STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275147	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tobacco Root Mountains Care Center	326 Madison St Sheridan, MT 59749

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41951 Based on observation, interview, and record review, the facility failed to prevent an incident of physical and verbal abuse for 1 (#1) of 12 sampled residents. The event was identified as past non compliance due to the facility's actions. Findings include: Review of the facility reported incident, dated 12/18/24, showed resident #1 was seated in the dayroom, with his left leg elevated in a recliner. Staff member E had moved resident #1's wheelchair due to another event in the dayroom. Resident #1 became upset, yelled for his wheelchair to be replaced next to his recliner. Staff member E aggressively replaced his wheelchair next to his recliner, hitting his left leg with the wheelchair. When staff member E left the dayroom, she yelled, Is that what you wanted. Resident #1 was notably upset, assessed for injuries, with a dime sized reddened area noted on his left lower leg. Staff member E was removed from further interactions with any of the residents, while an investigation took place. Review of staff member E's employee file, on 4/8/25, showed she was last educated on the facility's abuse policy on 4/23/24. During an interview on 4/7/25 at 1:10 p.m., resident #1 stated he did not recall an incident when a staff member was unkind to him or had hurt him. Review of resident #1's Quarterly Minimum Data Set, with an Assessment Reference Date of 3/11/25, showed a BIMS (Brief Interview for Mental Status) of 9, moderately impaired cognition. Review of resident #1's Incident Note, dated 12/18/24 at 5:10 p.m., showed resident #1 was assessed after the incident of alleged abuse. The physical assessment showed a dime size red mark on his left leg, no open area noted, and no medical treatment was needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigated the allegations of abuse with recorded video footage, and interviewed staff and residents present in the area at the time of the incident. The evidence the facility gathered showed the allegations of physical and verbal abuse, by staff member E was substantiated for resident #1. The facility continued to monitor resident #1 for any decline in his participation in activities of daily living or other psycho-social activities, which none were observed. Education to staff was completed on caregiver stress management and abuse after the incident, with documentation. The facility's QAPI (Quality Assurance Performance Improvement) committee included this abuse incident in their 1/15/25 meeting with a performance improvement project initiated. The facility had completed a root cause analysis, created a plan for improvement with additional education, and implemented continued monitoring of residents to sustain compliance. During an interview on 4/8/25 at 7:06 a.m., staff member C stated she witnessed staff member E's abuse of resident #1. Staff member C stated, she and staff member B interviewed resident #1 and assessed his leg for injury. Interviews took place with resident #1, other residents, and all the staff in the vicinity of the incident. Education was provided after the incident on CNA (Certified Nursing Assistant) burnout on 12/23/24 and abuse training on 1/28/25. Staff member C continued to monitor resident #1's psychosocial well-being for any changes, which there were none. During an interview on 4/8/25 at 10:56 a.m., staff member A stated abuse education was completed after the abuse incident, brought to QAPI, discussed with the medical director, and the facility's medical doctor. She stated additional education had been added to the onboarding process for staff and additional education for CNAs had been instituted. Staff member A stated during the abuse allegation interviews, there were areas identified to improve upon, including staff's understanding of abuse and additional educational information which was be provided to them. Review of the facility's policy titled, Abuse, Neglect, Exploitation, last reviewed 11/29/23, showed: - . Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. - . 1. 'Abuse' means the willful infliction of injury . and - .3. 'Verbal Abuse' means the oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident .