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	03/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49554 Based on observation, interview, and record review, the facility failed to maintain dignity for other residents when providing postmortem discharge of a resident for 1 (#47) of 30 sampled residents, which caused feelings of sadness; and failed to maintain dignity of a resident during an incontinent episode for 1 (#36) of 30 sampled residents, which caused them to be frustrated and angry. Findings include: 1. During an observation on 3/10/25 at 2:37 p.m., resident #47 was observed in the 300-wing hallway. Two unidentified individuals entered the room and came out with a resident on a stretcher covered fully with a blanket. They walked the stretcher past the nursing station where other residents were sitting. Resident #47 stated, What did I just see? Was that a dead body? An unidentified staff member stated, Yes, the resident passed away. During an observation on 3/10/25 at 2:40 p.m., two unidentified visitors were walking down the 300 wing, and one said to the other, Do you know what that was? It was a dead body. During an observation and interview on 3/13/25 at 8:06 a.m., resident #47 had a sad look on her face and stated, I saw a dead body the other day, and it really bothered me. I shouldn't have to see that. During an interview on 3/13/25 at 8:10 a.m., staff member DD stated, After a resident passes away, the nurse will make all necessary phone calls while CNAs do the postmortem cares. When the person comes to pick up the body, the CNAs usually make sure the hall is clear of others prior to them removing the resident; the staff also try to use the closest exit so they aren't going through the whole facility. Review of a facility document titled, Post Mortem Care, not dated, showed: . 7. Provide privacy . . 23. Notify the designated disposition location of the resident's death and fill out any post-mortem paperwork as per facility policy . [sic] 2. During an observation on 3/10/25 at 3:16 p.m., resident #36 was observed coming in from smoking and was observed to have had an incontinence episode, which left his sweat pants wet. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/10/25 at 3:21 p.m., resident #36 was sitting in his room in his wheelchair; his call light was on. A staff member entered the room and then left. Resident #36 stated, Yes, I peed in my pants. I am waiting for help, but they (staff) just keep coming in and telling me they will be right back. It is making me angry; I shouldn't have to sit here in wet pants and wait for them (staff). During an interview on 3/12/25 at 3:58 p.m., staff member F stated, Resident #36 is on a check and change schedule, and he should be checked and changed every two hours. Review of resident #36's care plan, with a revision date of 2/10/25, showed: Interventions: Toilet Use: [Resident name] requires dependent assistance by 2 staff for toileting. Is incontinent of B/B and uses brief. Will often refuse to allow staff to change him when he is up in his chair and prefers to wait until he goes back to bed. Educated [resident name] on risks of impaired skin integrity, respect his right to refuse and direct his care. [sic] Resident #36's electronic medical record failed to show a bowel and bladder schedule of check and change every two hours.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 52362 Based on observation, interview, and record review, the facility failed to supervise the self-administration of a metered-dose inhaler for 1 (#6) and two pain pills for 1 (#35) of 30 sampled residents. This deficient practice increased the risk for medication errors to resident's #6 and #35, as well as to confused residents, who may have wandered into resident #6 and #35's rooms. Findings include: During an observation and interview on 3/10/25 at 3:23 p.m., two blue pills were on resident #35's bedside table, in a plastic medicine cup, with no staff in the room. Resident #35 stated they were his Ibuprofen and Tramadol. Resident #35 stated some nurses offer to leave the medications so he can take them later, and some do not. During an observation and interview on 3/11/25 at 8:38 a.m., a metered-dose inhaler was sitting on resident #6's bedside table with no staff in the room. Resident #6 stated it was her rescue inhaler, she rarely used, but liked to have in her room just in case. During an interview on 3/12/25 at 9:30 a.m., staff member W stated when she administered medications, I always make sure they take them, so I don't get burned. We never leave them on the bedside table, it is our policy. I would need an order (from physician) to leave medications on the bedside table. During an interview on 3/12/25 at 9:50 a.m., staff member T stated if she found medications sitting out in resident #6 or #35's rooms she would give them to the nurse. During an interview on 3/12/25 at 4:24 p.m., staff member B stated her expectations were that residents were to be assessed by RNs to see if they were safe to self-administer medications. Staff member B stated if residents were found to be safe to self-administer medications, there should be the following: 1) An evaluation form filled out by the RN; 2) The MAR should reflect it was okay to leave medications at the bedside; 3) A lockbox for the medications, but stated, We don't have those, that is not our policy even for rescue inhalers. During an interview on 3/13/25 at 7:43 a.m., staff member A stated she did not have self-administration of medication assessments for residents #6 and #35, Because they're not supposed to self-administer meds. Review of resident #6 and #35's EMR, showed the care plans did not reflect self-administration and storage arrangements for a metered-dose inhaler or pain pills. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Resident Self-Administration of Medication, revised February 2023, showed, . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, . 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's room . 8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage . 11. When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications . are stored in the medication cart or medication room . 14. The care plan must reflect resident self-administration and storage arrangements .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on observation, interview, and record review, the facility failed to ensure it had an effective process in place for the most current and accurate code status and advance directives to be readily known and available to staff, in the event of an emergency, for 1 (#7) of 30 sampled residents. Findings include: During an interview on [DATE] at 11:12 a.m., staff member I stated a resident's advance directives were requested on admission and updated ongoing during care conferences. Staff member I stated multiple personnel could potentially get the POLST or advance directive information from the residents. Staff member I stated the current copies would be found uploaded in the electronic medical record. During an observation and interview on [DATE] at 4:33 p.m., staff member E stated on admission resident #7 did not have advance directives. Staff member E assisted resident #7 in filling out a POLST form as a brief full code. Staff member E turned it in to the doctor to sign. Staff member E stated she did not know she had another POLST showing DNR and went to check with the resident. While staff member E was talking with resident #7, she also called her son, and he told staff member E he had filled out advance directives with his mother, and she should have copies in her room. Resident #7 then dug out her new living will and POA paperwork, and staff member E took them to make copies as the facility did not have the advance directives on file. During an observation and interview on [DATE] at 8:10 a.m., resident #7 was sitting in her room in her wheelchair and stated, No big fanfare. If I'm dying, I'm dying . She [staff member E] put brief CPR for me, about her advance directives. During an interview on [DATE] at 8:41 a.m., staff member A stated all advance directive and code status changes were reviewed and updated daily in the stand-up and stand-down meetings. Staff member A stated the advance directives and POLSTs for code status were in a binder at the nurses' stations to use in the event of an emergency. During an interview on [DATE] at 9:56 a.m., with staff members L and M; staff member L stated resident #7 wanted brief CPR and her POLST was being reviewed again that day. Staff member L stated for resident #7's current code status, in the event of an emergency, she would go by the current order listed in the resident's record. Staff member M stated she would go by the most recent physician signed POLST, or call the family to verify. Staff members L and M stated the nurse on the unit, in the event of an emergency, would go to the electronic medical record and see the heading for the code status/advance directives, then go to the miscellaneous tab to print the POLST and other forms. Review of resident #7's electronic medical record census tab showed she was admitted to the facility on [DATE] and readmitted on [DATE] after a hospitalization . Review of resident #7's electronic medical record on [DATE] showed the miscellaneous tab had two different POLSTs uploaded, and no other advance directives. The care profile showed resident #7 was a full code/full treatment status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the POLST filled out on the [DATE] admission, by resident #7 and staff member E, was signed by the provider on [DATE]. Selections showed Yes CPR with BRIEF handwritten next to it, full treatment with Brief handwritten below it, and artificial nutrition by tube short-term/temporarily. Review of the POLST filled out on the [DATE] readmission by resident #7 and staff member I was signed by the provider on [DATE]. Options selected were no CPR, selective treatment, and no artificial nutrition by tube. Review of resident #7's physician's orders showed an active order for code status as full code, and full treatment as of [DATE]. No other listed orders for advance directives or code status were documented in the electronic medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49554 Based on observation, interview, and record review, the facility failed to provide an environment that was clean and well-maintained for 3 (#s 24, 30, and 36) of 30 sampled residents. This deficient practice bothered resident #30, wheelchairs were not cleaned for residents as needed, and unpainted surfaces were not corrected. Findings include: 1. During an observation and interview on 3/10/25 at 2:32 p.m., resident #30's wall, next to her roommate's bed, had paint chips along most of the wall. The bathroom was missing paint just above where the linoleum ends around the area of the sink, creating a non-cleanable surface. Resident #30 stated it was probably due to the wheelchairs hitting the wall. Resident #30 stated, It doesn't look good, which kind of bothers me. 2. During an observation on 3/10/25 at 2:46 p.m., resident #24's wheelchair had brown-colored debris covering the metal, around the footrest, near the front wheels of the wheelchair. Resident #24's bathroom was missing paint down, to the drywall just above the linoleum, on the wall around the sink. This was not a cleanable surface. During an observation on 3/11/25 at 9:42 a.m., resident #24's wheelchair had caked-on white-colored debris covering the front of the seat. There were white specks of debris covering the seat of the wheelchair. The metal around the front wheels and footrests was covered in brown dirt and debris. 3. During an observation on 3/10/25 at 3:22 p.m., resident #36's wheelchair was caked with white-colored debris on the front of the seat of the wheelchair. The metal around the front wheels was covered in a brown and white debris. The wall in the bathroom was missing paint above where the linoleum ends on the wall, across from the toilet, creating a non-cleanable surface. During an observation on 3/11/25 at 9:50 a.m., resident #36's wheelchair was still caked with a white-colored debris on the front of the seat of the wheelchair. The metal around the front wheels was covered in a brown and white debris. The wall in the bathroom was still missing paint above where the linoleum ends on the opposite wall of the toilet, creating a non-cleanable surface. During an interview on 3/12/25 at 1:14 p.m., staff member EE stated, We (the facility) use the Tells System for tracking maintenance orders. I focus on fire life safety issues first, and the other minor requests later if I get time to do them. I try to do patch jobs on the walls when I have time, or when the room is empty. During an interview on 3/12/25 at 3:58 p.m., staff member F stated, It is the night shift CNAs that clean wheelchairs. I know they don't get done; we don't have the time to clean wheelchairs and do all the other tasks required of us. Review of the facility maintenance logs showed there were no work logs in 2025 for fixing the missing paint in residents' rooms. Only four paint touch-ups were completed in 2024. Review of a facility document titled, Maintenance Inspection, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Policy Explanation and Compliance Guidelines: 1. The Director of Maintenance Services will perform routine inspections of the physical plant using the Maintenance Checklist. 2. All opportunities will be corrected immediately by maintenance personnel. [sic]

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

49554

Based on interview and record review, the facility failed to maintain a list of a resident's personal items and identify and investigate a grievance brought forth by a resident and their representative related to missing clothing for 1 (#85) of 30 sampled residents. Findings include:

During an interview on 3/12/25 at 8:50 a.m., NF1 stated the family was concerned with missing items of clothing after the resident's discharge. The facility was aware of the concerns.

During an interview on 3/12/25 at 4:13 p.m., NF3 stated, I didn't realize resident #85 didn't have all his clothes when I picked him up. We have expressed our concerns to the facility and haven't received a response.

During an interview on 3/13/25 at 8:10 a.m., staff member DD stated, Staff fill out an inventory list of resident items when they are admitted , and then the nurse double-checks them. The lists should be scanned into the resident's chart.

During an interview on 3/13/25 at 8:17 a.m., staff member H stated the CNAs usually fill out the inventory lists of personal items when a resident was admitted to the facility. Then the list should be scanned into the resident chart by medical records. Staff member H stated, CNAs gather the residents personal belongings and ensure the items go with the residents when they discharge.

During an interview on 3/13/25 at 8:26 a.m., staff member P stated, If a resident is missing clothing, the nursing staff fill out a sheet of paper with a description of the missing items, and we look for them. Most of the time clothes get lost because they aren't labeled. If we don't find the missing item, we (the facility) will replace the missing item. If there are resident items missing at discharge, we (the facility) gather the resident's contact information, and if we find the missing items, we notify them. If we don't find the missing items, we replace them or give them the monetary value of the item.

During an interview on 3/13/25 at 8:56 a.m., NF2 stated, [Resident #85's name] discharged home and did not have all his belongings when they got home. Some of the missing items were a gray hooded jacket, pajama sets, shoes, shirts, and pants. NF2 stated they had been in contact with the facility and NF1 did try to obtain the missing items. NF2 stated the facility was not responsive to requests made for resident #85's personal items. NF2 stated they had an itemized list and receipts for the residents' items that were missing.

Review of a facility document titled, Resident Grievance Log, dated October 2024 through March 2025, failed to show a grievance for resident #85's missing clothing.

Review of resident #85's electronic medical record failed to show an inventory list of personal items.

A request was made for resident #85's personal items inventory list, and the facility failed to provide documentation of inventory for resident #85, by the end of the survey period.

(continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document titled, Resident Personal Belongings, not dated, showed: Policy Explanation and Compliance Guidelines: . 3. All resident personal items will be inventoried at the time of admission by the social services designee or another designated staff member, and documentation shall be retained in the medical record. 11. Following the discharge or death of a resident, all personal clothing and items of a customized personal nature are to be given to the designated resident representative. 12. Inventories of all items are to be reviewed and examined by Social Services designee and the resident representative. Recipients of such personal items at the time of discharge or death shall sign-off with their legal signature, acknowledging receipt of all personal belongings presented. Review of a facility document titled, Resident and Family Grievances, with a revision date of 12/9/24, showed: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances. Policy Explanation and Compliance Guidelines: 1. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility . 3. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC facility stay . 6. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official . g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern. [sic]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41952 Based on interview and record review, the facility failed to ensure the care plan was accurate for a residents' code status change, for 1 (#7) of 30 sampled residents. Findings include: During an interview on 3/12/25 at 12:05 p.m., staff member I stated care plan updates were done by the department affected, and in the morning standup meeting someone would be assigned if a care plan update was needed. Review of resident #7's care plan focus of code status initiated on 2/14/25, and updated on 2/18/25, showed she was a full code per her POLST in her referral packet. Interventions included requesting copies of advance directives on admission and reviewing with the resident and responsible party on admission and at least quarterly. Review of resident #7's most recent POLST, signed by the provider on 2/17/25, showed the election of DNR.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 52362 Based on observation, interview, and record review, the facility failed to ensure staff member Z provided care consistent with professional standards during medication administration, resulting in residents possibly receiving the wrong medication(s) and having adverse outcomes from pre-poured and unlabeled medications, for 9 (#s 24, 27, 36, 43, 50, 58, 64, 65, 77) of 12 residents sampled for medication administration. Findings include: During observation and interview, on 3/12/25 at 1:40 p.m., staff member Z performed a medication pass for residents #27 and #36 from unlabeled medication cups found in the top right drawer of the medication cart. There were 12 unlabeled medication cups in the top right drawer of the medication cart with various pills in them. Staff member Z stated, I know who they belong to, I could not find them at the time. Staff member Z stated she thought the residents, who the unlabeled medication cups belonged to, were in an activity, and she didn't want to leave the cups of medications in the resident's room. During observation and interview on 3/12/25 at 1:55 p.m., staff member Z performed a medication pass for resident #58 from one of the unlabeled medication cups. During observation and interview on 3/12/25 at 2:27 p.m., staff member Z performed a medication pass for resident #77 from one of the unlabeled medication cups. During observation and interview on 3/12/25 at 2:29 p.m., staff member Z performed a medication pass for resident #24 from one of the unlabeled medication cups. During an observation and interview on 3/12/25 at 2:41 p.m., staff member Z noted all her afternoon medication passes had been signed off as given before she gave them. Staff member Z stated, I think I might have checked some off before I gave them, I know I'm not supposed to do that, but it's confusing, I didn't do it for all of them. Staff member Z performed a medication pass for resident #65 from one of the unlabeled medication cups. During an observation on 3/12/25 at 2:50 p.m., staff member Z performed a medication pass for resident #64 from one of the unlabeled medication cups. During an observation and interview on 3/12/25 at 2:55 p.m., staff member Z performed a medication pass for resident #50 from one of the unlabeled medication cups. Staff member Z stated, Those are [Resident #43's] medications in [Resident #50's] cup. Staff member Z removed pills from one unlabeled medicine cup and poured them into another unlabeled medicine cup, prior to the medication administration for resident #50. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/12/25 at 2:57 p.m., staff member Z recorded three medications removed, administered, and documented as given to resident #43 on the MAR at 1:35 p.m., including oxycodone 5 mg 2 tabs, but administered at this time (2:57 p.m.) from an unlabeled medicine cup. Staff member Z stated, I probably checked him off, but he was in the shower. Staff member Z stated she was finished at this time with her afternoon medication passes, but noted there were still 3 unlabeled medication cups in the top right drawer of the medication cart. Staff member Z stated, These cups I don't know about, so I'll have to figure it out. During an interview on 3/12/25 at 3:05 p.m., staff member B stated the pre-pouring of medications is not the best practice, medications should be delivered one at a time, and, If I found out otherwise, I would come unglued. Staff member B stated you could mark a medication as given, and if the resident does not take it, you can mark it back to ungiven, then store for a few minutes with a label on it inside the med cart. Review of the facility's policy, Medication Administration, dated 2024, showed, . 18. Observe resident consumption of medication. 20. Sign MAR after administered .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49554 Based on observation, interview, and record review, the facility staff failed to provide regular showers for 2 (#s 28 and 30) of 30 sampled residents, which made the residents feel dirty and/or upset. Findings include: 1. During an observation and interview on 3/10/25 at 2:57 p.m., resident #28's hair was oily and stringy. Resident #28 stated, Baths have not been consistent since I've been here. I have been here around seven months. Resident #28 stated, I prefer baths, but when they aren't available, I do my own little baths. The worst is my oily hair, and those dry shampoo rinses just don't do it for me. Review of resident #28's electronic medical record showed resident #28 had two baths in a 30-day look-back period. Review of resident #28's care plan, with a revision date of 2/17/25, showed, Interventions: BATHING/SHOWERING: [Resident name] requires set-up for showers/bathing. 2. During an observation and interview on 3/10/25 at 2:32 p.m., resident #30 was sitting on her bed, and her hair was oily and matted down. Resident #30 stated, We don't get baths on a regular basis. I'm not sure why. During an interview on 3/12/25 at 3:40 p.m., resident #30 stated, I'm supposed to get baths on Sundays and Thursdays. I haven't had one in a while. When I go without a shower, it makes me feel icky. Review of resident #30's electronic medical record showed resident #30 had one bath in a 30-day look-back period. Review of resident #30's care plan, with a revision date of 2/27/25, showed, Interventions: BATHING/SHOWERING: [Resident name] requires limited to extensive assist with showering based on energy and fatigue levels. During an interview on 3/12/25 at 3:58 p.m., staff member F stated, CNAs are responsible for doing baths on our assigned halls. We don't have the time to do them, and they often get missed. I would be very upset if I didn't get a bath regularly. Review of a facility document titled, Resident Showers, undated, showed: Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice. Policy Explanation and Compliance Guidelines: 1. Residents will be provided showers as per request or as per facility schedule.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 41951 Based on observation, interview, and record review, staff member N failed to follow provider orders for the administration of medications via gastrostomy tube (GT) and check for placement of the GT prior to administration of medications for 1 (#2) of 1 sampled enteral tube feeding observation. Findings include: During an observation on 3/11/25 at 8:15 a.m., staff member N had placed into a medication cup the following medications and liquids: - ferrous sulfate 325 mg, crushed, - oxybutynin chloride 5 mg, crushed, - ursodiol 300 mg capsule, contents of capsule emptied into medication cup, - methenamine hippurate 1 gm tablet, crushed, - metoclopramide HCL oral solution (liquid) 5 mg/5 ml, and - 10 ml of water. During an observation on 3/11/25 at 8:18 a.m., staff member N placed a medication cup, with all medications, a new enteral syringe, and an empty graduated measuring container on resident #2's bedside table. Staff member N filled the graduated measuring container with an unmeasured amount of tap water, in resident #2's bathroom, then placed the water filled container onto the bedside table. Staff member N pulled 10 ml of water with the enteral syringe from the graduated measuring container, then flushed resident #2's PEG tube. Staff member N did not check resident #2's PEG tube for correct placement by auscultation, as written in the provider orders. Staff member N placed all the crushed medications, which had 10 ml of water added to it at the medication cart and pushed it into resident #2's PEG tube. Staff member N then flushed the PEG tube with 10 ml of water. The total amount of water used during this medication administration for resident #2 was 30 ml of water. Per the provider orders, a total of 110 ml of water should have been administered during this medication administration. Review of resident #2's Order Summary Report, active orders as of 3/11/25, showed: - Give medications one at a time via GT with 10 ml H2O flush between each medication. Flush GT with 30 ml of H2O prior to and after administration of medications. Check for GT placement prior to meds via auscultation. every shift. [sic] (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 12:23 p.m., staff member N stated she checked for placement of resident #2's PEG tube at least one time a shift, when she administered medications. Staff member N stated she always did the medication administration the same way and it was the way she was taught. She also stated she understood the way she administered the medications for resident #2, was not the way the provider orders were written, and the total volume of water flush did not equal the correct amount. Review of the facility document titled, Care and Treatment of Feeding Tubes, last revised 12/4/24, showed: - .6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube): - a. Tube placement will be verified before beginning a feeding and before administering medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52362 Based on observation, interview, and record review, the facility failed to administer seven medications per prescriber's orders for 2 (#s 2 and 58) residents, out of 35 sampled resident medication orders, which led to a 20% medication error rate. Findings include: During and observation and interview on 3/12/25 at 2:11 p.m., staff member Z administered midodrine 2.5 mg to resident #58. The MAR for resident #58 showed midodrine 2.5 mg with meals. Staff member Z stated she did not know if resident #58 had eaten his lunch already. Staff member Z stated, The nurses have told me it is okay for him to take the midodrine without eating. During review of facility's policy, Medication Administration, dated 2024, showed, Medications are administered . as ordered by the physician . 10. Ensure that the six rights of medication administration are followed: .e. Right time . 41951 During an observation on 3/11/25 at 8:18 a.m., staff member N administered the following medications and liquid to resident #2 via PEG tube: - ferrous sulfate 325 mg, crushed, - oxybutynin chloride 5 mg, crushed, - ursodiol 300 mg capsule, contents of capsule emptied into medication cup, - methenamine hippurate 1 gm tablet, crushed, - metoclopramide HCL oral solution (liquid) 5 mg/5 ml, and - 10 ml of water. All medications were given at the same time, via syringe, into resident #2's PEG tube. The total volume of water administered during this medication administration for resident #2 was 30 ml of water. Per the provider orders, a total of 110 ml of water should have been administered during this medication administration. Review of resident #2's Order Summary Report, active orders as of 3/11/25, showed: - Give medications one at a time via GT with 10 ml H2O flush between each medication. Flush GT with 30 ml of H2O prior to and after administration of medications. Check for GT placement prior to meds via auscultation. every shift. [sic] During an interview on 3/11/25 at 12:23 p.m., staff member N stated she administered resident #2's medications in one cup all the time. She stated she was not following resident #2's provider orders as written, and the total volume of water flush did not equal the correct amount.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 52362 Based on interview and record review, the facility failed to ensure staff member X administered insulin in a safe manner resulting in a significant medication error, which put the resident's health and safety at risk and requiring immediate transfer to an emergency room for 1 (#6) resident of 30 sampled residents. Findings include: During an interview on 3/10/25 at 2:50 p.m., resident #6 stated she went to the hospital overnight because the nurse made a mistake and gave her another resident's insulin on top of her own insulin. During a telephone interview on 3/12/25 at 8:40 a.m., staff member X stated he had an issue giving insulin 3 weeks ago. Staff member X stated he was distracted doing different things and brought two pre-filled insulin pens into resident #6's room. Staff member X stated one pen was filled with 18 units of long-acting insulin meant for resident #6, and the other pen was filled with 42 units of fast-acting insulin meant for resident #6's roommate. Staff member X stated he gave both doses to resident #6, then realized his error and spoke with staff member Y before sending the patient to the emergency room . Staff member X stated after resident #6 went to the hospital, he was educated by the facility on the situation to prevent recurrence of such incident, cleaned out the medication cart of clutter, and marked the insulin pens more clearly. Staff member X stated he was working with staff member AA to receive further education on his workflow, to only do one resident's medication at a time. During an interview on 3/12/25 at 8:52 a.m., staff member BB stated it was hard to determine or speculate the outcome from someone receiving 18 units of long-acting insulin and 42 units of short-acting insulin by mistake without his toxicology handbook. Staff member BB stated outcomes could be hypoglycemia symptoms including confusion and unconsciousness. Staff member BB stated it could have caused death, but, It would depend on if the resident is brittle, running high/normal, how responsive are they to insulin, are they tolerant of low blood sugars. I don't know if it could have been a lethal dose without my toxicology handbook which is at home. During an interview on 3/12/25 at 9:50 a.m., staff member T stated she was not on duty during resident #6's insulin medication error, but, heard she was given way too much. During an interview on 3/12/25 at 11:47 a.m., staff member W stated she did not receive specific education regarding the insulin incident. During an interview on 3/12/25 at 1:17 p.m., staff member B stated she went over the 6 medication administration rights for residents, with everybody, like how to administer insulin one resident at a time, but I haven't gotten to everyone yet. Review of the facility's document, Licensed Nurse Competency, Employee Name: [staff member X], Hire Date: 1/29/25, Competency Type: Initial, dated 1/30/25, reflected: Training on the following topics was provided: . Medication Management . Injections . Assessment Method: Policy review, post test . direct observation (not marked) . [sic] (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's incident report #2377, dated 2/16/25, reflected: . Incident Description: . Contributing factors related to the error were: bringing both her and her roommate's insulin in at the same time during the med pass. The labeling on the insulin pen was not complete, and the label on the pen that was administered was only on the lid of the pen and not the body . Immediate Action Taken: . Immediately notified staff member Y about med error, . staff member AA was consulted, . staff member CC was notified, . staff member B was notified. After consulting with staff member Y, staff member X was informed to send [Resident #6] to the ER for continuous glucose monitoring . Predisposing Environmental Factors: Poor Lighting and Noise . [sic] Review of facility's IDT - Interdisciplinary Post Event Note, dated 2/17/25, reflected: . 1. Description of Event: Nurse administered another residents insulin to this resident after he had already given the resident her scheduled dosing. PCP indicated/requested resident send to ER for continual blood glucose monitoring related to increased dosage of medication. 2. Date and Time of Event: 2/16/25 08:00 . Behavioral Risk Factors: . 5. b. Poor safety awareness . E. Interdisciplinary Team . p. Other: Nurse medication error counseling performed w/ Staff member . [sic] Review of facility's document, [A Facility Name] In service Training, dated 2/24/25, reflected: Training: Medication Error - Insulin/6 Rights. Twelve staff members were signed in as present and understanding the training. Review of facility's document, Employee Warning Notice, dated 2/26/25, signed by staff member X on 3/11/25, and signed by staff member B on 2/27/25, reflected: . Employee Name: [staff member X] . First Warning . Medication error . Description of infraction: Nurse administered wrong medications to a resident . Resident required hospitalization for continuous monitoring related to medication error . [sic] Review of the facility's policy, Administration of Insulin, revised February 2023, reflected: . provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition . 1. All insulin will be administered in accordance with physician's orders . [sic] (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Medication Administration, dated 2024, reflected: . 10. Ensure that the six rights of medication administration are followed: . a. Right resident, b. Right drug, c. Right dosage .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41951 Based on observation, interview, and record review, the facility failed to ensure staff member N followed enhanced barrier precautions during the administration of medications via enteral tube feeding for 1 (#2) of 1 sampled enteral tube feeding resident; failed to ensure staff members N and Z adhered to proper infection control practices related to hand hygiene when changing of gloves and during medication administration for 6 (#s 2, 24, 58, 64, 67, and 77) of 30 sampled residents; failed to ensure staff member O adhered to proper infection control practices during wound care for 1 (#67) of 1 sampled resident for wound care; and failed to ensure staff member V followed infection control procedures to prevent potential contact transmission of an infectious agent or communicable disease for 1 (#38) of 8 sampled smoking residents. Findings include: 1. Enteral Tube Feeding Medication Administration During an observation on 3/11/25 at 8:18 a.m., staff member N entered resident #2's room with medications to be administered via PEG tube. On the wall, next to the entrance into resident #2's room, was a sign for Enhanced Barrier Precautions (EBP). Staff member N donned gloves to administer the medications via PEG tube, but did not don or wear a protective gown during the process. During an interview on 3/11/25 at 8:29 a.m., staff member N stated EBP was for residents who had a catheter or a trach. She stated the precautions were in place to protect the residents from infections because they were more susceptible. Staff member N stated she should have worn a gown during the administration of medications via PEG tube to resident #2. During an interview on 3/12/25 at 2:27 p.m.,, staff member C stated she had observations of PEG tube feeding today and knew there was employee/nursing skills to work on, including EBP. Review of the facility policy titled, Enhanced Barrier Precautions, date implemented 10/12/24, showed: - . Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities, and - . 4. High-contact resident care activities include: - a. Dressing, - b. Bathing, - c. Transferring, - d. Providing hygiene, - e. Changing linens, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- f. Changing briefs or assisting with toileting, and - g. Device care or use: central lines, urinary catheters, feeding tubes . 2. Hand Hygiene During an observation on 3/11/25 at 8:18 a.m., staff member N had just administered medications to resident #2 via PEG tube, doffed her gloves, reached into a dresser drawer to retrieve more supplies, then donned clean gloves. Staff member N did not sanitize her hands prior to donning the clean gloves. During an interview on 3/11/25 at 8:29 a.m., staff member N stated hands should be sanitized before and in between gloves changes. Staff member N stated she usually had hand sanitizer in her scrub pocket but did not that day. Staff member N stated she was educated on infection control practices upon hire and during onboarding in January 2025. During an observation on 3/12/25 at 11:41 a.m., staff member O entered resident #67's room for wound care with a box of clean gloves and donned a pair of gloves. Staff member O did not sanitize or wash her hands prior to donning the clean gloves. Staff member O cleaned the first wound, below the umbilicus (from left to right), applied skin prep, and applied the prescribed ointment. Staff member O dated the bandage, placed it onto resident #67's wound, then removed her gloves. Staff member O donned clean gloves, did not sanitize her hands, then cleaned the 2nd wound (from left to right on pannus). Staff member O removed her gloves after cleaning the 2nd wound and donned clean gloves. No hand sanitization was performed between glove changes. Staff member O cleaned the 3rd wound (from left to right), applied skin prep, removed her gloves, and donned clean gloves. No hand sanitization was performed between glove changes. Staff member O applied the prescribed treatment ointment to resident #67's wound, removed her gloves, and donned clean gloves. No hand sanitization was performed between the changing of gloves. Staff member O performed multiple glove changes during wound care for resident #67 on 3/12/25 but failed to perform hand hygiene (sanitization or washing with soap and water) during any of the glove changes. During an interview on 3/12/25 at 12:01 p.m., staff member O stated she was unaware of not sanitizing her hands between gloves changes. During an observation on 3/12/25 at 1:55 p.m., staff member Z did not perform hand hygiene before putting a medication into a medicine cup for resident #58. During an observation on 3/12/25 at 2:27 p.m., staff member Z did not perform hand hygiene before bringing medications to resident #77. During an observation on 3/12/25 at 2:29 p.m., staff member Z did not perform hand hygiene before preparing medications and before bringing medications to resident #24. During an observation on 3/12/25 at 2:55 p.m., staff member Z did not perform hand hygiene before preparing resident #64's medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25 at 2:27 p.m., staff member C stated she performed hand hygiene audits weekly but realized the audits needed to occur more frequently. During an interview on 3/12/25 at 3:05 p.m., staff member B stated her expectations for performing hand hygiene during the medication administration process was as follows: 1) Before going into the cart; 2) After touching hair/face/keys; 3) Before leaving the cart to give medications; and 4) Upon returning to the cart after giving medications. Review of the facility policy titled, Hand Hygiene, undated, showed: - a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's policy, Medication Administration, dated 2024, showed, . 4. Wash hands prior to administering medication per facility protocol . 19. Wash hands using facility protocol . 3. Wound Care Infection Control During an observation on 3/12/25 at 11:37 a.m., staff member O entered resident #67's room, placed a plastic medication cup with prescribed treatment ointment mixture and wound cleaner on his bedside table. Staff member O did not clean the bedside table, which had numerous personal items on it or place a protective barrier onto the table. During an observation on 3/12/25 at 11:41 a.m., staff member O placed the wound cleaner onto resident #67's bedspread with the nozzle facing down onto the bedspread. No protective barrier was placed under the wound cleaner. During an observation on 3/12/25 at 11:46 a.m., staff member O prepared to place a bandage on resident #67's 3rd wound. Staff member O reached into her scrub pants pocket and retrieved scissors. The scissors were not cleaned prior to cutting the bandage. The bandage was cut and placed over resident #67's 3rd wound, with the cut edge of the bandage touching the wound bed. Another bandage was placed over the cut bandage to cover the entire surface of the 3rd wound bed. During an interview on 3/12/25 at 12:01 p.m., staff member O stated she had cleaned the scissors to cut resident #67's bandage, but the cleaning was performed before she had placed the scissors into her unclean, scrub pants pocket. She stated the scissors would not be considered clean after they were in her pants pocket. Staff member O stated she placed the wound cleaner onto resident #67's bedspread, not thinking about placing a protective barrier onto the bedspread so the surface would be clean. Staff member O stated she was still learning about wound care. 4. Other Infection Control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 3/11/25 at 11:02 a.m., staff member V picked up a cigarette from the floor and put it back in the cigarette box belonging to resident #38. Staff member V did not perform hand hygiene. Staff member V stated resident #38 would have wanted her to put it back in the cigarette box. Staff member V stated she did see an infection control issue with putting a cigarette from the floor back into the cigarette box. 52362

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41951 Based on interview and record review, the facility failed to ensure residents who were screened and consented to pneumococcal immunizations (Prevnar13, Prevnar20, and PPSV23) were provided the vaccine for 3 (#s 2, 8, and 67) of 5 sampled residents for immunizations (influenza, COVID-19, and pneumococcal). Findings include: Review of resident #2's EHR document titled, Immunization Informed Consent Record, dated 2/5/25, showed the resident had consented to the pneumococcal vaccine. Review of resident #2's EHR document titled, Immunization Report, printed 3/12/25, showed no pneumococcal vaccine was administered. Review of resident #8's EHR document titled, Immunization Informed Consent Record, dated 2/10/25, showed the resident had consented to the pneumococcal vaccine. Review of resident #8's EHR document titled, Immunization Report, printed 3/12/25, showed no pneumococcal vaccine was administered. Review of resident #67's EHR document titled, Immunization Informed Consent Record, dated 2/10/25, showed the resident had consented to the pneumococcal vaccine. Review of resident #67's EHR document titled, Immunization Report, printed 3/12/25, showed PPSV23 was administered on 8/17/22. Resident #67 had not received Prevnar20, as recommended by the CDC. During an interview on 3/12/25 at 2:26 p.m., staff member B and staff member C stated they both started working at the facility in January of 2025. Staff member B stated when they started at the facility, limited information for resident vaccines was documented. Staff member B stated both herself and staff member C were waiting for access to the Montana Immunization Information System to ensure the facility's documentation was up to date. Review of the facility's policy titled, Pneumococcal Vaccine (Series), undated, showed: - 5. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record, and - 6. The type of pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations.

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 03/13/2025
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)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951 Based on interview and record review, the facility failed to maintain documentation in which each staff member was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine, that staff members were offered information on obtaining the COVID-19 vaccine, and records of the COVID-19 vaccine status of each staff member. Findings include: During an interview on 3/12/25 at 2:26 p.m., staff member B stated she would look for staff COVID-19 documentation, but did not believe there was documentation on any of the facility staff related to the COVID-19 vaccine. During an interview on 3/12/25 at 5:15 p.m., staff member A stated, regarding staff COVID-19 vaccination status or declination, We don't have it. A written request was made to the facility on [DATE] at 9:20 a.m., for five random staff members' documentation on COVID-19 vaccine education and vaccine status. No documentation was provided to the State Survey Agency prior to the survey exit on 3/13/25. Review of the facility's policy titled, COVID-19 Vaccination, undated, showed: - 19. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such, and - 20. The facility will maintain documentation related to staff COVID-19 vaccination and includes at a minimum: - a. Education to the staff regarding the risks, benefits, potential side effects of the COVID-19 vaccine; - b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; and - c. The COVID-19 vaccine status of staff and related information as indicated by NHSN . [sic]