STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275133	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blackfeet Care Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to complete a thorough investigation, monitoring, and documentation for allegations of staff-to-resident abuse for 1 (#28), resident-to-resident physical abuse for 2 (#s 40 and 41), and resident-to-resident sexual abuse for 2 (#s 6 and 40) of 17 sampled residents. This deficient practice had the potential to place all residents at risk of abuse. Findings include:1. Review of a Facility Reported Incident reported to the State Survey Agency, dated 10/9/25, showed resident #28 had reported to staff member P that staff member O had blown marijuana vape smoke in his face.Review of the investigation completed by the facility showed staff member O admitted to vaping marijuana in the resident's room and stated, That was me I did not think my pen was that strong. [sic] Staff member O resigned from the facility.Review of resident #28's nursing progress notes, dated 10/9/25-10/20/25, showed no nursing documentation of the incident or monitoring of resident #28 post-incident.During interviews on 3/24/26 at 9:11 a.m., 3/24/26 at 2:21 p.m., and 3/26/26 at 9:18 a.m., resident #28 refused to talk about the incident involving staff member O.During an interview on 3/26/26 at 10:29 a.m., staff member D stated he spoke to resident #28 about the incident, and resident #28 told him that staff member O had blown marijuana smoke in his face. Staff member D stated resident #28 did not want to report the incident right away because staff member O was his friend. Staff member D stated he did not interview staff member O or any other staff who were on shift on that date. Staff member D stated he did not complete the ongoing follow-up with resident #28 to monitor for any changes, but he had completed a psychosocial impact assessment tool. Staff member D stated that no abuse education was provided after the incident.Review of a facility form titled Psychosocial Impact Assessment Tool, dated 10/22/25, showed: . Has ALERT Charting been done by Nursing and Social Services? NO . was marked. Review of staff member O's personnel file showed she had acknowledged and signed the facility's abuse and prevention policy on 1/22/25 and 10/7/25.Staff member P was not available for an interview during the survey.2. Review of a Facility Reported Incident reported to the State Survey Agency, dated 10/18/25, showed resident #40 was sitting in a wheelchair by the nurse's station when resident #40 stated to staff member Q that resident #41 had hit him. Staff member Q assessed resident #40 and saw a red mark on his head. Staff member Q notified resident #40's family, and they requested an evaluation at the emergency room. Staff member Q sent resident #40 to the emergency room for evaluation.Review of nursing progress notes, dated 10/18/25-10/25/25, showed no documentation of the incident involving resident #40, and no post-incident monitoring.Review of nursing progress notes, dated 10/18/25-10/25/25, showed no documentation of the incident involving resident # 41, and no post-incident monitoring.During an interview on 3/26/26 at 10:29 a.m., staff member D stated staff member Q called and notified him on 10/25/25 of the incident involving residents #40 and #41. Staff member D stated he had come to the facility to initiate the investigation. Staff member D stated he had watched video footage of the incident and concluded resident #s 40 and 41 had gotten their wheelchair wheels locked together, and both residents were trying to get the wheels unlocked when resident #41 struck resident #40 with an open hand on the left side of his head. Staff member D stated he had interviewed both residents about the incident, but it was only documented in the incident report. Staff member D stated resident #41 (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was placed on one-on-one care for a while and educated not to hit other residents, but there was no monitoring of resident #40 after. Staff member D stated he did not interview other staff on shift or other residents. Staff member D stated there was no education provided to staff on abuse after the incident.3. Review of a Facility Reported Incident reported to the State Survey Agency, dated 11/11/25, showed resident #6 was found in the room of resident #40 by staff. When staff entered the room, resident #40 was seen removing his hands from inside resident #6's pants and shirt. Staff removed resident #6 from resident #40's room, and resident #6 told staff, It hurts down there. Resident #6 was sent to the emergency room for an evaluation.Review of resident #6's medical diagnosis list showed, Unspecified symptoms and signs involving cognitive functions and awareness, anxiety, depression, and cerebral infarct.Review of resident #40's Brief Interview for Mental Status (BIMS) score was 14, showing he was cognitively intact.During an interview on 3/23/26 at 3:41 p.m., NF1 stated she was notified of an incident where resident #6 was sent to the emergency room because another resident had sexually assaulted her. NF1 stated resident #6 had a developmental delay and had the mentality of an 8-year-old. NF1 stated she felt resident #6 was safer after the other resident left the facility.Review of resident #6's nursing progress notes dated 11/11/25-11/26/25 showed no documentation of the incident involving residents #6 and #40, and no post-incident monitoring.Review of resident #40's nursing progress notes dated 11/11/25-11/26/25 showed no documentation of the incident involving residents #40 and 6, and no post-incident monitoring.During an interview on 3/26/26 at 10:29 a.m., staff member D stated he was called in about the incident. Staff member D stated he had watched the video, and what resident #6 had told staff matched what was on the video. Staff member D stated Law Enforcement was notified and came out to the facility, and interviewed resident #40. Law enforcement was unable to determine if a sexual assault had occurred or not. Staff member D stated he had educated resident #40 on not touching female residents and let him know that he could not be alone with other female residents. Staff member D stated he checked on resident #6 post-incident, but had not completed any documentation. Staff member D stated he did not interview staff on shift or other residents for the investigation. Staff member D stated there was no education provided to staff on abuse after the incident or for protecting the resident. During an interview on 3/26/26 at 11:48 a.m., staff member A stated the expectation for all investigations was for all staff on shift to be interviewed, residents to be interviewed, have social services and nursing staff monitor and assess the affected residents for a period of time to ensure there were no adverse effects from the incidents, and all information, assessments, and monitoring needed to be documented in the medical record.Review of a facility document titled Abuse Prevention Policy and Procedures, with a revision date of 10/2025, showed: . G. Investigation.3. Retrieve written statements. that are signed and dated along with titles.4. The actual investigation will include:a. Date, time, location;. e. Interviews with all people involved;f. Interview residents and/or family member(s). Obtain signed statements regarding the incident, as well as their reaction, who was involved, and what they hope the outcome will be. [sic]

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility nursing staff failed to ensure a resident's anticoagulant medication was clarified on admission for 1 (#36) of 19 sampled and supplemental residents, and the resident received a medication that was discontinued while in the hospital before being admitted . Therefore, the medication was unnecessary and should not have been provided to the resident. The resident experienced a significant change and decline in status due to the medication being given, which resulted in a low hemoglobin of 6.9 g/dl and required a blood transfusion. On 3/25/26 at 4:22 p.m., the facility Administrator and Office Manager were notified of an immediate jeopardy situation for F757. This involved one resident, #36. The severity and scope were identified at the level of J, and when the immediacy was removed, lowered to a G. The facility provided an acceptable plan to remove the immediacy, which was verified at 1:11 p.m. on 3/26/26. The IJ pertained to resident#36, receiving an anticoagulant medication that was discontinued before the admission, and the resident had a decline and was hospitalized for ongoing acute care. Findings include:A review of a complaint received by the State Survey Agency, on 3/4/26, showed that resident #1 was provided an unnecessary medication, as it was discontinued while in the hospital, and the resident had a negative outcome and was hospitalized as a result. A review of resident #1's medical record showed no admission orders for the date the resident was admitted on [DATE]. During an interview on 3/26/26 at 12:03 p.m., staff member N stated he expected the nurses to call and clarify physician orders for any re-admissions or new admissions. Staff member N stated it was the expectation for nurses to follow the physician's orders. Staff member N stated he was usually available via text for any medication concerns. During an interview on 3/25/26 at 1:58 p.m., NF2 stated resident #36 was residing at the facility since 2024 and had not had any concerns until this incident. NF2 stated the resident was in the hospital from [DATE] through 2/18/26. On 2/18/26 the family of resident #36 picked her up from the hospital and transported the resident to the facility. NF2 stated the resident's anticoagulant was supposed to be discontinued on admission. NF2 stated the resident had received a blood transfusion at the hospital. NF2 stated that following the administration of the anticoagulant, the resident's nephrostomy bag had blood in it. NF2 stated resident #36 was aware there was blood in her urine drainage bag and was aware she was not supposed to have the anticoagulant medication. On 2/22/26, NF2 stated the family decided the resident would not go back to the facility, due to concerns for her health, and the staff had not been following the physician's orders. NF2 stated when the resident was first admitted , the care was good. Review of resident #36's After Visit Summary, dated 2/18/26, page one, showed instructions to pause the medication, apixaban (blood thinner). Review of the After Visit Summary, page four, showed the medication was paused until the physician started it again. Review of resident #36's Emergency Department provider note, dated 2/22/26, page two, showed the resident presented to the ER with hypoxia, hypotension, and hematuria. The resident was pale and sleepy, but easily arousable. Page 10 showed the resident had hypotension, profound weakness, respiratory distress, and received two units of blood.Review of resident #36's Hospital History and Physical, dated 2/22/26, page 11, showed the resident presented to the hospital with profound weakness, anemia, hypoxia, and acute kidney injury. The resident had been admitted on [DATE] for hematuria and received three units of blood. During the 2/8/26 admission, the resident had gone into renal failure.Review of resident #36's Emergency Department to Hospital Admission, dated 2/22/26, showed the resident had a low hemoglobin level of 6.9 (critical), had received an anticoagulant, and had gross hematuria (blood in the urine). The resident was experiencing hypotension and symptoms of weakness and respiratory distress. The resident received two units of packed red blood cells. The resident's medical record showed the anticoagulant was supposed to have been paused on the previous admission date of 2/18/26. Page 20 of the document showed that apixaban, the anticoagulant, was discontinued. Review of resident #36's Root Cause Analysis, dated (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/25/26, for the resident's hospitalization, showed the resident was discharged back to the facility on 2/18/26. The apixaban physician's order showed it was to be paused, without a duration noted, and there was no restart date or physician clarification completed for the medication. The medication was restarted when the resident was re-admitted to the facility on [DATE]. The documentation showed:- 2a. Why do you think this event occurred? The response was it was due to ambiguity in the discharge communication and medication reconciliation workflow.- Section 2b. showed What could have been done to prevent the event? The response was clear discharge orders from the hospital. The document also showed that medication was paused. The order was not complete, and there was no documented duration for the medication. The corrections showed to prevent an event from occurring again, the facility need to get clarification of orders before administering the medication.- Section 3c. showed it was now going to be recommended that two nurses need to review discharge orders and medication reconciliations.Review of resident #36's Medication Administration Record, dated 2/1/26-2/28/26, showed the resident received seven doses of apixaban after re-admission to the facility on 2/18/26.Review of resident #36's care plan, with an admission date of 2/18/26, did not show any identified problems, goals, and interventions for anticoagulant medications, safety related to the use of anticoagulants, or monitoring side effects. Review of resident #36's nursing progress notes, dated 2/18/26 through 2/22/26, showed:- The resident was readmitted to the facility after hospitalization on 2/18/26. The resident was on enhanced barrier precautions related to right-sided nephrostomy and colostomy. There was yellow urine observed from the right-sided nephrostomy tube draining into the drainage bag.- On 2/20/26, there was blood observed from the right-sided nephrostomy tube draining into the resident's drainage bag. There was no documentation that the provider was contacted regarding the blood in the urine- On 2/21/26, blood was observed from the right-sided nephrostomy tube draining into the drainage bag. There was no documentation that the provider was contacted regarding the blood in the urine.- The resident's oxygen saturation was 85%. Her oxygen was raised to 3L and her oxygen level only came up to 87%. The resident had been weak and had not been eating. She was unable to stay in a sitting position and would fall back or sideways on the bed. The resident was transported to the local hospital via ambulance at 9:50 a.m. The family was notified that the resident had been sent to the ER.- On 2/26/26, the following late entry was noted in resident #36's nurse's progress note, Communicated with physician regarding the resident's recent hospitalization for blood transfusion. When the resident returned to the facility, the discharge summary was overlooked and the order to hold apixaban was not implemented. As a result, the resident continued receiving apixaban and was readmitted to the hospital and was administered a blood transfusion. [sic]Review of resident #36's nursing progress notes showed the resident had hematuria in her nephrostomy bag two days before transfer to the hospital on 2/22/26, without physician notifications made, and action taken to address it by the facility. The facility did document in the medical record the blood in the resident's nephrostomy bag but failed to take measures to identify the cause or intervene for the resident's health and safety.