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

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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 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 (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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[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 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.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure the accuracy of staffing data submitted to CMS (the Centers for Medicare and Medicaid Services) through the PBJ (Payroll-Based Journal) system for October 1, 2025, through December 31, 2025. Findings include:Review of the PBJ Staffing Data Report for quarter 1 (10/1/25-12/31/25) showed the facility failed to include all nursing staff hours when compared to facility staffing schedules and payroll records for six days in October 2025, six days in November 2025, and three days in December 2025.During an interview on 3/25/26 at 11:10 a.m., staff member B stated she was responsible for submitting PBJ data and submitted the PBJ information on a quarterly basis. Staff member B stated once she inputs all the data, she will run off a copy of the information and check for any errors. Staff member B was uncertain why nursing hours were not correctly reflected on the PBJ information. Staff member B stated she did not compare the information submitted with the nursing department schedule.

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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 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to revise an individualized, comprehensive care plan to address end-of-life/comfort care needs for 1 (#8); failed to revise a resident's care plan addressing a suprapubic catheter, and interventions for a suprapubic catheter for 1 (#5); and failed to address psychotropic medication use for 1 (#6) of 17 sampled residents. This deficient practice increased the risk for resident #8 not receiving proper catheter care/services, for resident #5 not receiving necessary care/services for the suprapubic catheter, and for resident #6 to have unmet care needs related to end-of-life care and services. Findings include: 1. During an observation on 3/24/26 at 8:50 a.m., resident #5 was sitting in a wheelchair. Catheter tubing was observed, with a catheter bag, and was draining clear, yellow urine. Review of resident #5's care plan with a revision date of 2/26/26, failed to address resident #5's suprapubic catheter. There were no focus, goals, or interventions related to catheter care, scheduled catheter changes, or monitoring for signs or symptoms of infection related to catheter use. 2. Review of resident #6's care plan, with a revision date of 3/10/26, failed to include the use of mirtazapine for depression. There were no focus, goals, or interventions related to non-pharmacological interventions, signs or symptoms of increased depression, or monitoring for any adverse side effects from the medication taken by the resident. During an interview on 3/25/26 at 10:15 a.m., staff member H stated all the staff had access to resident care plans. Staff member H stated she does not look at the care plans for any changes. Staff member H stated if she needed to know about what side effects to look for with medication or a change with a resident's feeding or transfer status, she would just ask another staff member. During an interview on 3/25/26 at 10:20 a.m., staff member J stated that all staff have access to the care plans and should review them for any resident changes. Staff member J stated the nursing staff had the ability to update care plans, but most of the time, the interdisciplinary team made the updates and revisions to the care plans. Staff member J stated if there was a change in medication or status for a resident, she would notify a member of the interdisciplinary team so they could revise the care plan. Review of a facility policy titled Care Plans, Comprehensive Person-Centered, dated March 2022, showed: . 11. Assessments of the residents are ongoing, and care plans are revised as the information about the residents and the residents' conditions change. [sic] 3. During an interview on 3/26/26 at 12:05 p.m., staff member C stated there are no Hospice providers available in their area, and the facility provided end-of-life/comfort care for resident #8. Staff member C stated that comfort care should have been included on resident #8's care plan. Staff member C stated she did not know why end-of-life/comfort care was not included on resident #8's care plan. Staff member C stated, It may have just been missed. A review of resident #8's care plan showed that end-of-life/comfort care was not addressed in the resident's care plan, and there were no end-of-life/comfort care-specific interventions documented on (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the care plan. Resident #8's care plan did not include a focus that showed a shift in treatment or the approach to provide comfort care. Resident #8's care plan did not list interventions to address fears about dying, terminal restlessness, positioning related to comfort, changes in cognitive status, increased sleeping, reorientation needs, or education of the resident and family related to the dying process. A review of resident #8's Medical Visit, dated 1/9/26 at 2:56 p.m., showed: A. Reason for visit End of Life Care . I. Plan I spoke with [Residents name]'s [family member] . she agreed to comfort care measures. [sic] A review of resident #8's Care Area Assessment Worksheet, dated 1/9/26, showed: . 2. Cognitive Loss/Dementia . Mood and Behavior . She has been increasingly agitated according a charge nurse. . Medical Problems that can impact cognition . End of life [indicated with a check mark] . Other Considerations . Staff had said that [Resident Name] is sleeping more and needs more reorientation. . 9. Behavioral Symptoms . Analysis of Findings . Nature of the Problem/Condition: . expressed that she wants to rest more often, but at night she stays awake fearing she will die. [sic]

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review, the facility failed to ensure residents were seen by a physician within required timeframes (at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter) for 6 (#s 1, 3, 5, 6, 15, and 28) of 17 sampled residents. This deficient practice had the potential for an increased risk of unidentified changes in condition, delayed treatment, worsening of medical conditions, avoidable complications, or decline in resident health and safety. Findings include:Review of resident #1's medical visit note showed the last documented physician visit was on 6/11/25. The resident had not been seen by a physician for 227 days, exceeding the required frequency.Review of resident #3's medical visit note showed the last documented physician visit was on 6/3/25. The resident had not been seen by a physician for 235 days, exceeding the required frequency.Review of resident #5's medical visit note showed the last documented physician visit was undated. There was no documentation to confirm compliance that resident #5 had been seen by a physician within the last 60 days, exceeding the required frequency. Review of resident #6's medical visit note showed the last documented physician visit was on 6/13/25. The resident had not been seen by a physician for 225 days, exceeding the required frequency.Review of resident #15's medical visit notes showed resident #15 had been seen on 7/24/25 and again on 2/26/26. There were 155 days between physician visits, exceeding the required frequency.Review of resident #28's medical visit note showed the last documented physician visit was on 6/2/25. The resident had not been seen by a physician for 236 days, exceeding the required frequency. During an interview on 3/23/26 at 3:41 p.m., NF1 stated resident #6 had not seen a physician in the facility for many months and was concerned because of resident #6's ongoing medical conditions.During an interview on 3/25/26 at 12:04 p.m., staff member N stated he did not have a set schedule for seeing residents; his visits depended on his hospital schedule. Staff member N stated he was unsure if any other providers assessed residents between his visits.During an interview on 3/25/26 at 11:33 a.m., staff member A stated physicians were expected to evaluate residents when due and document the visit in the medical record.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure the resident's representative was provided information necessary to make an informed decision, including the risks, benefits, and alternatives, before the initiation of psychotropic medications; and the facility failed to obtain informed consent for the use of the medications, for 1 (#6) of 17 sampled residents. Findings include:During an interview on 3/23/26 at 3:41 p.m., NF1 stated resident #6 was prescribed medications for depression and anxiety. NF1 stated she was notified when medications were started or discontinued but the facility did not explain the risks, benefits, or alternatives of the medications prior to initiation. NF1 stated she had been asked to sign forms on occasion, but the medications were not explained to her.A review of resident #6's pharmacy medication regimen review, dated 3/4/26, showed: [Resident Name] receives an antidepressant, mirtazapine, but no informed consent found in chart. Also need consent for clonazepam (recently re-started) [sic]Review of resident #6's electronic medical record showed no documentation of informed consent forms for mirtazapine (an antidepressant) or clonazepam (an antianxiety) before initiation of the medications.Review of resident #6's physician orders showed mirtazapine was started on 2/24/26, and clonazepam was started on on 3/16/26.During an interview on 3/24/26 at 3:10 p.m., staff member A stated informed consent forms were expected to be completed before the initiation of all psychotropic medications.During an interview on 3/26/26 at 12:25 p.m., staff member J stated informed consent forms should be completed when psychotropic medications were initiated or changed.Review of a facility policy titled Psychotropic Medication Use, with a revision date of July 2022, showed: . 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications.a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on observation, interview and record review, the facility failed to afford residents the right to receive visitors at a time of their choosing for 2 (#s 15 and 23) of 17 sampled residents. This deficient practice placed residents at risk for social isolation and or decreased quality-of-life due to unnecessary limitations on visitation and interference with their ability to maintain relationships with family or others. Findings include:During an observation on 3/23/26 at 11:22 a.m., a facility sign posted above the double doors to the left of the security desk showed, Resident Visiting Hours 8:00 A.M. - 8:00 P.M. During an interview on 3/25/26 at 10:44 a.m., resident #15 stated she did not like the limitations on visiting hours. Resident #15 stated she thought she should be able to have visitors at a time she chose.During an interview on 3/26/26 at 9:16 a.m., staff member G stated residents were not allowed to have visitors before 8:00 a.m. or after 8:00 p.m.During an interview on 3/26/26 at 9:20 a.m., staff member F stated visiting hours were between 8:00 a.m. and 8:00 p.m. Staff member F stated visitors were not allowed to come into the facility outside of those times. Staff member F stated if visitors came to the facility outside of visiting hours, they would need to ring the doorbell and would be told to come back during visiting hours. Staff member F stated, We are strict about our (visiting) hours.During an interview on 3/26/26 at 10:24 a.m., staff member C stated the facility did not have a separate policy regarding visiting hours, but stated it was included in the admission agreement. Staff member C stated visiting hours were from 8:00 a.m. to 8:00 p.m.During an interview on 3/26/26 at 10:37 a.m., resident #23 stated the facility did not allow visitors outside of the posted visiting hours. Resident #23 stated she thought residents should be allowed to decide when they have visitors. Resident #23 stated she likes to sleep late, and the visiting hours restricted her from having visitors later in the evening. Resident #23 stated It would be better for me to decide.Review of a facility document titled, [Facility name] admission Agreement, reviewed 1/26, showed: . Visitation Rights and Limitations7.1 Right to visitation- All residents have the right to visit anyone during visiting hours. [sic]

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	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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure accurate coding of medications on the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) Manual for 1 (#5) of 17 sampled residents. Findings include:Review of resident #5's MDS with an ARD (Assessment Reference Date) of 2/7/26, showed under Section N (Medications) item N300 (number of injections received in the last 7 days) was coded as 1, and item N350 (number of days insulin injections were received in the last 7 days) was coded as 1.Record review of resident #5's physician's orders, dated 11/17/25, showed, Ozempic, inject 1mg subcutaneously every Monday for Diabetes. Ozempic is a GLP-1 (Glucagon Like Peptide-1) which is a hormone that is used for weight loss and diabetes and is not considered insulin.During an interview on 3/26/26 at 9:40 a.m., staff member C stated she was responsible for completing Section N of the MDS and acknowledged she coded Ozempic as insulin because it was used to treat diabetes. Staff Member C stated she had not received formal training on MDS completion and was not familiar with the RAI Manual.Review of a facility policy titled, Resident Assessments, with a revision date of March 2022, showed: . All persons who have completed any portion of the MDS resident assessment must sign the document attesting to the accuracy of such information.Review of the facility policy titled Resident Assessments, revised March 2022, revealed the policy had not been updated to reflect current RAI Manual guidance for accurate coding of medications, including differentiation between insulin and non-insulin injectable medications.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review, the facility failed to ensure physician services provided appropriate assessment and adjustment of treatment for a resident's medical condition for 1 (#15) of 17 sampled residents. This deficient practice resulted in frequently elevated blood sugar levels. Findings include: During an interview on 3/24/26 at 10:44 a.m., resident #15 stated her blood sugars had frequently been running high. Resident #15 stated her blood sugars were over sometimes over 300 mg/dL. During an interview on 3/25/26 at 12:12 p.m., staff member N stated he would consider day-to-day blood sugar readings of 150-200 mg/dL acceptable in geriatric residents. Staff member N stated if a resident was frequently having a blood sugar reading above 200 mg/dL their insulin regime should be evaluated for adjustment. Staff member N stated he was aware resident #15's blood sugars had been above 200 mg/dL, and he felt it was due to the amount of snack foods she consumed. Staff member N stated he did not feel resident #15's diabetes was adequately controlled and stated resident #15's insulin should have been adjusted due to her high blood sugars. Staff member N stated resident #15 did not have orders for sliding scale insulin. Staff member N stated resident #15 should have been evaluated for sliding scale insulin due to snacks being part of the cause of her elevated blood sugars. Staff member N stated his evaluation of residents in the facility was not as often as it should be.During an interview on 3/26/26 at 11:43 a.m., staff member C stated resident #15's blood sugars were not well controlled. Staff member C stated the dietician visited with resident #15 and educated her on selecting healthy snacks but resident #15 continued to eat foods that contributed to increased blood sugar levels. Staff member C stated resident #15 had not been ordered sliding scale insulin in the past and did not currently have an order for sliding scale insulin. Staff member C stated she was not sure if staff member N had reviewed resident #15's blood sugars or if nursing staff had asked him to review them. Staff member C stated she felt resident #15's blood sugars and insulin regime should have been evaluated for needed changes.Review of resident #15's physicians' orders showed: There were no sliding scale insulin orders for resident #15. The last adjustment made to resident #15's insulin orders was on 12/8/25 at 2:57 p.m.Review of resident #15's blood sugars for the period (prior to staff member N's assessment) from 1/30/26 to 2/26/26 showed:- 8 blood sugar readings recorded under 200 mg/dL- 47 blood sugar readings recorded over 200 mg/dL- 4 blood sugar readings over 300 mg/dLReview of resident #15's Medical Visit, dated 2/26/26 at 1:28 p.m., showed: A. Reason for VisitAssessment. D. Record Review1. Medications Reviewed [indicated with a check mark]. E. Systems Review. 11. Endocrine [fields blank with no information filled in]. F. Physical Exam.1e. Most recent blood sugarBlood Glucose: 205.0 mg/dL Date: 2/26/26 06:04 [a.m.]. I. Plan[Residents Name] has been a long term patient of the Care Center. She is doing well. [sic]A review of resident #15's blood sugars for the period (after staff member N's assessment) from 2/27/26 to 3/25/26 showed:- 9 blood sugar readings recorded under 200 mg/dL- 47 blood sugar readings recorded over 200 mg/dL- 9 blood sugar readings over 300 mg/dLThere was an increase in blood sugar readings over 300 mg/dL after staff member N's assessment on 2/26/26 at 1:28 p.m.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure expired medications and medical supplies were removed from the medication and supply rooms and that medications and biologicals were stored securely in 1 of 1 sampled medication room and 1 of 2 sampled supply rooms. Findings include:During an observation on 3/23/26 at 11:30 a.m., the medical supply room door was propped open with an ice chest and left unsupervised, allowing residents access. During an observation on 3/24/26 at 10:38 a.m., in the medication supply room, one vial of Tuberculin Purified Protein Derivative was labeled with an open date of 1/26/26 and a discard date of 2/25/26.During an observation on 3/24/26 at 10:49 a.m., the medical supply room door was unlocked and unsupervised. The following items were not in a locked cabinet:1 box of 25-gauge 1-inch needles, and1 box of 1cc, 27-gauge 1/2 inch needles and syringes.During an observation on 3/24/26 at 10:51 a.m., the following expired items were found in the medical supply room:Four blue top blood tubes with an expiration date of 1/31/26,Three green top blood tubes with an expiration date of 7/31/25, and eight of them with an expiration date of 12/31/25; and, 47 Xeroform petrolatum dressings with an expiration date of 1/2026.During an interview on 3/24/26 at 11:18 a.m., staff member H stated she does not look at expired medications or supplies. Staff member H stated that either a nurse or a pharmacy staff member would look through the medications and supplies.During an interview on 3/25/26 at 10:58 a.m., staff member J stated the nursing staff would look for expired medications and supplies. Staff member J stated the night shift staff would look for expired medications and supplies, but medications and supply expirations should be checked before the item was used.Review of a facility policy titled Medication Labeling and Storage, dated February 2023, showed: The facility stores all medications and biologicals in locked compartments. Only authorized personnel have access to keys. 3. If the facility has discontinued, outdated, or deteriorated medications . the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.4. Compartments (including, but not limited to, drawers, cabinets, rooms.) containing medications and biologicals are locked when not in use, . items are not left unattended if open or potentially available to others. 5. Multi-dose vials that have been open or accessed (needle punctured) are dated and discarded within 28 days .

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review, the facility failed to ensure the medical director was active in his role for QAPI and review, development, and revision of the facility policies and procedures. Findings include:During an interview on 3/26/26 at 10:50 a.m., staff member A stated the medical director was not always at their QAPI meetings. Staff member A stated staff member N did not always participate in reviewing and revising the policies and procedures for the facility but did sometimes. Staff member A stated there was a new medical director starting with the facility (in the near future). During an interview on 3/26/26 at 12:03 p.m., staff member N stated he was not the medical director but was the medical provider. Staff member N stated he works full-time at another healthcare entity and comes to see residents about every other week. Staff member N stated he just got access to the facility's electronic medical record. Information was requested for the medical director's involvement in QAPI activities and policy reviews. The facility did not provide documentation to show staff member N's involvement (or any other medical director) related to QAPI or policy and procedure reviews and or development, before the end of the survey. Review of a QAPI at Risk Meeting document, not dated, showed the medical director's name was not present on the list of IDT members who attended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility staff failed to ensure staff adhered to accepted infection control standards, including proper hand hygiene and glove use, during a medication pass for 2 (#s 3 and 5) of 17 sampled residents. This deficient practice had the potential for an increased risk of the transmission of infections. Findings include:During an observation on 3/24/26 at 8:35 a.m., staff member H was observed at the medication cart preparing medications. Staff member H donned a pair of nitrile gloves without performing hand hygiene prior to donning the gloves. While wearing gloves staff member H touched multiple potentially contaminated surfaces including the medication cart, computer, computer mouse, personal hair, shirt pocket, medication keys, and door handles. Staff member H removed packaged medication cards and bottles and placed them on top of the medication cart and prepared the medications into a clear plastic cup. Staff member H doffed her gloves and donned a new pair without performing hand hygiene between glove changes.Staff member H pushed the medication cart down the hallway, knocked on resident #3's door and entered the room, after touching the door handle. Staff member H administered medications to resident #3 without performing hand hygiene prior to administering the medications.Staff member H exited resident #3's room doffed her gloves, performed hand hygiene and donned a new pair of gloves. Staff member H touched the medication cart, computer, and computer mouse then prepared resident #5's medications. Staff member H entered resident #5's room after touching the door handle without performing hand hygiene. Staff member H administered medication to resident #5 without performing hand hygiene prior to administration.During an interview on 3/24/25 at 10:22 a.m., staff member H stated she had been educated on proper hand hygiene and stated she should have performed hand hygiene in between donning and doffing gloves, prior to administering medications, and in between residents.Review of a facility policy titled, Administering Medications, undated, showed: . Staff follows infection control procedures (e.g., handwashing, antiseptic technique, gloves.) for the administration of medications.According to guidance from the Centers for Disease Control and Prevention (CDC), hand hygiene should be performed before touching a patient, after contact with a patient, after contact with potentially contaminated surfaces, and before preparing or administering medications.https://www.cdc.gov/infection-control/hcp/core-practices/