

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Blackfeet Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 728 S Government Sq Browning, MT 59417	

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 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 complete thorough incident investigations and address psychosocial impacts of abuse for those affected, for (#s 3, 7, 31, 32, and 34) of 9 sampled resident abuse allegations and investigations. Resident #32 was then reportedly afraid, #31 was uncomfortable with the employee's actions and lack of follow up by the facility, and #3 was tearful during the investigation. Findings include:</p> <p>1. Review of a Facility Reported Event, submitted to the State Survey Agency on 2/4/25, showed resident #34 reported NF3 refused to change her soiled brief.</p> <p>During an interview on 6/18/25 at 3:25 p.m., staff member B stated he investigated the incident. Staff member B stated NF3 was sent home pending investigation and CNAs were interviewed. Staff member B stated he determined the incident to be a personality conflict between resident #34 and NF3. Staff member B stated his investigation did not include interviews with any other residents cared for by NF3, and did not include an assessment of any psychosocial impact for resident #34 following the incident.</p> <p>2. Review of a Facility Reported Event, submitted to the State Survey Agency on 2/12/25, showed resident #3 reported NF1 was rude, abrupt, and rough with her care. The investigation documentation showed resident #3 was tearful when discussing the incident with staff member C.</p> <p>During an interview on 6/18/25 at 3:25 p.m., staff member B stated his investigation did not include interviews with any other residents cared for by NF1, and did not include an assessment of any psychosocial impact for resident #3 following the incident.</p> <p>3. Review of a Facility Reported Event, submitted to the State Survey Agency on 2/12/25, showed staff member B had learned of a second incident involving NF1, while investigating another incident on the same date. The investigative report showed resident #32 reported that NF1 was rough with her care and caused an abrasion to her lower left leg. The investigation documentation showed resident #32 stated several times she was afraid of NF1 and was subsequently hesitant to receive showers.</p> <p>During an interview on 6/18/25 at 12:12 p.m., staff member D stated She (NF1) was not a good (stated position). You could tell she was just here for the paycheck. She was lazy and rough with the residents and made fun of them . She (Resident #32) was tearful and afraid to take a shower for a while after that (incident).</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/25 at 3:25 p.m., staff member B stated he investigated the report regarding NF1, was very concerned regarding the allegations, and NF1's contract was terminated on 2/12/25. Staff member B stated his investigation did not include interviews with any other residents cared for by NF1, and did not include an assessment for any psychosocial harm for resident #32.</p> <p>4. Review of a Facility Reported Event, submitted to the State Survey Agency on 3/27/25, showed resident #31 reported concerns regarding a staff member possibly taking pictures of him while he was showering on 3/27/25.</p> <p>During an observation and interview on 6/17/25 at 4:45 p.m., resident #31 was seated in a wheelchair in his room. Resident #31 stated he had reported a concern to the facility when NF2 remained in the shower room while he showered independently, and she was holding her phone up facing him. Resident #31 stated the encounter made him uncomfortable, and he stated, . because I felt like she was filming or taking pictures. Resident #31 held his phone up several times during the conversation to demonstrate the position NF2 held her phone up at eye level, facing him. Resident #31 stated, They (facility staff) told me they doubt she was taking pictures, but with these phones, you just don't know, and I don't know if they ever found out. I don't think that girl works here anymore. no one came back to talk to me about it; haven't heard anything.</p> <p>During an interview on 6/18/25 at 3:45 p.m., staff member B stated the investigation and reporting of incidents in the facility was the responsibility of either himself or staff member A. Staff member B stated he investigated the 3/27/25 reportable incident, and he was unable to interview the accused staff member, as she had already been terminated. Staff member B stated his investigation did not include interviews with any other residents cared for by NF2, and did not include an assessment for psychosocial harm for resident #31. Staff member B stated, I just talked to him to see what happened.</p> <p>Review of all staff education between January and June of 2025, showed staff most recently received abuse refresher training on 3/19/25; over one month after the 2/12/25 incidents.</p> <p>5. Review of a Facility Reported Event, submitted to the State Survey Agency on 3/15/25, showed resident #7 was sprayed intentionally in the face by a staff member, with water, during a shower. The temperature was up and this made the resident yell out. This was reported to have happened on 2/15/25.</p> <p>Review of the facility findings showed, Once administration learned of this incident, [staff member F] was taken off the schedule, his company was notified and his contract terminated.</p> <p>Review of the nursing schedule for June 2025 showed staff member F was still working in the facility.</p> <p>During an interview on 6/18/25 at 3:25 p.m., staff member B stated, The process for investigation of incidents would be that the charge nurse would inform the DON of the incident, the DON would contact the Administrator, and the administrator would inform social services. Social services would then report it to the BOUNDS system and proceed with gathering information for the investigation. In most cases, if a staff member is involved, they will be sent home until the investigation is complete. We reported the incident as soon as we found out about it. We were not sure of the exact date of the incident so I picked a day that both staff members were scheduled to work together.</p> <p>(continued on next page)</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>Review of resident #7's bath log showed her bath days were on Wednesday and Sunday, and 2/15/25 was on a Saturday.</p> <p>Review of the nursing staff schedule for February and March showed Wednesday, March 5th was the only date the two staff members worked together which correlated to resident #7's bath schedule.</p> <p>During an interview on 6/18/25 at 4:10 p.m., staff member B stated, I remember closing out a lot of bounds that day, and the recommendation was to let that staff member go. Under the direction of staff member A, I went and interviewed other staff about the incident. I did not interview other residents. After talking to other staff, I did not substantiate the incident and never went back in to update my findings. I did not talk to that staff member directly; I think he was out on days off. The resident involved does not remember the incident. I never thought of looking at the bath schedule during the investigation. The investigation submitted to the State Survey Agency did not show the employee received abuse education immediately following the event or when the employee returned to work at the facility.</p> <p>Staff member B stated he did not assess resident #7 for any psychosocial impact related to the incident.</p> <p>Review of a facility document, titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, showed the following:</p> <ul style="list-style-type: none"> . 7. The individual conducting the investigation as a minimum: . j. interviews other residents to whom the accused employee provides care or services . l. documents the investigation completely and thoroughly. [sic] 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>Based on observation, interview, and record review, the facility failed to assess and update a care plan with interventions for wandering for 1 (#7) of 9 sampled residents. This deficient practice increased the risk of injury to resident #7 and increased the risk of lack of privacy for other.</p> <p>Review of a facility reported event, dated 3/20/25, showed resident #7 was wandering and opening and closing other residents' doors, causing other residents to become angry.</p> <p>Review of resident #7's electronic health record showed resident #7 had dementia, low vision, and was hard of hearing.</p> <p>During an interview on 6/18/25 at 10:16 a.m., staff member B stated, Interventions for resident #7 are to work with the doctor on medication management. We don't do a formal assessment of behaviors.</p> <p>During an observation on 6/18/25 at 2:05 p.m., resident #7 was observed wandering the halls in the facility. She went behind the nursing station and was grabbing items on the desk.</p> <p>During an interview on 6/18/25 at 2:15 p.m., staff member E stated, When she is wandering around or bothering others, we usually give her a drink or take her outside. I think she just wants attention. I would ask a CNA what her interventions are.</p> <p>Review of resident #7's electronic health record showed a wandering assessment was completed on 12/24/24 and showed a score of 2.0; a low risk of wandering.</p> <p>Review of resident #7's nursing progress notes for March through June 2025 showed resident #7 was frequently wandering in and out of other rooms, combative towards staff, and wandering inside the facility.</p> <p>Review of resident #7's care plan, with a revision date of 3/4/25, showed:</p> <p>Focus: The resident is an elopement risk/wanderer r/t significantly intrudes on the privacy or activities.</p> <p>Interventions: .The resident's triggers for wandering/eloping are age, disease and smoking related. The resident's behaviors is de-escalated by (specify). [sic]</p> <p>Review of a facility document titled Wandering and Elopements, undated, showed:</p> <p>1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services for the assessment and identification of underlying cause(s) of behaviors displayed for a resident with dementia, for 1 (#7) out of 9 sampled residents. Findings include:</p> <p>Review of a Facility Reported Event, submitted to the State Survey Agency on 3/20/25, showed resident #6 hit resident #7 for opening and closing his door multiple times.</p> <p>During an interview on 6/18/25 at 10:16 a.m., staff member B stated, Interventions for resident #7 are to work with the doctor on medications. We don't do a formal assessment for behaviors.</p> <p>During an observation on 6/18/25 at 2:05 p.m., resident #7 was observed wandering the halls in the facility. She went behind the nursing station and was grabbing items on the desk.</p> <p>During an interview on 6/18/25 at 2:15 p.m., staff member E stated, When she (resident #7) is wandering around or bothering others, we usually give her a drink or take her outside. I think she just wants attention. I'm not sure if there are interventions documented for her. I would ask a CNA what her interventions are.</p> <p>Review of resident #7's electronic health record showed a wandering assessment was completed on 12/24/24 with a score of 2.0, meaning the resident was at a low risk of wandering.</p> <p>Review of resident #7's nursing progress notes for March 2025 showed resident #7 was consistently wandering in and out of others rooms, combative towards staff, and wandering inside the facility.</p> <p>Review of a facility document titled Root Cause Analysis and Outcome, dated 3/20/25, showed:</p> <p>Section B:</p> <p>2a. WHY do you think this event occurred? [resident name] goes in and out of rooms and is very mean.</p> <p>2c. HOW can this be prevented in the future? Monitor residents location for safety. [sic]</p> <p>The document did not show underlying factors identified by the facility contributing to the behaviors displayed by the resident, or what interventions may work to resolve or reduce the behaviors she displayed.</p> <p>Review of resident #7's care plan with a revision date of 3/4/25, showed:</p> <p>Focus: The resident is an elopement risk/wanderer r/t significantly intrudes on the privacy or activities.</p> <p>(continued on next page)</p>

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