STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275144	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastern Montana Veterans Home	2000 Montana Ave Glendive, MT 59330

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a complete investigation of a facility reported incident was provided to the State Survey Agency, and failed to maintain and provide accurate documentation of investigative findings for 3 (#s 2, 4, and 7) of 12 sampled residents. Findings include:During an interview on 12/10/25 at 1:03 p.m., staff member A stated he could do better with documentation of facility reports of incidents. Staff member A stated that one of the incidents being looked at took place four weeks ago, and he could not provide more documentation for it. Staff member A stated it was busy in November (2025), and four incidents happened in one week, and all of them needed to be reported. Staff member A stated, I don't have anything else for that incident (between resident #4 and resident #7). The documentation provided included one paragraph of findings that would have been submitted to the State Survey Agency, and no other event forms, documents, or evidence related to the event. During an interview on 12/10/25 at 2:50 p.m., staff member A stated his desk had been full of papers, and this week he had the opportunity to review and go through them. Staff member A stated he started his position in August (2025), and in September (2025) was the main staff member to report incidents. Staff member A stated that staff member B could also report incidents. Staff member A stated that some incident findings were based on his own interview notes with staff. Staff member A stated that those were all written in the findings section for the investigation information. Staff member A stated he saved those as reports and considered the notes to be the investigation findings, and he did not keep separate interview templates or documents. A. Review of a facility reported incident, dated 11/23/25, showed a resident-to-resident altercation between resident #4 and resident #7, which took place in a dining room. The report noted there was a verbal disagreement which led to resident #7 pushing a table towards resident #4. Review of the facility reported incident findings, submitted 12/2/25, showed findings related to an incident with resident #2, and a former travel staff member, and the information did not mention resident #4 and #7. The facility did not conduct a complete and accurate investigation of the incident between residents #4 and #7. There was no evidence of interviews completed with residents, staff, or witnesses involved. There were no interventions taken to address the incident between resident #4 and #7, for analysis and prevention of a recurrence between the two residents. B. Review of a facility reported incident, dated 11/26/25, showed an allegation of staff to resident verbal abuse. A contracted staff member spoke to resident #2 in an inappropriate way. The staff member was suspended, and an investigation was started. Review of the facility reported incident findings, submitted 12/3/25, showed the administrator interviewed other residents in the hall where resident #2 resided. The facility confirmed that the verbal abuse occurred, and the contracted staff member did not return to work at the facility. The facility did not conduct a complete and thorough investigation of the incident between resident #2 and the contracted staff member. The findings provided were the same reports viewed by the State Survey Agency, and the evidence did not include which residents were interviewed and their responses. The findings did not include interviews with other staff members who witnessed the incident. Review of a facility document, titled Incidents and Accidents, dated 5/16/25, showed: It is the policy of this facility for staff to utilize the risk management section. to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The purpose of incident reporting can include:- Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Compliance Guidelines:. 3. Incidents or accidents involving employees or visitors will be documented per facility protocol. 5. The following incidents/accidents require an incident/accident report but are not limited to:- . Resident to resident altercations- Resident injuries due to staff handling. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. 15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator. Review of a facility policy titled, Abuse, Neglect and Exploitation, revised 7/6/25, showed: . V. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 6. Providing complete and thorough documentation of the investigation. VII

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff members followed policies, procedures, and protocols to maintain resident safety by providing sufficient and necessary supervision on a secure care unit, for 4 residents (#s 6, 9, 10, and 12) of 6 residents sampled for injuries/abuse. This deficient practice contributed to resident altercations, and resident #10 sustained a hip fracture, which required hospitalization and surgical repair for the major injury; and resident #10 was not transferred properly and per the facility policies and procedures, after the fall, which may cause or contribute to an injury. Findings include:1. Review of a facility reported incident, dated 11/10/25, showed a resident-to-resident altercation occurred on the secure care unit between resident #10 and resident #12 on 11/9/25. The residents were sitting in the dining room together, and resident #12 pulled resident #10's wheelchair over, causing resident #10 to fall to the floor. Resident #12 was placed on one-to-one monitoring, and resident #10 had no injuries when assessed after the incident. The next day on 11/10/25, resident #10 was in pain and transferred to the ER for evaluation. Review of facility reported incident findings, submitted 11/18/25, showed resident #10 returned to the facility on [DATE] after surgery to repair his left hip fracture, sustained in the event with resident #12. The facility confirmed the incident did occur, with a plan to hold education with staff on the stages of dementia and behaviors, for those working on the secure care unit. During an interview on 12/10/25 at 2:08 p.m., NF2 stated staff called her the evening of 11/9/25 to inform her of a fall resident #10 had that day. NF2 stated staff informed her that resident #10 was doing ok and explained that resident #10 had been pushed over in his wheelchair by resident #12 and fell over onto the dining room floor. NF2 stated the next morning, 11/10/25, staff called to inform her of resident #10's noticeable pain level, with a plan to transfer him to the ER. NF2 stated resident #10 was admitted to the hospital and had surgery for a hip fracture. NF2 stated she was concerned that the incident could have caused a worse injury, like head trauma, and that would have been very serious. NF2 stated the facility had reviewed camera footage of the incident on 11/9/25 and apologized for the incident. NF2 stated the video footage showed that no staff were monitoring the dining room area, which was part of a large common room on the secure unit. NF2 stated, the staff member who should have been in the dining room area monitoring the residents should not have left them alone. NF2 stated she wondered why the staff member did not wait for others to be in the dining room before going into the kitchen area to put dishes away. NF2 stated the staff member should have immediately come back to the dining room to stop resident #12 from pushing resident #10 over. NF2 stated she was concerned about the lack of staff in the immediate area. During an interview on 12/10/25 at 10:15 a.m., staff member H stated she arrived on shift the morning of 12/10/25 and went to check on the residents in the secure unit. Staff member H stated she saw resident #10 moving around in bed and he looked like he was in pain. Staff member H stated she notified NF2 that resident #10 was going to transfer to the hospital for further evaluation. Staff member H stated staff on the secure unit were expected to be on the unit monitoring residents, and if a resident was identified to be a one-to-one monitoring status, the staff were to be within an arm's reach of the resident. Staff member H stated there are at least two CNAs on the unit for constant supervision of the residents. Staff member H stated that staff members have another staff member come replace them if they need to leave the unit, to go to break or lunch. During an interview on 12/10/25 at 11:28 a.m., staff member J stated she was working on the secure unit on 11/9/25 when resident #10 and resident #12 were in the dining room with staff member L. Staff member J stated she left to use the restroom on the unit since staff member L was with the residents. Staff member J stated staff member M left the unit to talk to the on duty nurse, and was not sure why staff member M did not use her radio or wait for another staff member to take her place. Staff member J stated she did not remember either resident #10 or resident #12's wheelchair wheels touching each other, or their wheels locked together. Staff member J stated staff member L went into the kitchen area, where the room divider was partially closed, out of the dining room area. Staff member J stated staff member L was speaking loudly to resident #12 since he was hard of hearing, saying, No, and so she ran out of the restroom to the dining room to help. Staff member J stated she went to get the nurse on duty and staff member M right away for assistance. Staff member J stated the nurse, another CNA on duty, and herself, transferred resident #10 from the floor to his wheelchair, manually, supporting him under both arms and holding the back of his pants. Staff member J stated that a gait belt was not used, but the gait belts were kept in the secure unit in a cabinet. Staff member J stated, We can do better about using gait belts, we don't