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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
	275132	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitefish Care and Rehabilitation	1305 E 7th St Whitefish, MT 59937

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 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. 45448 Based on interview and record review, the facility failed to report allegations of abuse within 24 hours of the incident for 2 (#s 1 and 4) of 7 sampled residents for abuse. This deficient practice had the potential to delay investigation activities to identify the presence of abuse. Findings include: 1. Review of a facility reported incident for resident #1, dated 6/8/24, showed resident #1 complained of being verbally assaulted by a nurse when he asked her to turn down her music. The nurse was playing music on a personal device while dispensing medication. The incident was witnessed by other staff members. The incident was reported to the State Survey Agency on 6/10/24. 2. Review of a facility reported incident for resident #4, dated 9/1/24, showed resident #4 was involved in a verbal altercation with a staff member D. The police were called to the facility. The incident was reported to the State Survey Agency on 9/4/24. During an interview on 10/23/24 at 3:42 p.m., staff member B said she expected to be notified immediately when any allegations of abuse was suspected or reported. Staff member B said she had not been notified of the incident with resident #4 until she had returned from vacation on 9/4/24. Review of a facility policy, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revision dated 1/28/24, showed: .a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion.

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	Respond appropriately to all alleged violations. 45448 Based on interview and record review, the facility failed to provide evidence of a thorough investigation for allegations of abuse for 5 (#s 1, 2, 4, 7, and 10) of 7 sampled residents for abuse. This deficient practice had the potential to allow residents to be exposed to further abuse. Findings include: 1. Review of a facility reported incident for resident #7, dated 6/2/24, showed an unidentified CNA reported an allegation of abuse occurred at breakfast with another unidentified CNA forcing a resident to drink water. Review of a written statement by a facility CNA, showed resident #7 was not done eating, and another CNA came to take her to her room. The reporting CNA witnessed resident #7 being forced to drink fluids by the CNA coming to get resident #7. Review of an Adult Protective Service Investigation Report, resident showed #7 was unable to drink fluids herself, nor voice any concerns for hydration. No abuse was substantiated by Adult Protective Services. Review of a facility document, Abuse Allegations, not dated, showed the investigation was conducted, residents and staff were interviewed, allegations could not be confirmed. Documentation did not contain who conducted the investigation, proper identification of alleged abuser or the person making the allegations, interventions to protect the resident from further possible abuse while investigation was ongoing, interviews with staff or residents, education provided to staff, care plan interventions. 2. Review of a facility reported incident for resident #1, dated 6/8/24 at 11:00 p.m., showed resident #1 complained of being verbally assaulted by a nurse when he asked her to turn down her music while dispensing medication. The report provided did not contain the name of the alleged abusive nurse. Investigation showed the incident was substantiated and the nurse resigned. Review of a facility document, Incident Report-Investigation Summary, not dated, showed resident #1 said he had received his night medication very late from the nurse, at 1:00 a.m., and she was playing music at a loud volume. Resident #1 asked the aide if the music could be turned down. The nurse entered the room and asked if her music was blasphemous. He asked the nurse why she was playing music at 8:30- 9:00 p.m. and it was blasting. They began yelling at each other, and the nurse left the room, slamming the door. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility document, Incident Report-Investigation Summary, dated 6/9/24, showed staff member I heard the nurse yelling at resident #1. Staff member I noticed resident #1's call light was on and was going to respond to the call light. The nurse told her, Before you go in there just know it's bad. Staff member I entered the room and asked resident #1 if there was something she could help him with. Resident #1 responded, We need to get someone in here to call the authorities, that nurse just came in here and verbally assaulted me. The nurse then returned to the room and began to defend herself, and resident #1 requested the authorities be called. The nurse told resident #1 to call the authorities and let her know when they arrive, she then walked away. Staff member I notified management for direction. Review of a facility document, Abuse Allegations, not dated, showed the investigation was conducted, residents and staff were interviewed. Several residents confirmed the nurse dispensed medications very late and confirmed hearing loud music coming from the nurse's medication cart. Nursing staff confirmed the nurse was yelling at resident #1. Resolution showed the nurse was to be terminated for medication administration violations. Documentation did not contain who conducted the investigation, full name of the nurse accused of abuse, the nurse accused of abuse interview, nursing staff interviews, interventions to protect the resident or other residents from further verbal abuse, education provided, or the abuse allegation being substantiated for verbal abuse. 3. Review of a facility reported incident for resident #10, dated 6/27/24, showed the resident alleges neglect of care and services. Review of a facility document, Neglect Allegations, not dated, showed resident #10 alleged he did not receive any care or services on 6/27/24 night shift. Resident #10 did not have his foley bag changed or addressed and it leaked all over him and his bed. Social services conducted interviews with staff who stated the CNA did not provide care and was assigned the resident on 6/27/24. Residents stated that the CNA does not help with resident care on multiple occasions. The investigation was substantiated, and the CNA was terminated. Documentation did not contain who conducted the investigation, proper identification of alleged abuser, interviews with staff or residents, education provided to staff, or care plan interventions. 4. Review of a facility reported incident for residents #2 and #4, dated 7/13/24, showed the residents were involved in an altercation at the smoking patio doorway. Resident #2 had propped the outside door to the smoking area open. Resident #4 yelled at resident #2 and threw her tea at the resident #2, hitting the door. Resident #2 then shoved resident #4 out of the way. Review of a facility document, written by staff member J, dated 7/13/24, showed staff member J overheard an altercation outside in the resident smoking area. She came out of her office to investigate. Resident #4 had removed the block resident #2 had placed to prop the smoking door open. Resident #4 began yelling at resident #2. Resident #4 had thrown her tea at resident #2. Resident #4 requested staff member J call the cops. Staff member J educated the residents that the smoking door could not be propped open. Staff member K arrived and explained to the residents they could not treat each other this way because the smoke area is for the enjoyment and relaxation of all residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation in the investigation file did not contain who conducted the investigation, interviews with residents involved, interviews with any witnesses, interviews with staff providing supervision, interventions to protect the resident from further interactions, education provided, or care plan interventions put into place to prevent future altercations. Reporting was identified as neglect by the reporting facility. During an interview on 10/23/24 at 3:42 p.m., staff member B said she expected to be notified immediately when any allegations of abuse was suspected or reported. Staff member B said social services was responsible for the investigations for reportable events. The social services director responsible for the investigations was no longer working for the facility. Staff member B said he was not filing the documentation of the investigations, and she was unable to find the documentation for the complete investigation. Review of a facility policy, Abuse, Neglect and Exploitation, revised 1/1/24, showed: [sic] .V. investigation of alleged abuse, Neglect and Exploitation . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . 6. Providing complete and thorough documentation of the investigation .

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45448

Based on interview and record review, the facility failed to provide services which meet professional standards for care necessary to promote healing of wounds for 1 (#9) of 3 sampled residents with wounds. This deficiency had the potential to affect healing for residents with wounds. Findings include:

During an interview on 10/23/24 at 12:03 p.m., resident #9 said she was sent to the facility for care of a wound that required a wound vac. The wound vac care she received was not correct, and she only had the wound vac functioning for a week. Resident #9 said the wound vac would alarm and staff would tell her to sit on it to seal the suction. Resident #9 said the wound was getting worse so she signed herself out of the facility against medical advice on 7/31/24.

During an interview and record review on 10/23/24 a 7:54 a.m., staff member F said he had been trained on wound care, and the wound documentation. Staff member F said resident #9 was admitted for wound treatments and had a wound vac placed. The wound vac would alarm so the dressing was removed and packed. Staff member F was unable to find documentation on the difficulties on the wound vac management, reinforcement of wound vac dressing, drainage amounts, changing of cannister, or reason for removing the wound vac and placing a wet dressing, or notification of physician for modification of treatment changes. Staff member F said he believed the cannister would be changed when it became full but did not believe the staff documented anything on the drainage description or amounts, or if the staff was having difficulty with maintaining a seal.

During an interview on 10/23/24 at 3:42 p.m., staff member B said the wound nurse was out on maternity leave and trained staff member F to care for resident wounds. Staff member F was responsible for documentation of wounds and working with the wound care clinic. Staff member B said the facility had a mock survey and wound care and documentation was an area identified needing improvement. Staff member B said resident #9 had a wound vac and the staff would tire of it alarming and remove the wound vac and pack the wound. Staff member B said staff member F was having difficulty with documentation of wounds and would go to the facility physician to have orders changed from what was ordered by the wound clinic. Staff member B said she expected staff to document any interventions that addressed wound care.

Record review of resident #9's electronic record showed she was initially admitted on [DATE] with a readmission of 6/5/24, following a hospital stay for pulmonary embolism and deep vein thrombosis to her right upper extremity. Resident #9 had a diagnosis of chronic pain syndrome, neuromuscular dysfunction of bladder, colostomy, acute osteomyelitis, pressure ulcer of bilateral hips, pulmonary embolism. Resident #9 signed out from the facility against medical advice on 7/31/24.

Record review of resident #9's care plan, dated 6/5/24, failed to show a focus areas for wounds, catheter care, colostomy care, activities of daily living and pain management with goals and interventions specific to resident #9.

Record review of resident #9's physician orders from the wound clinic showed:

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 5/29/24 .2. Replace wound vac dressing & sponge on Mon, Wed, and Fri (with) initials and date on dressing. If wound vac alarms, or looses suction, Do not turn off but replace dressing & if alarm continues, remove dressing & fluff cavity (with) vashe (wound cleaner) dampened kerlix until the next scheduled wound vac changes . [sic] 6/12/24 VAC change to continue MWF Be sure to get Foam to BASE (of wound @ 12'o) . [sic] 6/26/24 Continue VAC & (dressing changes) 3X wk, If vac not working pack right with 4 X4 & ABD & change daily . 7/17/24 .2. R ischium- NPWT device (wound vac) to be started ASAP! Unti then, 1 4X4 gauze into cavity then cover (with) ABD + tape QD -wound vac 125 mmHg continuous suction & change on Mon, Wed, Fri. -Please be sure to start wound vac within 1 wk . Review of resident #9's electronic medical record order review showed: 5/21/24- If wound vac malfunctioning: cleanse R IT wound, pat dry. Loosely pack with moist gauze, cover with abd pad and tape. Discontinued 6/4/24 5/21/24- R ischial tub wound care: Black foam into wound bed, tunneling piece at 12:00. Skin prep and draping to periwound, bridge to hip. Wound vac 125 suction, continuous. Every day shift every Mon, Wed, Fri for wound care and as needed for soiled or detached dressing. Discontinued 6/4/24 5/24/24- Check function of wound vac. If malfunctioning and unable to fix seal, use PRN orders for wound care. Discontinued 6/4/24 6/5/25- Wound Vac: Site: R ischium. Ensure Wound Vac dressing is sealed/intact & setting at 125mn Hg every shift. Discontinued 8/6/24 6/5/24- Wound Vac: if unable to achieve Vac seal, remove Vac dressing, cleanse with NS and apply wet as needed. Discontinued 7/17/24- Notes: Rt no longer has a wound vac. 7/22/24- R ischium- NPWT device (wound vac) to tarted ASAP. Until then 1 4X4 gauze with ABD + tape QD. Wound vac 125mmhg continuous suction & change mon, wed, fri. Please be sure to start wound vac within 1 week. Discontinued 8/6/24. 7/22/24- If wound vac is malfunctioning, pack with moist gauze into tunneling and undermining, cover with Tegaderm adhesive. Discontinued 8/6/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #9's Skin and Wound Evaluation, dated 7/29/24 for the right ischial tuberosity wound showed a pressure wound at Stage 4. The wound had 80% granulation with 20% slough, moderate serosanguineous exudate, normal temperature, and non-attached edges. The assessment showed the dressing was missingm and the resident had negative pressure wound therapy. The progress of the wound was deteriorating. The notes showed the resident has been removing the wound vac as reported by nursing staff, requiring frequent dressing changes and overall being noncompliant with recommended treatment. The wound was noted to have increased depth and surface area. The resident was being followed by the wound clinic. No documentation of resident #9's noncompliance or need for frequent dressing changes was found in the electronic medical record or provided by the facility. Review of a facility policy, Wound Treatment Management [Facility Name], revision date 1/1/24, showed: . 3. Wound assessments are documented at the time of each treatment. If no treatment is due, an indication of the status of the dressing shall be documented each shift (i.e., clean, dry, intact). 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and effectiveness of current intervention c. Any treatment for pain, if present d. Modifications of treatments or interventions e. Notifications to physician and/or responsible party regarding wound or treatment changes Review of a facility policy, Wound Treatment Management [Facility Name], revised 1/1/24, showed: .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of dressing change .