

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Whitefish Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47752</p> <p>Based on interview and record review, the facility failed to adhere to accepted standards of practice by administering medications and not following physician's medication orders for 3 (#s 18, 23, and 24) of 26 sampled residents, when standards of practice and physician's orders dictated the medication should not have been administered. Findings include:</p> <p>a. Review of resident #18's physician's orders dated 1/1/25, showed:</p> <p>Midodrine HCL oral tablet 2.5 Mg</p> <p>Give 2.5 mg by mouth three times a day hold if systolic &gt;120, diastolic &gt;60 related to ORTHOSTATIC HYPERTENSION. Notify provider for held medications. [sic]</p> <p>A review of resident #18's medication administration record, dated January 2025, showed:</p> <p>Midodrine HCL 2.5 mg was administered 20 times while blood pressure measurements were outside of ordered parameters.</p> <p>During an interview on 1/22/25 at 12:50 p.m., staff member Y stated vital signs should be done before administering a medication with ordered parameters. Staff member Y said, You never give a medication with parameters if the vital signs are not recent, and you follow the physician's order. Staff member Y stated if there were orders to hold a medication with parameters of systolic greater than 120, and diastolic greater than 60, then the medication was not to be administered. Staff member Y stated she followed the six rights to medication administration. Staff member Y stated for a blood pressure of 128/74 she would have held the medication. Staff member Y could not verbalize why she had administered resident #18's Midodrine with a blood pressure on 128/74.</p> <p>b. Review of resident #23's physician's orders dated 12/31/24, showed:</p> <p>Midodrine HCL oral tablet 5 Mg</p> <p>Give 2 tablets by mouth, three times a day, for Hypotension hold if systolic &gt;120, diastolic &gt;60. [sic]</p> <p>A review of resident #23's medication administration record, dated January 2025, showed, Midodrine HCL 5 mg was given 13 times while blood pressure measurements were outside of ordered parameters.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/22/25 at 12:20 p.m., staff member D stated when a medication had ordered parameters the blood pressure and pulse should be done just prior to when the medication is scheduled to be administered. Staff member D stated it was part of the six rights of medication administration. Staff member D stated if a blood pressure or pulse is not within the ordered parameters, the medication was to be held and not given.</p> <p>c. Review of resident #24's physician's orders, dated 12/28/24, showed:</p> <p>Atenolol oral tablet 50 mg. Give 50 mg by mouth in the evening for essential hypertension. Hold if BP &lt;100/60 or HR &lt;60.</p> <p>A review of resident #24's medication administration record, dated January 2025, showed:</p> <p>Atenolol 50 mg was administered 15 times with not documentation of blood pressure or pulse before administration.</p> <p>During an interview on 1/21/25 at 4:32 p.m., staff member H stated blood pressure and pulses should be taken right before administration of a medication when parameters are on the physician's orders. Staff member H said the blood pressure and pulse should be as accurate as possible before administering the medications. Staff member H said if the medication had parameters included in the order, then the order should be followed. Staff member H could not recall resident #24's blood pressure or pulse but had administered the ordered dose of Atenolol.</p> <p>During an interview on 1/22/25 at 12:25 p.m., staff member U stated if a medication was ordered with a set of parameters, the blood pressure or pulse needed to be done just prior to giving the medication. Staff member U stated when vital signs were outside the parameters, the medication was to be held, and the physician was notified.</p> <p>A review of a facility document titled, Medication administration, undated, showed:</p> <p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>. 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.</p> <p>. 10. Ensure the six rights of administration are followed:</p> <p>a. Right resident</p> <p>b. Right drug</p> <p>c. Right dosage</p> <p>d. Right route</p> <p>e. Right time</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff had the necessary skills and training for CPR for 2 (#s 1 and 3) of 26 sampled residents. Resident #s 1 and 3 expired in the facility. The facility failed to ensure a process was in place for identifying and tracking staff CPR certifications. The facility failed to obtain the supplies necessary, and ensure they were in stock and on the crash cart, for staff to perform high-quality CPR during emergent situations, which affected 2 (#s 1 and 3). The facility failed to have a process in place to identify and ensure supplies, including respiratory supplies, were on hand and readily available.</p> <p>On [DATE] at 11:09 a.m., an Immediate Jeopardy was announced to the Administrator and the Corporate Clinical Recourse Nurse related to F678 - Cardiopulmonary Resuscitation. The Severity and Scope identified for the Immediate Jeopardy were Identified to be at the level of J, and upon removal of the immediacy, lowered to a G. An acceptable plan for the Removal of Immediacy was approved and verified on [DATE] at 5:00 p.m.</p> <p>Resident #1 coded on [DATE]. A nurse called the code and started chest compressions. The crash cart was located across the facility, in a different hallway. There was no Ambu bag on the crash cart, and no protective barrier present so respirations could be provided safely during CPR. Resident #3, coded on [DATE], and the nurse on shift started CPR. No Ambu bag or protective barrier was on the crash cart to initiate respirations.</p> <p>Findings Include:</p> <p>a. During observation and interview on [DATE] at 11:55 a.m., staff member C showed the crash cart was located in the hallway by the medication room and the nursing station on the 100 and 300 hallway. The crash cart was wedged in between a treatment cart and a wall and was not easily accessible. There was a light blue, tarp-like cloth, covering the crash cart. Staff member C stated a secondary cart was located in a utility room, but it was not used, because staff could not access it easily. The crash cart in the utility room was in a back corner blocked in by intravenous poles and wheelchairs. Staff member C stated she did not know when the crash carts were last stocked or when the equipment was last tested .</p> <p>During an interview on [DATE] at 12:02 p.m., staff member D stated she was on shift when resident #1 coded. Staff member D stated the code was called for resident #1's emergent event, and the staff member had to run across the building to retrieve the crash cart, and the crash cart did not have the supplies needed. Staff member D stated an AED or Ambu bag was unavailable on the crash cart for staff use. Staff member D stated, When I asked about an AED, I was told by staff member K no one knew how to use it, so we don't have one Staff member D stated there had been another code in the facility in [DATE]. Staff member D stated she did not know who was responsible for checking or stocking the crash cart.</p> <p>During an interview on [DATE] at 2:43 p.m., Staff member A stated, Ambu bags were now on the crash carts, and it is corporate policy not to have an AED in the building, it's not required.</p> <p>(continued on next page)</p>

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of resident #1's electronic medical record, from [DATE] - [DATE], showed:</p> <p>Resident #1 was hospitalized on [DATE] for acute pneumonia and respiratory failure with hypoxia. Resident #1 was readmitted to the facility on [DATE].</p> <p>Review of resident #1's POLST, dated [DATE], showed full code with limited interventions.</p> <p>Resident #1 expired in the facility on [DATE].</p> <p>Review of an emergency services document titled, Prehospital Care Report, dated [DATE], showed:</p> <p>EMS dispatched on [DATE] at 8:27 a.m., arrived on scene at 8:42 a.m., arrived at patient at 8:44 a.m. Depart at 9:11 a.m. Response Delay: Unable to locate.</p> <p>During an interview on [DATE] at 7:08 p.m., an anonymous staff member stated respiratory supplies had been requested back in the middle of [DATE]. The anonymous staff member stated staff members A and K were notified of the need for more respiratory supplies which were not ordered until after [DATE]. The staff member said there had been two residents in the facility who coded and expired in the facility, and there was a delay in care during the first code because a staff member had to leave resident #1's room to go searching for an Ambu bag, one was found, and the staff member returned to resident #1's room and took over the code. The Ambu bag was the last one in the facility, and staff members A and K were notified again. The anonymous staff member stated, About a week later there was another resident who coded in the facility, and there still were no Ambu bags available for use.</p> <p>During an interview on [DATE] at 7:22 p.m., staff member E stated she was involved in the code for resident #1. Staff member E stated resident #1 was found down in his room and staff member H was the nurse on shift, and she started chest compressions. Staff member E stated, When I arrived in resident #1's room there was not an Ambu bag on the crash cart, I had to leave the code to go and find one. Staff member H was just doing compressions. I had to look in multiple areas and then had to run to a storage room located across the building from where resident #1's room was located. I was able to locate an Ambu bag and return to resident #1's room after several minutes. When I returned to resident #1's room it was chaotic, unorganized, no one really knew what they were supposed to do. The communication was very poor. When EMS arrived they took over CPR efforts and attached an AED to resident #1. EMS delivered at least two shocks, under the direction of the AED. If the facility has full code patients, they need to make sure we have the tools to perform our jobs, especially in emergent situations. There also needs to be more than one crash cart available to use. I know that another resident coded in the facility about a week later, but that was in the middle of the night, and I am not sure of the details.</p> <p>(continued on next page)</p>

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:50 a.m., staff member H stated she was working when resident #1 coded in his room. Staff member H stated, I was passing medications when staff member J yelled for me to come to resident #1's room. I entered resident #1's room and found he was not breathing, and had no pulse, but was still warm to the touch. I immediately started chest compressions and yelled for the crash cart. Staff member I came with the crash cart, but there was no Ambu bags or barriers on the crash cart. I continued with compressions. We called EMS, and they went to the wrong address the first time, and it took them a long time to get here. EMS used the AED and resident #1 was shocked at least twice. The one thing that bothers me is that no one knew where the crash cart was, and there were no Ambu bags or respiratory supplies available on the cart. Staff member H stated, If we would have had all the supplies we needed, and staff had training on emergency situations, it may have helped save his life. Staff member H stated resident #1 had expired. Staff member H stated she was not CPR certified and had not been CPR certified for two years. Staff member H said the facility had never offered any training or certification for CPR, and the employee did not know who was responsible for checking or stocking the crash cart.</p> <p>During an interview on [DATE] at 10:10 a.m., staff member I stated she went to find the crash cart and called 911 with the emergency for resident #1. Staff member I stated, I called 911 at 8:25 a.m., and at 8:37 a.m., 911 called back wanting the address again because they had gone to the wrong building the first time. When I was in resident #1's room during the code, there was no Ambu bag or barriers available on the crash cart. Staff member I stated staff member E had to leave the room to look for an Ambu bag, while staff member H performed compressions. There was a complete delay in care from us and from EMS. If we would have had the needed supplies available, it may have helped save resident #1. Staff member I did not know who was responsible for checking or stocking the crash cart.</p> <p>During an interview on [DATE] at 10:25 a.m., staff member Q stated she was not CPR certified and had never been offered training or certification in CPR. Staff member Q stated, Today was the first time I have been offered a CPR class and this is the first time the facility has offered one as far as I know.</p> <p>During an interview on [DATE] at 10:30 a.m., staff member J stated he was the staff member who found resident #1 in his room not breathing. Staff member J stated he had called for the nurse, and she had run down to the room, assessed resident #1, and started chest compressions. Staff member J stated there was no barrier or Ambu bag available for staff to use, staff had to try and locate one. Staff member J stated he had never been asked about CPR certification or been offered training or certification on CPR. Staff member J said he had kept his certification current on his own.</p> <p>During an interview on [DATE] at 10:55 a.m., staff member A stated that staff member L was responsible for ordering supplies, and, We do not have a designated person who stocked supplies, staff just go to the central supply closet and get what they need, there is no person that is actually responsible for stocking supplies.</p> <p>During an interview on [DATE] at 11:10 a.m., staff member L stated he was responsible for ordering supplies for the facility. Staff member L stated he ordered supplies on Tuesdays and Thursdays. Staff write down what supplies are needed on the paper hanging on the outside of the supply closet. Staff member L stated once he is made aware of needed supplies, he would order them, on the next order date.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a facility document titled, SUPPLIES NEEDED, Showed Ambu bags were written down on [DATE], the day after resident #1 coded.</p> <p>A review of a facility document titled, Purchase Order SWCN0000082733, dated [DATE] at 3:29 p.m. showed an order was placed for Ambu bags. Four days after Resident #1 coded.</p> <p>During an interview on [DATE] at 11:40 a.m., staff member A stated she did not have a record of when the supplies arrived but believed it was [DATE].</p> <p>During an interview on [DATE] at 1:10 a.m., staff member K stated her expectation was all staff should know where to find supplies and where the crash carts are located. Staff member K said, I would expect that night shift (will) be checking the crash cart, but there is no documentation on crash cart checks or supplies. I would expect if a staff member used supplies off the crash cart that they replace what was used and restock the cart. Staff member K said staff member A informed her there was no AED because the staff did not know how to use one.</p> <p>During an interview on [DATE] at 3:00 p.m., staff member B stated, My expectation for supplies is that they are available, and staff know where to find them. All staff should know where to find them at. That should be part of the floor training staff get during orientation. The crash cart should be fully stocked with supplies in case of an emergency, if not, what is the purpose of having a crash cart. Staff member B stated she wasn't sure how the facility ensured staff were trained and certified in CPR. Staff member B stated, That is a building process, I know we do not have an in-house CPR instructor, and I am not sure how they track who needs certifications and who doesn't.</p> <p>During an interview on [DATE] at 3:50 p.m., Staff member A stated, I do not have copies of the CPR cards, I don't track who needs it, and who doesn't. When a person on-boards, they should upload a copy of the certification, but no one has, I just went back and looked. It has been just me. I have not had a full-time Director of Nursing for a long time, I have had interim Directors of Nursing, no one permanent until now, and she just started.</p> <p>B. During an interview on [DATE] at 11:24 p.m., staff member M stated she was the staff member on shift when resident #3 coded. Staff member M stated another staff member brought the crash cart to resident #3's room and called 911. Staff member M stated she had started CPR on resident #3. Staff member M stated resident #3 was a full code. Staff member M stated no Ambu bag or mouth barriers available on the cart. Staff member M stated she had her pocket barrier which she carried with her in her pocket.</p> <p>During an interview on [DATE] at 12:08 p.m., staff member G stated she had witnessed staff member E notify staff members A and K of the need for more respiratory supplies in early [DATE]. Staff member G stated she could not recall the exact date or time but knew it was before resident #1 had coded. Staff member G stated supplies were not received before resident #3 coded, but arrived after.</p> <p>A review of resident #3's electronic medical record showed resident #3 was admitted to the facility on [DATE], from an acute care facility. Resident #3 had a diagnosis of acute chronic respiratory failure, acute and chronic bilateral pulmonary emboli, and obstructive sleep apnea. Resident #3 was a full code per the POLST, dated [DATE], with full interventions, and the resident expired in the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a document titled, Prehospital Care Report, dated [DATE] at 3:30 a.m., showed:</p> <p>EMS was dispatched to the facility o [DATE] at 3:30 a.m., At scene at 3:37 a.m., At patient at 3:39 a.m., and departed the facility at 4:19 a.m. [sic] Resident #3 expired in the facility.</p> <p>Review of a facility document titled, Cardiopulmonary Resuscitation (CPR), undated, showed:</p> <ul style="list-style-type: none"> <li>. 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR.</li> <li>. 4. Staff will maintain current CPR certification for healthcare providers .</li> </ul> <p>A review of a facility document titled, Emergency Crash Cart, undated, showed:</p> <p>It is the policy of this facility to ensure that the facility will maintain at least one emergency crash cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support.</p> <p>The purpose of this policy is to ensure that all supplies critical to basic life support are readily available on the emergency cart.</p> <ul style="list-style-type: none"> <li>2. The facility will store the emergency cart in a location that is accessible (Med room near ,d+[DATE] hall)</li> <li>. 4. The emergency crash cart is checked routinely .</li> <li>. 5. Clinical staff will be education on the location and use of the emergency crash cart . [sic]</li> </ul> <p>A review of the Facility Assessment, dated [DATE], failed to show any emergency respiratory supplies, such as Ambu bags were identified as needed or addressed.</p> <p>A request was made on [DATE] at 11:00 a.m., for a policy or procedure for ordering and stocking supplies, and CPR certifications for all nursing staff, to include the CPR certifications for staff members H and M. The CPR certifications for staff members H and M were not received before the end of the survey.</p> <p>On [DATE] at 2:10 p.m., Staff member A stated they did not have a policy or procedure for ordering and stocking supplies or for the staff CPR certifications. Staff member A said, I gave you what I could get.</p> <p>A request to speak with staff member AA was made on [DATE] at 2:02 p.m., and on [DATE] at 8:31 a.m. Staff member AA did not call prior to the end of the survey.</p> <p>A review of current CPR standards from the American Heart Association includes:</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to provide proper indwelling Foley catheter care daily to 2 (#s 21 and 26) of 26 sampled residents. This deficient practice caused resident discomfort and had the potential for an increased risk of catheter associated urinary tract infections. Findings include:</p> <p>During an observation and interview on 1/22/25 at 8:10 a.m., resident #26 was sitting in a wheelchair with a Foley catheter drain bag attached to the wheelchair. Resident #26 went down to his room and continued to sit in the wheelchair for the observation. Resident #26 had an indwelling Foley catheter. A foul urine odor was present. Resident #26's penile meatus was red, and there was a crusty solid like material on the Foley catheter, near the penile opening. Resident #26 pointed to the catheter and stated it hurt.</p> <p>During an observation and interview on 1/22/25 at 10:20 a.m., resident #21 way lying in bed, dressed in a hospital gown. Resident #21 stated staff were pretty good about doing his cares, but staff would get busy and forget at times. Resident #21 had a foul odor present in the groin area, and his room had a strong urine smell. Resident #21's penile meatus was red. Resident #21's Foley catheter had a solid, crusty like material, on the catheter near the penile opening. Resident #21 stated it had been a couple days since anyone had done any peri-care or cleaned his catheter.</p> <p>During an interview on 1/22/25 at 12:20 p.m., staff member D stated catheter care was signed off in the medication administration record as being done. Staff member D stated, I trust that the CNAs are doing what they are supposed to do.</p> <p>During an interview on 1/22/25 at 12:25 p.m., staff member U stated catheter care is done by the CNA staff, and the nurses document in the medication administration record. Staff member U stated she did not always double check to make sure catheter care had been completed.</p> <p>A request for Resident #21's catheter care for January 2025 was requested 1/23/25 at 8:00 a.m.</p> <p>During an interview on 1/23/35 at 8:29 a.m., staff member V stated there was no documentation of resident #21's catheter care. Staff member V stated the physician order was never put on the resident's medication administration record.</p> <p>Review of a facility document titled, Catheter Care, undated, showed:</p> <p>It is the policy of this facility to ensure that residents with indwelling Foley catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.</p> <p>1. Catheter care will be performed every shift and as needed by nursing personnel .</p>		

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NAME OF PROVIDER OR SUPPLIER  Whitefish Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1305 E 7th St Whitefish, MT 59937	
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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure proper respiratory supplies were readily available during emergencies, for 2 (#s 1 and 3) of 26 sampled residents. This deficient practice caused a delay in care during emergent situations, and an Immediate Jeopardy was cited for F678 - Cardio Pulmonary Resuscitation, which included concerns with the lack of supplies and availability. Findings include:</p> <p>During an observation and interview on [DATE] at 11:55 a.m., staff member C showed the crash cart was located in the hallway by the medication room and the nurse's station on the 100 and 300 hallway. The crash cart was wedged in between a treatment cart and the wall and was not easily accessible. There was a light blue, tarp-like cloth covering the crash cart. Staff member C stated a secondary cart was in a utility room but not utilized because they could not access it. The crash cart in the utility room was in a back corner blocked in by intravenous poles and wheelchairs. The crash cart was not covered. Staff member C stated she did not know when the crash carts were stocked or the equipment was tested .</p> <p>a. During an interview on [DATE] at 12:02 p.m., staff member D stated she was on shift when resident #1 had coded. Staff member D stated when the code was called staff had to run across the building to retrieve the crash cart and it did not have the supplies needed. Staff member D stated no AED or Ambu bag was available on the crash cart (for the prior emergent situations). Staff member D said she did not know who was responsible for checking the crash carts.</p> <p>During an interview on [DATE] at 2:43 p.m., Staff member A stated, Ambu bags are now on the crash carts.</p> <p>During an interview on [DATE] at 7:08 p.m., an anonymous staff member stated respiratory supplies had been requested back in the middle of December, and said staff members A and K were notified of the need for more respiratory supplies, and they were not ordered until after [DATE]. The anonymous staff member had to leave resident #1's room to search for an Ambu bag, one was found and the staff member returned to resident #1's room and took over the code . Staff members A and K were notified again about needed respiratory supplies.</p> <p>During an interview on [DATE] at 7:22 p.m., staff member E stated When I arrived in resident #1's room there was not an Ambu bag on the crash cart, I had to leave the code to go and find one. I had to look in multiple areas and had to run to a storage room located across the building from where resident #1's room was located. I was able to locate an Ambu bag and return to resident #1's room.</p> <p>During an interview on [DATE] at 9:50 a.m., staff member H stated I entered resident #1's room and . immediately started chest compressions and yelled for the crash cart. Staff member I came with the crash cart but there was no Ambu bags or barriers, so I could provide manual breathing safely . no one knew where the crash cart was and there were no Ambu bags or respiratory supplies available on the cart. Staff member H stated she didn't know who was responsible for checking or stocking the crash cart.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:10 a.m., staff member I stated she went to find the crash cart and called 911. Staff member I said, I called 911 at 8:25 a.m. When I was in resident #1's room during the code, there was no Ambu bag or barriers available so that manual respirations could be done safely. Staff member E had to leave the room to look for an Ambu bag. There was a complete delay in care from us. If we would have had the needed supplies available, it may have helped save resident #1. Staff member I stated she didn't know who was responsible for checking or stocking the crash cart.</p> <p>During an interview on [DATE] at 10:30 a.m., staff member J stated he was the staff member who found resident #1 in his room not breathing. Staff member J stated he had called for the nurse, and she had run down to the room and had started chest compressions. Staff member J stated there was no barrier or Ambu bag available for staff to use, they had to try and locate one. Resident #1 expired at the facility.</p> <p>b. [DATE] at 11:54 a.m., a call was placed to staff member M. Staff member M was on duty when resident #3 coded. A voice message was left.</p> <p>During an interview on [DATE] at 1:10 a.m., staff member K stated the expectation of the facility was for all staff to know where to find supplies. Staff member K stated, I would expect night shift be checking the crash cart, but there is no documentation of crash cart checks or supplies. I would expect if a staff member used supplies off the crash cart that they replace what was used and restock the cart.</p> <p>During an interview on [DATE] at 3:00 p.m., staff member B stated, My expectation for supplies is that they are available, and staff know where to find them at . That should be part of the floor training staff get during orientation.</p> <p>During an interview on [DATE] at 11:24 a.m., staff member M stated she had been called down to resident #3's room and found resident #3 was not breathing and had no pulse. Staff member M stated she had to use her own respiratory barrier she carried in her pocket because one was not available. Staff member M said there was no Ambu bag available to use. Staff member M stated she had continued to provide CPR until EMS arrived and took over.</p> <p>A review of the Facility Assessment, dated [DATE], failed to show information related to Respiratory Care and Services. The assessment did not include:</p> <ul style="list-style-type: none"> <li>- The type of care, services, or contracted services, provided to residents for Respiratory Therapy Services and a Pulmonary Program.</li> <li>- Changes in staffing as a result of adding a Pulmonary Program.</li> <li>- Equipment needed for residents who participated in the Pulmonary Program.</li> <li>- No staff training or competencies addressing the Pulmonary Program.</li> <li>- The medical supplies section did not address CPAP, BIPAP, or emergency respiratory supplies, such as Ambu bags.</li> </ul> <p>A review of a facility document titled, Emergency Crash Cart, undated, showed:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>It is the policy of this facility to ensure that the facility will maintain at least one emergency crash cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support.</p> <p>The purpose of this policy is to ensure that all supplies critical to basic life support are readily available on the emergency cart .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>47752</p> <p>Based on interview and record review, the facility failed to properly administer medications with physician-ordered parameters for 3 (#s 18, 23, and 24) of 26 sampled residents. This deficient practice increased the risk of a negative outcome as failing to follow the physician's order could cause an increase or decrease in a resident's blood pressure. Findings include:</p> <p>1. Review of resident #18's physician's orders dated 1/1/25, showed:</p> <p>Midodrine HCL oral tablet 2.5 Mg</p> <p>Give 2.5 mg by mouth three times a-day for hold if systolic &gt;120, diastolic &gt;60 related to ORTHOSTATIC HYPERTENSION. Notify provider for held medications. [sic]</p> <p>A review of resident #18's medication administration record, dated January 2025, showed Midodrine HCL 2.5 mg was given 20 times, on the following dates, while blood pressure measurements were outside of ordered parameters.</p> <ul style="list-style-type: none"> <li>- 1/1/25 at 6:00 a.m., with a blood pressure of 121/80, and 2:00 p.m., with a blood pressure of 142/67,</li> <li>- 1/2/25 at 6:00 a.m., with a blood pressure of 127/71, and at 2:00 p.m., with a blood pressure of 140/63,</li> <li>- 1/3/25 at 2:00 p.m., with a blood pressure of 126/67,</li> <li>- 1/14/25 at 2:00 p.m., with a blood pressure of 138/72, and at 8:00 p.m., with a blood pressure of 140/81,</li> <li>- 1/15/25 at 8:00 a.m., with a blood pressure of 135/80, at 2:00 p.m., with a blood pressure of 126/70, and at 8:00 p.m., with a blood pressure of 144/80,</li> <li>- 1/16/25 at 8:00 a.m., with a blood pressure of 135/79, at 2:00 p.m., with a blood pressure of 126/74, and at 8:00 p.m., with a blood pressure of 148/82,</li> <li>- 1/17/25 at 2:00 p.m., with a blood pressure of 125/67, and at 8:00 p.m., with a blood pressure of 135/69,</li> <li>- 1/18/25 at 2:00 p.m., with a blood pressure of 133/78,</li> <li>- 1/20/25 at 8:00 a.m., with a blood pressure of 133/75, and at 8:00 p.m., with a blood pressure of 120/71, and</li> <li>- 1/21/25 at 8:00 a.m., with a blood pressure of 128/68, and 2:00 p.m., with a blood pressure of 129/64.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of resident #23's physician's orders dated 12/31/24, showed:</p> <p>Midodrine HCL oral tablet 5 MG</p> <p>Give 2 tablets by mouth three times a day for Hypotension hold if systolic &gt;120, diastolic &gt;60. [sic]</p> <p>A review of resident #23's medication administration record, dated January 2025, showed:</p> <p>Midodrine HCL 5 mg was given 13 times, on the following dates, while blood pressure measurements were outside of ordered parameters.</p> <ul style="list-style-type: none"> <li>- 1/3/25 at 8:00 a.m., with a blood pressure of 131/72,</li> <li>- 1/5/25 at 8:00 a.m., with a blood pressure of 124/70,</li> <li>- 1/7/25 at 8:00 a.m., with a blood pressure of 127/72, and at 8:00 p.m., with a blood pressure of 122/75,</li> <li>- 1/10/25 at 8:00 p.m., with a blood pressure of 137/95,</li> <li>- 1/13/25 at 8:00 a.m., with a blood pressure of 128/74, and at 2:00 p.m., with a blood pressure of 125/100,</li> <li>- 1/14/25 at 8:00 a.m., with a blood pressure of 130/90, and 2:00 p.m., with a blood pressure of 121/96,</li> <li>- 1/15/25 at 8:00 a.m., with a blood pressure of 121/76, and 8:00 p.m., with a blood pressure of 122/70,</li> <li>- 1/16/25 at 8:00 p.m., with a blood pressure of 144/86, and</li> <li>- 1/20/25 at 8:00 a.m., with a blood pressure of 121/68.</li> </ul> <p>3. A review of resident #24's physician's orders dated 12/28/24 showed:</p> <p>Atenolol oral tablet 50 mg. Give 50 mg by mouth in the evening for essential hypertension. Hold if BP &lt;100/60 or HR &lt;60.</p> <p>A review of resident #24's medication administration record, dated January 2025, showed:</p> <p>Atenolol 50 mg was given 15 times, on the following dates, with no documentation of blood pressure or pulse before administration.</p> <ul style="list-style-type: none"> <li>- 1/1/25,</li> <li>- 1/2/25,</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 1/4/25,</p> <p>- 1/5/25,</p> <p>- 1/7/25,</p> <p>- 1/12/25,</p> <p>- 1/13/25,</p> <p>- 1/14/25,</p> <p>- 1/15/25,</p> <p>- 1/16/25,</p> <p>- 1/17/25,</p> <p>- 1/18/25,</p> <p>- 1/19/25,</p> <p>- 1/20/25; and</p> <p>- 1/21/25.</p> <p>During an interview on 1/21/25 at 4:32 p.m., staff member H stated blood pressure and pulses should be taken right before administration of a medication when parameters are on the physician's orders. Staff member H said the blood pressure and pulse need to be as accurate as possible before administering the medications. Staff member H could not recall resident #24's blood pressure or pulse but had administered the ordered dose of atenolol.</p> <p>During an interview on 1/22/25 at 12:20 p.m., staff member D stated when a medication has ordered parameters the blood pressure and pulse should be done just prior to when the medication is scheduled to be administered. Staff member D stated it is part of the five rights of medication administration.</p> <p>During an interview on 1/22/25 at 12:25 p.m., staff member U stated if a medication was ordered with a set of parameters, the blood pressure or pulse needed to be done before giving the medication.</p> <p>During an interview on 1/22/25 at 12:50 p.m., staff member Y stated vital signs should be done prior to administering medication if there were parameters on the orders. Staff member Y said, You never give a medication with parameters if the vital signs are not recent.</p> <p>A review of a facility document titled, Medication administration, undated, showed:</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>. 10. Ensure the six rights of administration are followed:</p> <ul style="list-style-type: none"> <li>a. Right resident</li> <li>b. Right drug</li> <li>c. Right dosage</li> <li>d. Right route</li> <li>e. Right time</li> <li>f. Right documentation.</li> </ul>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>47752</p> <p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and record review, the facility failed to ensure the Facility Assessment was reviewed and updated as necessary when a new pulmonary program was planned and initiated. This deficient practice increased the risk of any resident needing pulmonary care and services to have a negative outcome, which did occur, and cited in other deficient practice areas. Findings include:</p> <p>Review of the Facility Assessment, dated 1/7/25, failed to show any information related to Respiratory Care and Services or the addition of a Pulmonary Program. The assessment did not include:</p> <ul style="list-style-type: none"> <li>- The type of care, services, or contracted services provided to the resident in the area of Respiratory Therapy Services and a Pulmonary Program.</li> <li>- Changes in staffing as a result of adding Pulmonary Program.</li> <li>- Equipment needed for residents who participated in the Pulmonary Program.</li> <li>- No staff training or competencies addressing the Pulmonary Program.</li> <li>- The medical supplies section did not address CPAP, BIPAP, or any emergency respiratory supplies, such as Ambu bags.</li> </ul> <p>During an interview on 1/15/25 at 2:10 p.m., staff member A stated the facility had the Pulmonary Program for about a year. Staff member A, the administrator, stated she was unsure why the facility assessment did not include the Pulmonary Program, and staff member A was in the Administrator position when the program was implemented.</p> <p>During an interview on 1/15/25 at 3:00 p.m., staff member B stated, The respiratory program was implemented about a year ago, and this last summer we started recruiting for respiratory therapists. The respiratory therapists have only been in the building for a few months. The therapists are able to give more one-on-one respiratory attention to the residents, this helps take some pressure off of the nursing staff. We are constantly evolving this program. We use this program to help decrease the risk of infection, re-hospitalization, and help speed up recovery time by improving stamina. We help the residents be more independent. If you can breathe better, you can ambulate better, and this helps residents get home quicker. Staff member B stated she was not involved in the facility assessment, and it was a building process.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47752</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility staff failed to adhere to standards of infection prevention and control practices, and hand hygiene, for 5 (#s 16, 17, 18, 19, and 20), and for enhanced barrier precautions, for 1 (#25) of 26 sampled residents. This deficient practice had the ability to negatively affect all residents in the facility by increasing the risk for spreading infection. Findings include:</p> <p>During an observation on 1/22/25 at 8:42 a.m., staff member P was walking down the hallway heading back to the medication cart. Staff member P was carrying a clear plastic medication cup, and a small plastic cup of water. Staff member P set the two cups onto the medication cart and started touching the computer located on top of the medication cart. Staff member P locked the medication cart, picked up the two plastic cups, walked into resident #16's room, and administered the medications to resident #16. No hand hygiene was performed prior to entering or exiting resident #16's room, and the staff member touched unclean surfaces prior to entering the room.</p> <p>During an observation on 1/22/25 at 8:52 a.m., staff member S knocked on resident #20's door, grabbed the door knob, and went into the room. No hand hygiene was performed prior to entering resident #20's room. Staff member S picked up resident #20's breakfast tray, left the room, walked down the hall to a large metal meal cart, opened the door, and placed the tray inside the cart. No hand hygiene was performed after placing the breakfast tray in the metal cart. Staff member S walked down the hall to resident #17's room, knocked on the door, grabbed the door knob, and went into resident #17's room. No hand hygiene was completed prior to entering or exiting resident #17's room.</p> <p>During an interview on 1/22/25 at 8:56 a.m., staff member S stated, I usually wash my hands, we are supposed to wash hands or use sanitizer. Staff member S stated she could not recall the last time she had any infection prevention or hand hygiene training.</p> <p>During an observation and interview on 1/22/25 at 8:58 a.m., staff member P was standing at the medication cart. Staff member P opened the drawer on the medication cart, picked up resident #18's medication cards, and dispensed them into a clear, plastic, medication cup. Staff member P picked up the plastic medication cup, walked to resident #18's door, knocked on the door, and entered the room. Resident #18 had gloves, isolation gowns, face shields, and masks in a clear plastic container outside the door to the room, and a sign posted outside of the door which notified staff of the need for enhanced barrier precautions. No hand hygiene was completed prior to entering #18's room. Staff member P touched resident #18's bedside table and touched his hand. Staff member P handed the medication cup to resident #18, and he took the medications. Staff member P left resident #18's room, walked back to the medication cart, and touched the computer. No hand hygiene was completed after exiting resident #18's room. Staff member P stated she was not aware resident #18 was on enhanced barrier precautions and had not received any infection prevention education or training by the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 1/22/25 at 9:10 a.m., staff member R opened a large metal cart and picked up a breakfast tray, shut the door on the cart, and walked into resident #19's room. Staff member R placed the breakfast tray down on a table, opened drinks, and set up the breakfast tray. Staff member R stated resident #19 required assistance with eating. No hand hygiene was performed prior to entering the resident's room or before starting to set up the meal tray. Staff member R stated hand hygiene should have been done prior to picking up the breakfast tray out of the cart and again prior to setting up the breakfast tray. Staff member R stated she could not remember the last time she had been educated on infection prevention or hand hygiene.</p> <p>During an observation and interview on 1/22/25 at 12:20 p.m., resident # 25 was lying in bed, dressed in a hospital gown. Resident #25 is hooked up to a pump which delivered continuous tube feeding through a gastrostomy tube, and there was a catheter bag attached to the side of the bed. There was no signage or personal protective equipment inside or outside of resident #25's room. Staff member D stated, I thought he (resident #25) should have been on enhanced barrier precautions; he has a suprapubic catheter and the tube feeding. I was never trained or educated on the facility's infection control policies or procedures.</p> <p>During an interview on 12:25 p.m., staff member U stated resident #25 should have been placed on enhanced barrier precautions, but there was no sign or personal protective equipment for resident #25. Staff member U stated she did not know who to talk to about infection prevention and had not received any training or education on the facility's infection prevention policies and procedures.</p> <p>During an interview on 1/22/25 at 2:00 p.m., and 2:35 p.m., Staff member B stated the previous Infection Preventionist had resigned at the end of November 2024, and there had not been anyone officially doing infection prevention, until 1/21/25. Staff member B stated, Every time I am here, I look at all the residents with enhanced barrier precautions and make sure everything is set up correctly, the signage is up, and the supplies are all there.</p> <p>Review of a facility document titled, In service Training, Infection control, Hand washing, dated, 10/24/24, showed, staff member R and T attended and signed the in-service sheet.</p> <p>Review of a facility document titled, Hand Hygiene, with a revision date, 9/18/24, showed:</p> <p>Policy:</p> <p>All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.</p> <p>. 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .</p> <p>3. Implementation of Enhanced Barrier Precautions</p> <p>a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Whitefish Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1305 E 7th St Whitefish, MT 59937	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>. e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752</b></p> <p>Based on interview and record review, the facility failed to ensure there was an affective training program for new staff, existing staff, staff providing contracted services; failed to ensure staff received training during orientation, and ongoing through employment, related to supply locations, supply ordering procedures, the crash cart, and CPR certification for 6 (staff members D, E, H, Q, M, and one anonymous staff member) of 26 staff sampled. This deficient practice increased the risk of any resident having a negative outcome related to the lack of training. Findings include:</p> <p>During an interview on [DATE] at 1:09 p.m., staff member D stated she was contracted staff employee. Staff member D stated she had not been educated to where extra supplies were kept or how to get supplies ordered. Staff member D stated, I was told that if supplies were needed to write it down. I was not shown where supplies were kept or where the order page was when I started here.</p> <p>During an interview on [DATE] at 7:08 p.m., an anonymous staff member stated no training was received on supplies or ordering supplies. The staff member stated a verbal notification was given to staff member A and staff member K about needing more supplies. The staff member stated they did not know there was a place to write down needed supplies.</p> <p>During an interview on [DATE] at 7:22 p.m., staff member E stated she was involved in an emergency situation, but there was not an Ambu bag on the crash cart. Staff member E stated, I had to leave the room to try and find an Ambu bag, and stated she had to go to three different areas to find one, and there was not just one place for supplies. Staff member E stated she was never educated or trained on supplies or how to order supplies.</p> <p>During an interview on [DATE] at 9:50 a.m., staff member H stated she had never been offered any education or training for CPR in the two years she was employed by the facility. Staff member H stated she had not been provided any education or training on the crash cart. Staff member H stated, I have no idea what supplies are supposed to be on it (the crash cart), or who is responsible for checking it. No one even really knew where the crash cart was. We did not even know where Ambu bags were stored, no one ever told us.</p> <p>During an interview on [DATE] at 10:25 a.m., staff member Q stated she was not CPR certified, and was not offered any training. Staff member Q stated the first time she was offered any CPR training was on [DATE]. Staff member Q stated she was not sure who was responsible for supplies or stocking the crash cart.</p> <p>During an interview on [DATE] at 10:55 a.m., staff member A stated there was not a designated person to stock supplies. Staff member A stated, Staff members just go to the supply closet and get what they need, there is not just one person responsible for stocking supplies, but staff member L orders the supplies for the building.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 1:10 p.m., staff member K stated the expectation was all staff know where to find supplies and where the crash cart was located. Staff member K stated there was no documentation of supplies needed for the crash cart or who checks the crash cart. Staff member K stated she expected if a staff member used supplies off the crash cart, then that staff member would restock it.</p> <p>During an interview on [DATE] at 3:00 p.m., staff member B stated, My expectation for supplies is that they are available, and staff know where to find them at. Staff should know where supplies are located, it should be part of the floor training they (staff) get during orientation. The crash cart should be fully stocked with supplies at all times in case of an emergency, if not, what is the purpose of having a crash cart. Staff member B stated she was not sure how the facility ensured staff were trained or certified in CPR.</p> <p>A request for the staff training policy was made on [DATE] at 11:00 a.m. Staff member A stated they did not have a policy but would provide what information was in the employee handbook.</p> <p>Review of a facility document from the employee handbook, undated, showed:</p> <p>Orientation and Training</p> <ul style="list-style-type: none"> <li>. Your orientation should prepare you to perform your essential duties.</li> <li>. Occasionally, your supervisor or Administrator will call upon you to attend in-service programs to strengthen your skill and knowledge in a particular area.</li> <li>. The meeting, course, or lecture is related to your current job. Participation in our training programs is a condition of continuing employment.</li> </ul>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>47752</p> <p>Based on interview and record review, the facility failed to ensure new staff, existing staff, and contracted staff were trained on the facility's infection prevention and control program standards, policies, and procedures. This deficient practice increased the risk of a negative outcome for all residents in the facility. Findings include:</p> <p>During an interview on 1/22/25 at 8:58 a.m., staff member P stated she had just started working at the facility. Staff member P stated she was not provided any education on infection prevention or hand hygiene policies and procedures, and she was just doing what I know. Staff member P stated she was not aware of who the Infection Preventionist was.</p> <p>During an interview on 1/22/25 at 12:20 p.m., staff member D stated she was contracted staff and had been working in the facility for over one month, and she had not been provided any education on infection prevention or hand hygiene policies and procedures. Staff member D stated she was not aware who the Infection Preventionist was.</p> <p>During an interview on 1/22/25 at 12:25 p.m., staff member U stated she had just started working in the facility not long ago. Staff member U stated she had not been trained on infection control or hand hygiene policies and procedures. Staff member U stated she did not know who the Infection preventionist was.</p> <p>During an interview on 1/22/25 at 1:50 a.m., staff member A stated there had not been an Infection Preventionist since the end of November 2024.</p> <p>During an interview on 1/22/25 at 2:00 p.m. and 2:35 p.m., staff member B stated the last Infection Preventionist resigned, and staff member Z started as the facility's Infection Preventionist on 1/21/25. Staff member B stated no one was officially employed as the Infection Preventionist.</p> <p>Review of a facility document titled, Infection Prevention and Control Program, undated, showed:</p> <p>. 16 Staff Education</p> <p>a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function.</p>