

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to identify risks, provide training for van drivers, and ensure the safety of two unrestrained residents who fell to the floor when the van made abrupt stops for 2 (#s 1 and 2) of 9 sampled residents. This deficient practice increased the risk of negative outcomes and injury for residents required to use the facility van. On 7/9/26 at 9:55 a.m., an Immediate Jeopardy (IJ) was announced to the Administrator and Director of Nursing related to F689-Free of Accidents and Hazards and Supervision affecting two residents. The Severity and Scope identified for the Immediate Jeopardy were identified to be at the level of J, and upon verification for the removal of the immediacy, lowered to a D. An acceptable plan for the Removal of Immediacy was approved by the State Survey Agency on 7/9/26 at 1:30 p.m. Surveyors were on-site and verified the removal of immediacy on 7/9/26. 1. During an interview on 7/8/26 at 9:46 a.m., staff member B stated that during an out-of-town trip, the facility van was stopped, and the driver was looking to turn out onto a main street. An oncoming car with its blinker on indicated it was turning in front of them. The facility van started to pull forward, but the other car kept driving straight, so the brakes were applied, which caused the van to stop abruptly. This caused resident #1 to fall out of her wheelchair. Staff member B stated resident #1 was on her knees on the ground and was pinned up between the backseat and her wheelchair. Staff member B stated the resident's wheelchair had been secured, but her lap belt was not. Staff member B stated, to their knowledge, the van driver was responsible for securing the resident's belts. During an interview on 7/8/26 at 10:00 a.m., staff member C stated they had never heard of a specific rule on who was responsible for securing residents' wheelchairs and seatbelts during a transport, and it was just common sense that the person driving should be the one to secure the seatbelts. During an observation and interview on 7/8/26 at 10:17 a.m., resident #1 showed bruising on her knees from her fall during the transport. Resident #1 stated she was worried about other residents getting hurt in the same manner. Resident #1 stated she had been in a prior car accident, which led to her disability. Review of resident #1's Medical Diagnoses showed a history of diffuse traumatic brain injury. Resident #1 was mostly wheelchair bound. During an interview on 7/8/26 at 1:41 p.m., staff member F stated not everyone was aware lap belts were in the van. Staff member F stated they had taken it upon themselves to scan the code for training in the back of the van and watch the tutorial, but that had not been a facility-wide practice. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 275133
		If continuation sheet Page 1 of 8

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#2 fell off the seat and slid to the floor of the van when it stopped. Staff member J said resident #2 must have removed her seatbelt sometime on the drive home. Staff member J said she was unable to monitor and supervise the residents in the van to ensure their safety, as she was driving. Staff member J said resident #2 said she was not hurt. Staff member J said she was not trained and could not take resident #2's vital signs or provide any care assistance. She brought the resident into the building and told the nurse that resident #2 had fallen while in the van. Staff member J said she had not received any training on the seat belt or shoulder harness system when using the van to ensure proper anchorage (of wheelchairs). Review of resident #2's nursing note, dated 6/18/25 at 5:00 p.m., showed the driver said the van stopped fast and resident #2 moved around on the seat. The staff member wrote, When I spoke with the resident, she states she didn't fall and didn't hit anything. During an observation and interview on 7/9/26 at 8:27 a.m., resident #2 was sitting up independently on the side of her bed, eating breakfast. When asked about the fall she had in the van, resident #2 said, Oh, it was nothing. Resident #2 said she released her seat belt so she could lie down on the seat in the van. Resident #2 said the van driver stopped fast, and she (the resident) slipped off the seat onto the floor. Resident #2 denied any injuries. During an interview on 7/9/26 at 11:46 a.m., staff member K said the van driver told her resident #2 fell in the van and hit her knee. Staff member K said resident #2 told her the van had to stop abruptly and she slid off the seat, landing on the van floor. Resident #2 told staff member K she hit her knee but was not hurt.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on observation, interview, and record review, the facility failed to develop and implement an effective training program for all staff who transported residents in the facility vans to ensure the residents were safe when transported and seat belts and safety harnesses were secured properly. This failure contributed to the Immediate Jeopardy situation(s) identified in F869 - Accidents and Hazards, and if not corrected, this failure may affect any resident not transferred properly by untrained staff. Findings include: During an interview on 7/8/26 at 9:45 a.m., staff member B said resident #1 fell out of her wheelchair because staff member H tethered resident #1's wheelchair to the van but did not place a waist/lap belt on resident #1 for resident safety. Staff member B said she could be asked to drive the van if needed and she did not have training on the van or aspects related to safety with the use of the van. Staff member B said any staff member could put the safety harnesses on the residents in the van, but the ultimate responsibility for that, and the safety of the resident, should fall to the van driver. During an interview on 7/8/26 at 10:00 a.m., staff member C said the facility took a copy of her driver's license, but she did not have any training for the use of the facility van(s) seat belts or placement of the harness straps when a transfer occurred. Staff member C said the facility recently got a couple of new vans, and there was no training for the seat belts or harness safety. During an observation and interview on 7/8/26 at 10:16 a.m., resident #1 showed the healed abrasion scar on her right knee from falling in the van on 6/12/26. Resident #1 said the vans need more seat belts. Resident #1 said she was not secured with the seat belts tight enough, and she slid out of her chair under the seatbelt. During an interview on 7/8/26 at 10:30 a.m., resident #4 said the van driver drives too fast, and she was upset by her driving. Resident #4 said that when she went on the van on 6/12/26, the van was traveling at a fast speed, which caused her to bounce up and down in her wheelchair, causing her to get bruises. Resident #4 said she was not secure enough in her seat belt. During an interview on 7/8/26 at 1:40 p.m., staff member F said not all the staff were aware there were lap seat belts on the van. Staff member F said the van had QR codes that could be scanned on the phone, and then a video would show how the seat and harness belts were to be used. Staff member F said strapping and securing the resident was the most important task to be done before the van was taken on an outing. Staff member F said she thought the training she completed that morning was not very effective because staff were standing outside, to the side of the van, so you could not see to observe the demonstration. Staff member F said if staff watched the video or practiced placing the seatbelts themselves, the training would be more effective. Staff member F said not everyone was aware of the lap belts, including staff member H, who was the designated van driver. Staff member F stated all residents who used wheelchairs should wear a lap belt and a shoulder harness when riding in the van for safety. During an interview and record review on 7/8/26 at 2:51 p.m., staff member H said on the first day of her employment, the training to be a facility driver consisted of making sure the resident's medical information was taken to physician appointments and how to lower and raise the wheelchair ramp in the old van. Staff member H said she did not receive any other training until after she was suspended; then she watched a video. Review of the employee's training record showed staff member H completed a video-type training on 6/22/26 related to driving safety. The education was not van-specific, nor did it contain seat belt and harness application. Staff member H said she still had not received any hands-on training or competency evaluations for seat belt application. Staff member H said there was only one (red) seat belt for the waist restraint in each van, but multiple residents in wheelchairs go in the vans at one time. Staff member H said she worked (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	one day with the prior driver. During that day of training, staff member H said the prior van driver didn't place the required four tether straps on the wheelchair (2 in front and 2 in back); rather, he placed one in back and one in front, and no seatbelt was placed on the resident. During an interview and record review on 7/8/26 at 3:27 p.m., staff member A said the facility was short staffed for van drivers. Staff member A said the facility had to make other staff drive the van to get residents to their medical appointments. Review of the facility transportation log from 6/9/26 to 6/23/26 showed 13 different staff initials showing those staff drove residents in the van. Staff member A said the maintenance department tracked education for the van's lifts and seat belts. Staff member A said she looked for return demonstrations and education for the 13 staff listed and no education could be found for van safety, restraint use, or and seat belt education. During an interview on 7/8/26 at 4:14 p.m., staff member J said she was not a certified nurse assistant. Staff member J said she drove the van on occasion but not routinely. Staff member J said the van safety education consisted of how to lower and raise the lift gate on the big van. Staff member J said she had some education on locking wheelchairs when in the van(s) but had no training in securing seat belts or shoulder harnesses. During an interview on 7/9/26 at 9:28 a.m., staff member E said he was informed that resident #1 fell out of her wheelchair on the van. Staff member E said the staff told him the van was traveling too fast and resident #1 was not properly secured with a lap seat belt.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure a system was in place for grievances to be filed orally, and the facility staff failed to address or act upon a grievance submitted for 1 (#4) of 9 sampled residents. This deficient practice resulted in the resident's ongoing feelings of fear during van transports. Findings include: During an interview on 7/8/26 at 10:30 a.m., resident #4 said she was afraid to ride in the van when staff member H was the driver. Resident #4 said staff member H drives too fast on the highway, doing 70 or 80 miles an hour. Resident #4 said that during the trip she went on in June, she bounced around in her chair, and she got bruises all over her arms. Resident #4 said the bruises were there, and staff member C took pictures of the bruises. Resident #4 said she made a complaint to staff member F right after this trip. Resident #4 said she told staff member F about her fear and the safety concerns with staff member H's driving too fast. Resident #4 said she had post-traumatic stress disorder (PTSD) because of a car wreck in her past and said: They don't care about me; nothing had been done. During an interview on 7/8/26 at 1:40 p.m., staff member F said resident #4 told her the other day that staff member H drives too fast. Staff member F told resident #4, who had minimal movement in her arms, that she would need to write up a statement and type it. Once that was done, she would give the grievance to management before anything could be done. Staff member F said resident #4 told her she does not feel safe with the driver. Staff member F said resident #4's disability was caused by a traffic accident, and she developed PTSD. Grievances were requested for the last six months on 7/7/26. No grievances were provided by the end of the survey on 7/9/26 for the event.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to submit an incident for a Facility Reported Incident timely to the State Survey Agency for 1 (#1) of 9 sampled residents. Findings include: Review of a Facility Reported Incident submitted to the State Survey Agency on 6/15/26, involving resident #1, showed that on 6/12/26, resident #1 was riding in the facility van and the driver of the van slammed on the brakes, which caused the van to come to an abrupt stop. This caused resident #1 to fall out of her wheelchair and onto the van floor. The initial report of this incident was not submitted to the State Survey Agency within the required reporting timeline. During an interview on 7/8/26 at 3:27 p.m., staff member A stated, I was not told about the incident (with resident #1 falling in the van) until late on Monday 6/15/26. Staff member A said that when she became aware of the situation, three days after the event, the staff member (driving the van) was suspended pending investigation of the event. Staff member A said she reported the incident to the State Survey Agency on 6/15/26.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to ensure that a resident did not experience re-traumatization during transports, for 1 (#4) of 9 sampled residents by use of the individualized care plan and interventions. This deficient practice resulted in a resident being fearful of transportation in the facility van. Findings include: During an interview on 7/8/26 at 10:30 a.m., resident #4 stated, [Staff member H's] driving gives me PTSD. Resident #4 stated that when the van moved too fast on the highway, she was bumped around in her wheelchair and got bruised all over her arms. Resident #4 stated she had told staff before that she was uncomfortable in the facility van when staff drove too fast but said, nobody cares. During an interview on 7/8/26 at 1:41 p.m., staff member F stated resident #4's disability had happened because of a car accident, and they had stressed with staff that resident #4 experienced PTSD from that. Staff member F stated resident #4 had mentioned multiple times that she felt unsafe when the van was traveling at high speeds. During an interview on 7/8/26 at 2:35 p.m., staff member D stated resident #4 was seeing a counselor related to her traumatic car wreck. Staff member D stated there was a long period of time when resident #4 would not talk about her car accident with anyone. Review of resident #4's Medical Diagnoses, dated 6/5/24, showed an admitting diagnosis of quadriplegia C1-C4. Review of resident #4's care plan, with a recent revision date of 7/6/26, failed to include concerns related to the resident's PTSD and her car accident or fear of being transported.		