitted to the State Survey Agency, showed resident #30 was struck on her right shoulder by resident #29. The report showed resident #29 was having difficulty adjusting to her new environment. Neither of the residents were able to recall or discuss the circumstances surrounding the incident.</p> <p>Review of the investigative file showed the facility failed to identify any possible triggers for the physical abuse perpetrated by resident #29 or how resident #30 would be protected from further abuse by resident #29.</p> <p>Review of resident #30's Admission MDS, with an ARD of 10/16/24, showed the resident was admitted to the facility on [DATE], had severe cognitive impairment associated with wandering behaviors. The wandering behaviors occurred daily and impacted other residents and staff at the facility.</p> <p>Review of resident #30's care plan, dated 10/22/24, failed to show the resident's wandering behaviors made her vulnerable and placed her at an increased risk of abuse by other cognitively impaired residents, specifically resident #29.</p> <p>During an interview on 12/4/24 at 2:16 p.m., staff member A stated she investigated the altercation between resident #29 and #30, which occurred on 10/17/24. Staff member A stated the incident did occur, but she felt it did not rise to the level of abuse because neither resident was able to remember the interaction, due to cognitive impairments, and resident #30 did not sustain an identifiable injury. Staff member A stated the facility identified the interaction as mistreatment rather than abuse.</p> <p>(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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a second Facility-Reported Incident, dated 10/24/24, submitted to the State Survey Agency, showed resident #29 and resident #30 were sitting in the TV area across from the nursing station. The report showed resident #29 stood up, walked approximately eight feet toward resident #30. Resident #29 said, Why don't you get up and do something. Resident #29 then hit resident #30 on the top of the head and pulled her hair. Staff who were present immediately separated the residents and assessed resident #30 for any injuries. The facility failed to protect resident #30 from further abuse as evidenced by a second incident involving resident #29 striking resident #30.</p> <p>Review of resident #29's care plan, dated 11/14/24, showed the resident was admitted to the facility on [DATE], was cognitively impaired, and was having difficulty adjusting to her new surroundings. The care plan identified the need to monitor the resident for potentially abusive interactions, but failed to identify resident #30 as a target of the potentially abusive interactions.</p> <p>During an interview on 12/4/24 at 2:47 p.m., staff member B investigated the incident which occurred on 10/24/24. Staff member B stated she did not feel the interaction was abuse because neither resident could recall the incident and resident #30 did not sustain any injuries. Staff member B stated she believed the incident involved mistreatment rather than abuse.</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, not dated, showed the purpose of the policy was to prevent any type of abuse (physical, verbal, mental, or sexual), including abuse by a resident towards another resident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>41652</p> <p>Based on observation, interview, and record review, the facility failed to thoroughly investigate resident to resident altercations, alleged to be abuse, for 3 (#s 19, 29, and 30) of 19 sampled and supplemental residents. Findings include:</p> <p>1. During an interview on 12/4/24 at 2:50 p.m., staff member A stated she submitted the initial report and findings for the incident, which occurred on 10/17/24. The incident involved an injury of unknown origin for resident #19. Staff member A felt the injury of unknown origin found on resident #19's forehead was not from an unwitnessed fall. Staff member A stated if resident #19 had fallen, she would not have been able to get back in her wheelchair without assistance. Staff member A stated there were no reports of any unwitnessed falls for resident #19. Staff member A stated resident #19 and resident #29 were roommates on 10/17/24 when resident #29 was observed being the aggressor in an altercation with another resident. Staff member A stated she felt there was a possibility the injury to resident #19 was sustained during an unwitnessed altercation between resident #19 and resident #29. Resident #19 would not have been able to defend herself due to her physical and cognitive limitations. Staff member A stated resident #19 was moved to a different room, away from resident #29.</p> <p>Review of a Facility-Reported Incident, dated 10/17/24 and submitted to the State Survey Agency, showed resident #19 was found to have a new bruise on her forehead, above her left eye. The incident findings, reported on 10/22/24, failed to show what the potential causes were for the injury to resident #19, including staff member A's feeling the injury may have been caused by resident #19's roommate, resident #29. The report submitted also failed to show resident #19 was moved to a different room for her safety.</p> <p>2. Review of two Facility-Reported Incidents, dated 10/17/24 and 10/24/24, showed the physical altercations which occurred between resident #29 and resident #30. The 10/17/24 incident showed resident #29 was seen punching resident #30 in the right shoulder. The investigation failed to show observations of resident #29's interactions with other residents, interviews with other residents and staff regarding the incident and any other similar interactions, and corrective actions implemented to protect resident #30 and other vulnerable residents from abuse. The second incident occurred on 10/24/24 and showed resident #29 hit resident #30 on the top of the head and pulled her hair. The investigation failed to show interviews with residents and staff regarding the incident or any corrective actions implemented to protect resident #30 and other vulnerable residents from abuse by resident #29.</p> <p>During an interview on 12/04/24 at 2:27 p.m., staff member B stated she investigated the altercation which occurred on 10/24/24. Staff member B stated both residents were cognitively impaired, and therefore it was only mistreatment rather than abuse by resident #29. Staff member B was not able to describe how residents were protected from abuse other than monitoring residents and separating residents if any incidents occur.</p> <p>Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, not dated, showed the follow-up investigation report contained sufficient information to describe the incident and any corrective action taken. The policy failed to show what was done when the incident involved residents rather than staff and residents.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>51133</p> <p>Based on observation and interview, the facility failed to provide proper oversight for the use of personal refrigerators in a resident's rooms for 3 (#s 1, 3, and 4) of 3 sampled residents with personal refrigerators. The deficient practice put any resident with a personal refrigerator at risk for consuming food not stored at safe temperatures and consuming outdated food. Findings include:</p> <p>During an observation on 12/3/24 at 8:27 resident #4's personal refrigerator contained no means to measure the temperature of the refrigerator. The freezer contained an unidentified substance in a clear plastic bag that was not labeled or dated. The freezer had a thick layer of ice built up inside and outside of the freezer compartment. There was an unidentified food item wrapped in a napkin in the refrigerator door which did not have a label or date. There was a food item wrapped in brown deli paper with no label or date. There were two green, plastic bags, which contained what resembled fruit which were not labeled or dated.</p> <p>A request was made on 12/3/24 at 1:10 p.m. for the facility's personal refrigerator policy. There was no information received prior to the end of survey.</p> <p>During an observation on 12/4/24 at 10:00 a.m., resident #1's personal refrigerator did not have a temperature gauge inside of the refrigerator to measure the temperature. There was granola bar in an opened wrapper not dated or labeled.</p> <p>During an observation on 12/4/24 at 10:04 a.m., resident #3's personal refrigerator did not have a temperature gauge to measure the temperature or to ensure the temperature was maintained at a safe level.</p> <p>During an interview on 12/4/24 at 10:07 a.m., when asked who managed the personal refrigerators in resident's rooms, staff member M stated, I guess we (housekeeping department) do. When asked how it was managed staff member M stated the housekeeping supervisor did it. When asked what happened when the housekeeping supervisor was not in the facility staff member M stated, I don't know.</p> <p>During an interview on 12/5/2024 at 10:07, staff member A stated she did not know how many residents had personal refrigerators in their room, and could not explain how they were managed for food safety.</p>		