

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 08/07/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to ensure vulnerable residents were free from physical abuse by another resident for 5 (#s 9, 13, 34, 73, and 98); and protect residents from misappropriation of medications for four (#s 34, 40, 57 and 67) of 16 sampled residents. Resident #9 was involved in 5 resident-to-resident altercations within the last five months. Findings include: 1. Resident to Resident Abuse Events: a. Review of resident #13's nursing progress notes, dated 7/27/25, showed that resident #13 was crying and upset. Resident #9 had grabbed #13's face and would not let it go. The nurse intervened and removed resident #9, but resident #13 was instantly upset. The progress notes did not contain any information regarding interventions for the prevention of abuse for #13, by resident #9. During an interview on 8/7/25 at 8:20 a.m., staff member B said the event between residents #9 and #13 was not reported to the State Survey Agency as abuse. Staff member B said resident #13 is either usually very happy or she cries. The staff thought her crying was just part of her usual behavior. The facility did not identify this event as reportable event or put safety interventions in place for future prevention of abuse by #9. Review of Facility-Reported Incidents, dated 3/11/25 through 6/11/25, submitted to the State Survey Agency, showed resident #9 was responsible for three resident-to-resident altercations in which resident #9 was the aggressor and one altercation where resident #9, was the victim, due to her wandering into another resident's room. b. Review of resident #34's nursing progress notes, dated 6/18/25 at 5:08 p.m., showed the nurse reported another resident (#9) attempted to choke resident #34. The note showed this altercation had happened the week prior, when there was a singing activity in the activity room. Resident #9 initially had her hands on resident #34's shoulders, but when the staff asked her to stop, resident #9 put her hands around resident #34's neck. Review of resident #34's progress notes showed no further actions were taken to prevent abuse or altercations between the two residents to ensure #34 was safe. During an interview on 8/5/25 at 2:10 p.m., staff member H said she was in the activity area when resident #9 had her hands on resident #34's throat. Staff member H said she asked the resident to remove her hands, but resident #9 wouldn't let go. Staff member H said she had the certified nurse assistant help the residents. Staff member H said she reported to the charge nurse on duty. The nurse in charge told her to mind her own business. Staff member H said she did not tell anyone else and did not make a report. Staff member H was unaware who was designated as the facility abuse coordinator. During an interview on 8/6/25 at 8:37 a.m., staff member J said a report was given to the nurse regarding resident #9 choking resident #34 in the activity room. Staff member J could not identify the date the event occurred. Staff member J said the activity was a movie. Staff member J said resident #34 was sitting in a chair, and resident #9 was standing behind her, rubbing her shoulders. Resident #9 then began rubbing the front of #34's neck. Staff member J said she heard resident #34 say, Don't you're choking me. Record review of a Facility-Reported Incident, dated 6/11/25, submitted to the State Survey Agency, showed resident #34 was at an activity when resident #9 came up behind #34 and put her hands on resident #34's shoulders. When resident #9 was asked to stop, she put her hands around resident #34's neck and grasped her firmly by the neck. c. Review of the Facility Reported Incident, submitted 3/18/25, to the State Survey Agency, showed resident #9 was in resident #98's room. Resident #98 was upset with resident #9 taking things out of her room, and resident #9 was hit on the head by the door. Review of the investigative files for the incidents noted above, showed the facility failed to identify any possible triggers for the physical abuse perpetrated by resident #9. 2. Review of a Facility-Reported Incident, dated 6/11/25, submitted to the State Survey Agency, showed resident #13 wandered into resident #73's room. Resident #13 yelled at resident #73. Resident #73 then slapped resident #13. The Facility Reported Incident, with the section of the report showing corrective actions taken, was blank. There were no interventions put into place to prevent further abuse or altercations or for the protection of either resident involved. During an interview on 8/5/25 at 11:00 a.m., staff member B said if the staff observed the residents and saw what was happening, there would not be any further investigation. Staff member B said the facility event reports are the only documentation the facility uses for investigations. Staff member B said a review of the resident event reports is only completed once a week. 3. Misappropriation of Drugs: During an interview on 8/5/25 at 9:11 a.m., staff members B and C were present for the interview. Staff member B said starting in May 2025, resident #46 ran out of Serquel about 14 days earlier than she should have. This was the first missing medication identified. Staff member B said she emailed the Drug Enforcement Agency for guidance but has not received any feedback from them. The investigation for the missing medications continued.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm 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 interviews and record reviews, the facility failed to report initial allegations or final summaries of abuse or misappropriation of property to the State Survey Agency in the required timelines established by the federal regulations, to meet the initial or final summary reporting requirements, for 7 (#s 5, 9, 13, 21, 34, 73, and 98) of 16 sampled residents. Findings include: 1. Review of a drug investigation packet, provided to the surveyor by the facility, showed that potential drug diversion occurred with resident medications, with the investigation starting in May 2025. The facility did not report the allegation or suspicion of drug diversion immediately at the time of the event. A review of the facility's Facility Reported Events showed they reported the drug diversion to the State Survey Agency on 7/30/25; they were delayed in reporting. During an interview on 8/5/25 at 9:11 a.m., with staff members B and C, staff member B said that starting in May 2025, resident #46 ran out of Seroquel, which was about 14 days earlier than she should have. These were the first missing medications, and the facility began investigating the situation. Staff member B said she emailed the Drug Enforcement Agency for guidance, but has not received any feedback from them as of the survey. Staff member B said she had not called the local law enforcement agency. Staff member B said the facility wanted to complete its medication audit before reporting anything to the police or the State Survey Agency. The facility did not report this information through a Facility Reported Incident to the State Survey Agency at the time of the initial allegation or suspicion of diversion. The facility did report the event to the State Survey Agency on 7/30/25. Review of a final drug diversion report the facility submitted to the State Survey Agency, on 8/8/25, showed the local police department was not contacted until 8/7/25, and the board of nursing was contacted on 8/7/25. 2. Review of the Facility Reported Incident, submitted to the State Survey Agency on 3/18/25, showed residents #9 and #98 were involved in a physical altercation. The final summary was not submitted until 3/26/25, eight days later, which did not meet the timely reporting requirements. 3. Review of the Facility Reported Incident, submitted to the State Survey Agency, on 5/3/25, showed residents #9 and #73 were involved in a resident-to-resident altercation. The final summary report was not submitted to the state survey agency until 5/12/25, but should have been sent in by 5/9/25. 4. Review of Facility Reported Incident, submitted to the State Survey Agency on 6/11/25, showed residents #13 and #73 had a physical altercation. This abuse report showed the altercation took place on 6/2/25, nine days before the report was submitted to the State Survey Agency, so the abuse event was not reported timely. 5. Review of Facility Reported Incident, submitted on 6/16/25, to the State Survey Agency, showed residents #9 and #34 had an altercation on 6/11/25. The initial report of abuse was submitted to the State Survey Agency five days after the altercation. Therefore, the allegation was not reported timely per the federal regulations. 6. Review of an untitled facility report dated 6/11/25, showed resident #5 had a bruise of unknown origin on her left foot, right thigh, and left upper calf. Review of the Facility Reported Events for the facility showed the initial report for #5's bruising was submitted on 6/11/25 to the State Survey Agency. The final summary was not submitted until 6/19/25. During an interview on 8/5/25 at 1:50 p.m., staff member B said she talked to resident #5's son, and he said the resident always bruised easily. Staff member B said there were no further actions taken on the investigation into the causes of the bruising. Staff member B said she did not know why the final summary report sent to the State Survey Agency was late in being finalized.</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>Based on observation, interview, and record review, the facility failed to thoroughly investigate resident-to-resident altercations, alleged to be abuse, for 5 (#s 9, 13, 34, 73, and 98) and failed to investigate bruising of unknown origin, for 1 (#5) of 16 sampled. Findings include: 1. Review of an untitled facility report, dated 6/11/25, showed resident #5 had a bruise on her left foot, right thigh, and left upper calf. The bruises were of an unknown origin. A Facility Reported Incident was submitted on 6/11/25 to the State Survey Agency. Review of Resident #5's nursing progress notes showed there was no progress note written to clearly identify or describe the bruises or the causes for them in resident #5's medical record. During an interview on 8/5/25 at 1:50 p.m., staff member B said she had talked to resident #5's family member, and he said the resident always bruised easily. Staff member B said there was no further investigation completed as to the cause of the bruises. A thorough investigation into potential causes or interventions to prevent the unknown bruising or potential abuse was not completed. 2. Review of a Facility-Reported Incident, dated 6/2/25 and submitted to the State Survey Agency, showed that resident #73 yelled at and slapped resident #13. The incident findings, reported on 6/11/25, failed to show what the potential causes were for #73 slapping and yelling at #9, and there were no interventions to prevent future abuse. 3. Review of Facility-Reported Incidents showed abuse events involving resident #9 and other residents, including: a. The 3/11/25 incident showed resident #9 sprayed alcohol and sanitizer on resident #34's face. The investigation failed to show observations of resident #9's interactions with other residents, interviews with other residents and staff regarding the incident, and or any other similar interactions, or corrective actions implemented to protect resident #34 and other vulnerable residents from abuse. The medical record did not show the responsible party was notified. b. Review of Facility-Reported Incidents, dated 3/18/25, showed a physical altercation which occurred between resident #9 and resident #98. Resident #98 hit resident #9. The untitled facility risk report did not show the root causes, interviews obtained from staff or other residents, or any actions taken to investigate this event. c. Review of the Facility Reported Incident, submitted on 5/3/25, showed resident #9 punched resident #73 in her back. The facility provided an untitled risk event report, which was said to be the only investigation for the abuse event. The facility failed to investigate further to identify root causes or precipitating factors for the abuse, or to identify or implement interventions for future prevention of abuse. d. The 6/11/25 incident showed resident #9 choked resident #34. The investigation failed to show interviews with residents and staff regarding the incident, or any corrective actions or interventions implemented to protect resident #34 and other vulnerable residents from abuse by resident #9. e. Review of the Facility-Reported Incident, dated 6/11/25, submitted to the State Survey Agency, showed resident #9 came up behind resident #34 and put her hands on resident #34's shoulders and choked her. Review of resident #9's nursing progress notes, dated 6/11/25, showed no progress note was written for the resident on this day. A request was made on 8/4/25 for an investigation into the event between #9 and #34, and no investigation was received by the end of the survey. f. Review of resident #13's nurse progress notes dated 7/27/25 showed resident #13 crying and upset. Resident #9 grabbed her face and would not let it go. The nurse intervened and removed resident #9, but resident #13 was instantly upset. The progress notes did not contain information regarding precipitating factors or interventions for the prevention of further abuse. During an interview on 8/5/25 at 11:00 a.m., staff member B said, Well, if the staff observed the residents and saw what was happening, there would not be any further investigation. Staff member B said the facility reviews the event reports every week, and the event reports are what the facility uses for investigations. There isn't anything else for investigations, as the facility uses the risk management forms. During an interview on 8/7/25 at 8:20 a.m., staff member B said resident #13 is either usually very happy or she cries. The staff members thought her crying was just part of her usual behavior.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm 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>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to revise and individualize comprehensive care plans to reflect the individualized needs or interventions to protect residents, for 6 (#s 5, 9, 13, 34, 73, 98) of 16 sampled residents, and the staff responsible for updating the care plans were not aware of what to add to the care plans for resident concerns related to abuse or protecting the resident. Findings include: 1. Review of resident #98's nursing progress notes, dated 7/5/25 at 3:34 p.m., showed the resident was found on the floor in the bathroom. Review of #98's untitled facility risk management report for the fall failed to show that a root cause was identified. The resident sustained a laceration to her face. The fall was not investigated for a cause, and there was no evidence that the facility reviewed the fall to prevent further falls. Review of resident #98's care plan with a revision date of 6/16/25, failed to show if the care plan was reviewed or updated related to the fall with injury on 7/5/25, or if interventions were identified to prevent future falls. 2. A review of resident #34's medical record showed the resident was the recipient of a physical assault by another resident on 3/11/25 and again on 6/11/25. Review of resident #34's care plan failed to show if any interventions were identified or added by the facility staff to ensure the protection of the resident, or if the resident was vulnerable to other residents for specific reasons. During an interview on 8/5/25 at 1:00 p.m., resident #73 said the resident who had been coming into her room does not bother her as much anymore, since she moved downstairs (to another wing of the facility). Resident #73 said the other resident threw alcohol on her face, and it got into her eyes, and she thinks her vision is blurrier since that time. Resident #34 said she feels more isolated in the new room, but she likes her own company. The resident's care plan had not been updated to address her vulnerability related to abuse and the physical aggression, or the isolation resident #34 is feeling since she moved rooms. 3. Review Facility-Reported Incident, dated 6/11/25, was submitted to the State Survey Agency, and it showed resident #5 had bruising of unknown origin to her left foot, her right thigh and her left upper calf. A review of the resident's current care plan failed to include the risk factors for bruising and the interventions for managing the potential for bruising. During an interview on 8/5/25 at 1:50 p.m., staff member B said the care plan for #5 should have been updated. 4. Review of Facility-Reported Incident, dated 6/2/25, and submitted to the State Survey Agency on 6/11/25, showed residents #13 and #73 were involved in a physical altercation. Review of resident #13's care plan was not updated and did not show any potential problems with resident-to-resident altercations, either as the aggressor or the resident being personally abused. 5. Review of resident #9's nursing progress notes, dated 5/25/25 at 6:21 p.m., showed resident #9 was observed coming back into the building after she eloped. The nursing note showed the staff observed resident #9 leave the building at 5:10 p.m., as well. Resident #9's care plan failed to include interventions to prevent elopement when attempting to follow her family or other people through the exit door, and the resident is cognitively impaired. 6. Review of the Facility Reported Incident, dated 5/2/25, and submitted to the State Survey Agency on 5/3/25, showed that resident #73 was involved in a physical altercation. Review of resident #73's care plan showed there were no interventions to prevent resident #73 from continuing to be involved in physical altercations. During an interview on 8/5/25 at 11:00 a.m., staff member B said the facility talked about making changes to the care plans during shift reports, but the care plans may not have been updated. Staff member B said she was not sure what could be done as there were many residents with dementia and the facility could not just restrain them. During an interview on 8/5/25 at 12:47 p.m., staff member D said she works part-time doing MDS assessments and care plans. Staff member D said the nurses will reach out to her when a care plan need to be updated. Staff member D said she also checks notes and incident reports weekly to identify things that need to have care plan updates on, and she will update care plans as needed. Staff member D said she believes she always gets notified when a care plan needs to be updated, and the care plans should be current. During an interview of 8/5/25 at 1:43 p.m., staff member E said she completed the behaviors, mood, psychosocial, communication, and dietary areas on the resident care plans. Staff member E said she only adds to the care plan to separate the residents if there has been an altercation. Staff member E said she did not know what to put on a care plan for the prevention of resident-to-resident abuse altercations. Staff member E said the interdisciplinary team does not work on the care plans as a group. Staff member E said half the time she is not in the facility when an altercation occurs, and she is not always informed of the issues. During an interview on 8/5/25 at 3:21 p.m., staff member I said investigations should occur after incidents to determine the cause of the event. Staff member I said the investigations should include interviews with other residents</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review, the facility failed to ensure the residents' highest practicable level of physical and psychosocial well-being was met for 2 (#s 13 and 34) related to medically related social services, of 16 sampled residents. Resident #34 felt isolated after her move, and #13 was upset over an abuse event; neither resident had a social service follow-up after the abuse event. Findings include: During an interview on 8/5/25 at 1:00 p.m., resident #34 said she did have some problems with another resident coming into her room. Resident #34 said the other resident was in her room, and stated, She squirted my eyes with some hand sanitizer. Resident #34 said she is still having problems with her left eye being blurry. Resident #34 said it made her feel very vulnerable. Resident #34 said she was moved to another area of the building, and she feels isolated now. Review of resident #34's progress notes showed no additional interventions related to social services or the resident's emotional well-being, following the physical abuse by resident #9. A review of Facility Reported Events showed resident #9 acted out on #34 on two occasions, on 3/11/25 and 6/11/25. During an interview on 8/6/25 at 12:09 p.m., staff member E said she was not even aware of resident #9 squirting hand sanitizer in resident #34's eyes. Staff member E said she only assesses the residents quarterly, or as needed, if she thinks it is necessary. Review of resident #34's medical record showed resident #34 had a (PHQ-9) Patient Health Questionnaire-9 completed on 1/7/25 and 7/1/25. The assessment was not completed quarterly, as stated by staff member D. The PHQ-9 is used to assess the resident for depression. 2. Review of resident #13's nursing progress notes dated 7/27/25 showed resident #13 was crying and upset. Resident #9 grabbed #13's face and would not let it go. The nurse intervened and removed resident #9, but resident #13 was upset. The progress notes did not contain any information regarding interventions for the prevention of abuse or to address the resident being upset. During an interview on 8/7/25 at 8:20 a.m., staff member B said resident #13 is either usually very happy or she cries. The staff thought her crying was just part of her usual behavior, and did not correlate it to the other resident grabbing her face. Review of resident #13's progress notes reflected that there was no documentation to show the resident's psychosocial or emotional health was assessed specifically following the abuse that caused her to cry and become upset.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview, and record review, the facility failed to maintain a system to store and monitor controlled drugs was in a manner to contain sufficient detail to enable an accurate reconciliation; and prevent diversion for 5 (#s 34, 40, 46, 57, and 67) of 16 sampled residents. 1. Review of a facility investigation file showed the facility began an investigation for missing medications in May of 2025. 2. During an interview on 8/5/25 at 9:11 a.m., staff members B and C were present for the interview. Staff member B said beginning in May 2025, resident #46 ran out of Seroquel about 14 days earlier than she should have. This was the first missing medication identified. Staff member B said she emailed the Drug Enforcement Agency for guidance but has not received any feedback from them. 3. During an interview on 8/5/25 at 12:32 p.m., staff member B said the investigation continued through 7/ 30/25. Staff member B said the common denominator with all the missing medication was NF5. Staff nurse NF5 continued working and signing for narcotics until she was terminated 7/30/25, over two months after the first narcotic was missing. NF5 refused to write a statement for the facility. 4. Review of the narcotic sheets showed the facility used three-hole punched loose-leaf paper placed in a binder for the tracking log. The pages were not numbered chronologically and did not correspond to the card of narcotics. The process did not provide a security check. This system allowed the card of medication to be removed from the secured medication cart, and the notebook paper was easily removed. 5. The facility completed its investigation and found: - Resident #46 was missing Seroquel of unknown quantity, - Resident # 40 was missing 3 tablets of Alprazolam, - Resident #57 was missing 17 tablets of Mirtazapine,- Resident #67 was missing 73 tablets of Tramadol, and- Resident #24 was missing 153 tablets of Norco. 6. Review of a final drug diversion report the facility submitted to the survey agency on 8/8/25, showed the local police department was not contacted until 8/7/25, and the board of nursing was contacted on 8/7/25. 7. During an interview on 8/5/25 at 4:04 p.m., staff member M said she was the consultant pharmacist for the facility. She said she was made aware of the drug diversion only a couple of weeks ago but did not remember the exact date. Staff member M said she did not assist the facility in any way with the drug diversion investigation. Staff member M said she does not look at assessments to determine if residents are experiencing freedom from pain. Staff member M said the facility used to be pretty good, and they would call her, and she would help with narcotics destruction. This had changed, and now the facility uses two people to destroy narcotics. Staff member M said she did not monitor any narcotics reconciliation logs because there are two nurses counting and signing off between shifts. 8. The facility policy titled Controlled Substances from MED-PASS, revised November 2022, was provided. The policy showed, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection and follow-up.If a major discrepancy or pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the and administrator and consultant pharmacist immediately. The administrator, consultant pharmacist, and /or the director of nursing services determine whether other actions are needed, e.g. notification of police or other enforcement personnel. the medication regimen of residents using medications that have discrepancies are reviewed to assure the resident has received all medications order and the goal of therapy is met (example: a resident receiving a pain medication complaints of unrelieved pain). The consultant pharmacist or designee routinely monitors controlled substance storage records.</p>		