STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275070	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Memorial Nursing Home	440 W Laurel Ave Plentywood, MT 59254

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to safely use a sit-to-stand lift when transferring a resident, causing injuries to include fractured ribs, and the resident was hospitalized for further evaluation, for 1 (#26) of 4 sampled residents for accidents. Findings include:Review of a facility reported incident, sent to the State Survey Agency, dated 6/20/25, showed resident #26 was found to have a large area of bruising over his right chest wall with swelling. The area was firm and tender to touch. Resident #26 was sent to the ED for further evaluation. The facility investigation concluded the used of the sit-to-stand lift for transferring resident #26 was the cause of the injury. The investigation did not show if the facility determined the lift sling being used was appropriate for resident #26. The resident was found to have an elevated PT/INR that caused significant bruising and hematoma on the right chest wall. Resident #26 did not complaint of pain in that area, per the documentation, until the morning of 6/20/25 when the bruising was noted by staff when getting resident #26 dressed. During an observation and interview on 7/30/25 at 8:47 a.m., staff member O demonstrated the use of the sit-to-stand device when transferring a resident from the wheelchair to a recliner. Staff member O said she had worked with resident #26 for several years, and he was transferred with the assistance of the sit-to-stand lift. Resident #26 was a bigger man and required an XXL sling when using the lift. Staff member O said PT would evaluate the resident and determine if a sit-to-stand lift was appropriate for the resident and make recommendations on the strap size to be used. Staff member O said if a staff member used a sling that was too small, it would force a resident against the metal bars of the device, and the strap would be too tight across the resident's chest. Staff member O said she felt a strap that was too small for resident #26 was used to transfer him, and he sustained the rib fractures. Staff member O said resident #26 had good leg strength when he transferred. During an interview on 7/30/25 at 2:40 p.m., staff member B said resident #26 had sustained two rib fractures, and due to his coumadin use, a large hematoma occurred, which was from the use of the sit-to-stand lift. The incident had been investigated for a fall and abuse, however, the location of the right-sided rib fractures was in the area of the strap used for the resident's transfer. Staff member B said it was noted that resident #26 had been leaning to his right-side while being transferred, for the week before his injury. Staff member B said a PT evaluation for the continued use of the sit-to-stand lift was going to be scheduled. Staff member B said the use of the sit-to-stand had been discussed in a huddle (group staff discussion). Staff member B said an individualized check-off for staff on the use and operation of lifts had not been provided following the injury to resident #26. During an interview on 7/30/25 at 2:57 p.m., staff member F said she was responsible for the investigation of resident #26's injury. Staff member F said she was notified on 6/20/25 of the injury of unknown origin that had occurred for #26. An investigation was initiated, and it was determined that the strap on the sit-to-stand lift had caused the resident's rib (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	fractures. Staff member P decided to stop the use of the lift, and then a Hoyer lift was used for transfers until resident #26 could be evaluated for the use of the sit-to-stand lift. Staff member F said the findings were shared in a staff huddle, and staff were shown the appropriate use, sling placement, and how to use the stand correctly. The facility was attempting to have enough slings for each resident to have an individual sling. The staff had Relias (staff training program) training on lift use, but the staff had not received actual individualized check-off evaluations for the correct use of the lift since the injury had occurred with resident #26. Staff member F said she believed the sit-to-stand lift was included in resident #26's care plan but did not believe the sling size for use was listed on the care plan. Review of resident #26's Emergency Department Reports, dated 6/20/25, showed: .History of Present Illness [AGE] year old male patient who presented to the [Hospital Name] ER from [Facility Name] with complaints of bilateral chest wall pain; right more than left.patient does have dementia. He is anticoagulated on oral Coumadin. Medical Decision Making . A CT scan of the chest revealed a bilateral chest wall hematoma measuring approximately 13.6 cm x 5.5 cm x 4.2 cm. Due to patient position, it is only partially visualized therefore difficult to fully characterize. Suspected minimally displaced acute to subacute fractures involving posterior aspects of right-sided ribs 10 and 12.Assessment/Plan .2. Rib fractures Patient with minimally displaced acute to subacute fractures involving posterior aspects of right-sided ribs 10 and 12. 3. Atrial fibrillation, chronic Patient with known, chronic Atrial Fibrillation on chronic anticoagulation with Coumadin 8 mg daily. Most recent INR of 5.7. Will hold his oral Coumadin for 1 week. [sic] Review of resident #26's Resident Plan Report, not dated, showed: .ADLS Resident is at risk for self care deficit related to cognitive loss at baseline, legally blind, needing staff assistance for all ADLs. 2. [Resident #26] needs staff assistance with all transfers. 3. [Resident #26] uses the sit to stand for all transfers. [sic] Review of a facility-provided document, Care Plan Modification- Post-Injury, dated 6/20/25, approved by staff member F, showed: . As per the Safety/Risk Nurse request, the resident's care plan has been updated following a recent injury and emergency room visit. The following measures are to be implemented (for #26) to ensure the resident's safety and prevent further injury: Lift Use Restriction: Due to rib fractures and a large hematoma on the right side, the resident is no longer permitted to use the sit-to-stand lift. Transfer Protocol: Effective immediately, all transfers must be performed using the Maxi Move or full-body lift only. [sic]

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize, identify, and call a physician for confirmation of a coumadin order not being discontinued or held, for a resident with a critical lab value, for 1 (#26) of 3 sampled residents on coumadin. Findings include:During an interview on 7/30/25 at 10:47 a.m., staff member B said resident #26 was discharged from the emergency department with no medication changes. Resident #26's Coumadin dosage was not stopped, and it was not questioned by the nursing staff. Staff member B said his expectation was for staff to use their nursing judgment and if they had a question, contact the provider for clarification. Staff member B said critical thinking should have been used, especially when the patient had a known elevated PT and INR.During an interview on 7/30/25 at 2:40 p.m., staff member C said he had intended to hold the Coumadin for resident #26. The medication was held in the hospital EMR system but the hold order did not follow through to the long-term care EMR system. The INR level was not above ten, so there was no need to treat the elevated level with a reversal agent. Staff member C said he had intended for the medication to be held, and it was an error on our part. Staff member B said that during the investigation, a communication problem between the hospital and the long-term care facility was identified.During an interview on 7/30/25 at 2:57 p.m., staff member F said she was responsible for the investigation of resident #26's injury. The investigation identified that the injury was caused by the use of the sit-to-stand lift. The large hematoma was from the use of Coumadin. Staff member F said she knew resident #26 was on Coumadin but did not include the medication as a part of the investigation. She had not done an investigation for the Coumadin order not being correct.Review of a facility document, Hospital Progress Note, dated 6/10/25, written by staff member C, showed: . Assessment/Plan1. Atrial fibrillation, chronic[AGE] year old male patient with known, chronic Atrial Fibrillation on chronic anticoagulation with Coumadin 7mg daily, Most recent INR of 1.4 Will increase to oral Coumadin 8mg daily. Recheck INR in 2 weeks. [sic]Review of resident #26's Emergency Department Reports, dated 6/20/25, showed: .Assessment/Plan.3. Atrial fibrillation, chronicPatient with known, chronic Atrial Fibrillation on chronic anticoagulation with Coumadin 8mg daily. Most recent INR of 5.7. Will hold his oral Coumadin for 1 week.Review of a facility document, Long Term Care/Swing Bed Documents, dated 6/20/25, written by staff member P, showed: Resident returned to the nursing home from the hospital at 10:45. Report was received from the ED nurse, who noted no changes in the resident's medications. The ED documented a large hematoma on the right side of the chest, along with rib fractures at the 10th and 12th ribs (confirmed via CT scan). [sic]Record review of resident #26's Discharge Instructions, dated 6/20/25, showed: .Medications. Unchanged, warfarin (warfarin 3 mg oral tablet), 1 tablet by mouth, every day, take with 5mg tab for a total of 8mg qdUnchanged, warfarin (warfarin 5 mg oral tablet), 1 tablet by mouth, every day, Take with 3mg tablet to total 8mg QPM.Record review of resident #26's Medication Administration Record, showed resident #26 received:6/20/25 at 3:35 p.m., Warfarin 8 mg orally6/21/25 at 3:37 p.m., Warfarin 8 mg orallyReview of resident #26's Resident Plan Report, not dated, showed: .Bleeding PrecautionsAt risk for bleeding related to anticoagulant therapy due to atrial fibrillation treatment.8. Nursing to follow Anticoagulant Therapy policy and procedure for [Facility Name].Review of a facility policy, Anticoagulant Therapy review, dated 6/11/25, showed: .Procedure:.II. Lab results are communicated to the primary care provider (PCP), or on call provider when PCP is unavailable, via HER [sic] message center or a direct call from lab or nursing. If the INR is:.D. greater than 3.2 with bleeding or greater than 6.0 without bleeding - the nurse will hold the medication, and the provider will be notified within two (2) hours for additional orders. [sic]