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Form Approved OMB
No. 0938-0391

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	01/30/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32998 Based on observation, interview, and record review, the facility failed to ensure dignity and privacy of a resident was protected for 1 (#25) of 17 sampled residents. Resident #25 had a sign on the outside of her door which showed her name and instructions for the emptying of her nephrostomy tube bag. Findings include: During an observation of the outside of resident #25's door, on 1/29/25 at 2:40 p.m. and again on 1/30/25 at 8:00 a.m., the following sign was posted on the resident's door. [Resident's name] is requesting for her urine bag to be checked and emptied every two hours please and thank you. During an interview on 1/30/25 at 8:15 a.m., staff member B stated resident #25 had a nephrostomy tube. Staff member B stated the bag for the tube was emptied as needed. Staff member B stated the sign should not be on the outside of the resident's door. During an interview on 1/30/25 at 9:00 a.m., resident #25 stated the sign on the door for her nephrostomy tube bothered her because everybody could see it, and it had her name on it. Resident #25 stated a staff member put it up, but she was no longer at the facility. During an interview on 1/30/25 at 9:09 a.m., staff member L stated she did not know who put the sign up.

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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NAME OF PROVIDER OR SUPPLIER Blackfeet Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 728 S Government Sq Browning, MT 59417	

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 32998 Based on interview and record review, the facility failed to ensure the care and services for a nephrostomy tube were completed and documented in the medical record for 1 (#25) of 17 sampled residents. Resident #25 had a nephrostomy tube which required dressing changes. The facility failed to obtain orders for dressing changes for the nephrostomy tubing. The facility failed to document the care of the nephrostomy tube in the medical record. Findings include: During an interview on 1/30/25 at 8:15 a.m., staff member B stated resident #25 had a nephrostomy tube and colostomy. Staff member B stated the dressing change was as needed. Staff member B stated there were no orders for dressing changes for the nephrostomy tube. Staff member B stated any dressing changes should be documented in the medical record. During an interview on 1/30/25 at 8:28 a.m., staff member H stated there was not an order for changing the dressing on resident #25's nephrostomy tube. Staff member H stated the dressing is changed when the resident wants it changed which was every two to three days. Staff member H stated it should be documented in the medical record. During an interview on 1/30/25 at 9:00 a.m. resident #25 stated the dressing on her nephrostomy tube is changed when she goes to the doctor, which is every three months. During an interview on 1/30/25 at 9:12 a.m., staff member A stated there was not a physician's order for the dressing changes for resident #25's nephrostomy tube. Review of #25's physician orders, dated 1/1/25 - 1/31/25, failed to show an order for the dressing changes for the nephrostomy tube. Review of resident #12's Medication Administration Record and Treatment Administration Record, dated 1/1/25 - 1/31/25, failed to show dressing changes were completed for the nephrostomy tube. Review of the facility policy titled, Nephrostomy Tube, Care of, showed the dressing was to be changed every one to three days, or as ordered, using a sterile technique. The documentation should show the date and time the procedure was performed, the resident's response to the procedure, and a nursing assessment obtained during the procedure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41951 Based on observation, interview, and record review, the facility failed to implement and follow enhanced barrier precautions (EBP) for 4 (#s 3, 9, 14, and 19) of 17 sampled residents; and failed to ensure staff member H adhered to standard precautions during medication administration via a tube feeding, by placing medications to be administered on an unclean surface without a protective barrier in place, for 1 (#14) of 2 sampled residents observed during enteral medication and nutritional supplement administration. Findings include: 1. Enhanced Barrier Precautions During an observation on 1/27/25 at 3:22 p.m., resident #19 was lying in bed and talked about her accident which caused paralysis. Resident #19 had a urinary catheter in place. No EBP signage was observed on the room door to alert staff of the precautions. No personal protective equipment (PPE), such as gowns, were observed in the room, outside of the room, or in the hallway. During an observation on 1/27/25 at 3:25 p.m., resident #9 was not present in her room. Resident #9 was supplied her medications and nutritional supplement via tube feeding, No EBP signage was observed on the room door to alert staff of the precautions. No PPE, such as gowns, were observed in the room, outside of the room, or in the hallway. During an observation on 1/29/25 at 9:36 a.m., staff member H sanitized her hands, donned clean gloves, and entered resident #3's room. Staff member H did not wear a gown during the administration of resident #3's medications or nutritional supplement via enteral feeding tube. No EBP signage was observed on the room door to alert staff of the precautions. No PPE, such as gowns, were observed in the room, outside of the room, or in the hallway. During an observation on 1/29/25 at 11:35 a.m., staff member H entered resident #14's room for the administration of medications and nutritional supplement via enteral feeding tube. Staff member H washed her hands and donned clean gloves. Staff member H did not wear a gown during the administration of resident #14's medications or nutritional supplement via enteral feeding tube. No EBP signage was observed on the room door to alert staff of the infection control precautions in place. No PPE, such as gowns, were observed in the room, outside of the room, or in the hallway. During an observation on 1/29/25 at 12:12 p.m., the facility had four hallways where residents resided. No resident rooms had posted EBP signage on any of their doors and no PPE, such as gowns, were readily available on the units/hallways. During an interview on 1/29/25 at 12:18 p.m., staff member K stated EBP, such as a gown and gloves, were worn when emptying a catheter for a resident. Staff member K stated he would not need to wear PPE during other direct resident cares. During an interview on 1/29/25 at 12:20 p.m., staff member H stated she did not think nurses needed to wear a gown, in addition to gloves, to perform a tube feeding, when discussing the use of needed EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/30/25 at 8:57 a.m., staff member A stated EBP was one of the things the previous administration had not put in place when EBP was first initiated into the CMS regulations. She stated EBP signage, PPE, and education were being implemented at that time. Review of the facility's policy titled, Enhanced Barrier Precautions, dated August of 2022, showed: - .2. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. - a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). - 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: - a. dressing; - b. bathing/showering; - c. transferring; - d. providing hygiene; - e. changing linens; - f. changing briefs or assisting with toileting; - g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and - h. wound care (any skin opening requiring a dressing). [sic] - 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. - 11. PPE is available outside of the resident rooms. 2. Standard Precautions During an observation on 1/29/25 at 11:45 a.m., staff member H entered resident #14's room and placed his medications and nutritional supplement onto his bedside dresser. The bedside dresser had unidentified, dried spills on the top surface. The dresser was not cleaned, nor was a protective barrier placed onto the dresser. During an interview on 1/29/25 at 12:24 p.m., staff member H stated she did not clean or put down a clean barrier prior to placing resident #14's medications and nutritional supplement onto his bedside dresser. Staff member H stated she usually fed resident #14 in another room and did not think about it.