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	03/12/2026

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

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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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there was a clinical indication for a resident's long-term use of a Foley catheter; failed to follow up timely on a physician's PRN order for changing the catheter for over four months1 in an attempt to prevent infections or complications; failed to establish a voiding pattern; and failed to ensure a comprehensive individualized care plan was developed for the resident's long term catheter use, to include goals and interventions for the monitoring and care of the catheter, for 1 (#37) of 3 residents sampled for catheter use and care. Findings include:During an observation and interview on 3/10/26 at 9:51 a.m., resident #37 had a Foley catheter bag attached to the underside of his wheelchair. He stated he had the Foley for a while.Review of resident #37's urology notes, dated 2/10/25, showed the resident had BPH with obs/LUTS (obstructive/lower urinary tract symptoms). During this visit, the resident did not have a Foley catheter. Urodynamic testing showed that his post-void residual was 12 ml. Surgery for a bladder neck contracture was recommended should he go forth with orthopedic surgery to prevent post op retention. There were no further urology notes and no follow-up after his catheterization for acute urinary retention in the hospital in October 2025. Review of resident #37's medical record showed he was admitted to the facility on [DATE]. He did not have a Foley catheter present on admission. A review of resident #37's care plan, printed on 3/11/26, showed he had a Fall care plan, initiated on 9/19/25 and revised on 12/22/25, which included information showing the resident had a Foley catheter. There were no contributing factors related to the use of the catheter or diagnosis for the use, and there were no goals or interventions for the monitoring and or care of the catheter or risk of infections related to the catheter. The resident also had an Incontinence care plan that did not include any information related to the catheter use or risks associated with it. The interventions showed the facility would establish voiding patterns. The resident's ADL care plan showed he needed partial to moderate assistance with toileting, but there was no information related to catheter use. Review of resident #37's 5-day MDS assessment, with an ARD of 10/25/25, showed he had a new indwelling catheter.Review of resident #37's diagnosis list on 3/11/26 did not show a diagnosis supporting the use of a long-term Foley catheter.Review of resident #37's hospital history and physical, dated 2/19/26, showed, . reports a chronic indwelling Foley that was placed a number of months ago (September as reported), however has not been changed and perhaps in so many months . and UA s/p Foley exchange is positive for blood, nitrites, WBCs and 4+ bacteria, flu a PCR is positive, as is MRSA PCR. BCx have been obtained and are pending, empiric IV antibiotic therapy with vancomycin and Zosyn has been started; the hospitalist service has been consulted for admission. Under the Plan it showed the resident had purulent discharge noted at urethral meatus.A review of documentation of resident #37's Foley catheter changes and a void trial revealed there had not been a void trial or catheter change while he had resided at the facility, although the voiding pattern was identified on the care plan. Review of resident #37's historical and current physician orders, from his admission to the date of the survey, showed the following catheter-related directives: -Indwelling Urinary Catheter: change PRN if pulled out, leaking, or clogged as needed. The discontinuation date (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Actual harm Residents Affected - Few	was 2/24/25.-Foley catheter 16Fr with 10 cc balloon. Change monthly and PRN for obstruction. The start date was 3/11/26.During an interview on 3/11/26 at 3:02 p.m., staff member B stated that foley catheters were changed on a PRN policy unless specified otherwise by the doctor.1 Staff member B stated that for a long-term catheter, they would usually see obstructive uropathy or neurogenic bladder as diagnoses. Staff member B stated, We have a much better process of reviewing hospital documentation since resident #37's last admission, and our coder reached out to the physician to see if obstructive uropathy was the appropriate diagnosis for him. Staff member B stated they would have to check on the policy to see when void trials were indicated. Staff member B stated they would check for urology notes to support resident #37's newly documented diagnosis of obstructive uropathy. A request was made for resident #37's catheter change documentation, and a document was received that showed, No attempt has been made to remove [Resident Name] catheter while in the facility. Review of the facility policy, Post Void Protocol, no implementation date, 2025 The Compliance Store, showed: To safely assess a resident's ability to void spontaneously after indwelling urinary catheter removal . and support the highest practicable level of continence per CMS requirements. Scope applies to all residents in the facility who have had an indwelling urinary catheter removed, particularly those with recent short-term catheterization (e.g. post hospitalization, acute retention, or transient issues) . Indications for a voiding trial . resident was previously continent or voiding independently .Reference: 1SUNA (Society of Urologic Nurses and Association) Clinical Practice Procedure, Insertion of an Indwelling Urethral Catheter in the Adult Male. Urologic Nursing March-April 2021 Volume 41, Number 2; The optimal interval for changing IUCs is not well defined. According to the Centers for Disease Control and Prevention's Guideline for Prevention of Catheter-Associated Urinary Tract Infections, changing an IUC should be based on clinical indications, such as infection, obstruction, or when the closed system is compromised. However, clinical practice has been to change/replace chronic IUCs every four weeks to minimize stone formation and biofilm development.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure expired medications and supplies were removed from active stock for one medication room, one medication cart, and two central supply rooms. This deficient practice had the potential to affect all residents receiving medications and requiring supplies for care. Findings include:During an observation and interview on 3/10/26 at 11:34 a.m., with staff member B, the following items were found:- In the medication room on 200-hall:Prevnar 20 x 37 doses expired [DATE]% dextrose 1000mL IV bag x 2 expired 2/2026- In the CNA Back supply room:19 cases of sterile gloves on floor15 cases of cleaning cloths on floor4 cases of Jevity 1.5 on floor3 cases of urinals on the floor6 cases of chucks on the floortrash/debris on floor- Nurse's back supply room:9 - 22Fr catheters expired 1/15/262 -14Fr catheters expired 6/28/251 -20Fr catheter expired 3/4/251 -16Fr catheter expired 6/22/2538 red rubber catheters expired 5/20/252 suction swab kits expired 10/2023- Medication cart on 400-hall:Blood sugar control Assure dose expired 2/28/26Staff member B stated the medication and supply rooms were checked monthly. Staff member B stated she did not know how the expired items were missed during the monthly checks. Staff member B stated the facility was in the middle of changing the functionality of the medication and supply rooms, moving things, and suspected this was the cause of the items being missed.Review of the facility policy, Storage of Medication requiring Refrigeration, no date, reflected:- . c. Remove any expired medications from active stock and discard medication according to facility policy.Review of the facility policy, Medication Storage, no date, reflected:- . 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to ensure the discharge planning process addressed goals, needs and referrals necessary to support a resident's request for discharge to another location closer to family for 1 (#81) of 25 sampled residents, and this was upsetting to the resident as it was an ongoing issue over the last year, although the resident had requested assistance with looking into other facilities multiple times. Findings include:During an interview on 3/10/26 at 8:45 a.m., resident #81 reported he was from North Dakota and desired to be discharged back to North Dakota because his family lived there and he had no support system in Montana.During an interview on 3/11/26 at 1:51 p.m., NF8 stated it had been resident #81's goal to return to North Dakota. NF8 stated, The facility kept telling us they were working on it. NF8 reported he had visited his brother on his birthday the previous year, and he had spoken with [Staff member A] about resident #81's desire to discharge to North Dakota. NF8 further stated, We would really love to have him back in North Dakota.During an interview on 3/11/26 at 2:12 p.m., staff member E stated referrals related to resident #81's request for placement in North Dakota were sent earlier in the day after the State Survey Agency asked about the discharge planning efforts. Staff member E reported she did not know what actions, if any, had been taken previously to address the resident's request to discharge to North Dakota.During an interview on 3/11/26 at 3:29 p.m., resident #81 stated he requested the facility to investigate placement in North Dakota since he was admitted . Resident #81 stated the staff reported they are looking into discharge options, and it's been brought up at every quarterly meeting, but he had not heard any updates.Review of resident #81's comprehensive care plan with an admission date of 7/24/24 showed,Focus: discharge: [Resident #81] would like to discharge to another LTC closer to family in North Dakota, however it has been discussed that this is not feasible at this time. Date Initiated: 5/6/24 Revision on 10/28/24Goals: [Resident #81] will learn to cope with his new home environment through the review date. [Resident #81] will communicate an understanding of the discharge plan through the review date.Revision on: 3/3/26Interventions: Continue to check in with [Resident #81] on a potential return to North Dakota and his desire to do so. Date Initiated: 12/2/25Evaluate [Resident #81's] desire to return to the community. Date Initiated: 10/29/24 Help [Resident #81] decorate his room to remind him of home. Encourage [Resident #81] to hang up pictures of family. Date Initiated: 10/29/24The care plan interventions focused on assisting the resident with adjustment to the facility rather than discharge planning actions such as identifying potential facilities, coordinating with out of state providers, or initiating placement referrals.Review of resident #81's Occupational Therapy Evaluation and Plan of Treatment for Certification the Period 11/25/25 - 1/19/26 showed, .Patient Referral and History .Transition/DC: Transition/Discharge Plan = Patient to reside in this LTC facility. (pt states he would like to go home to N. (North) Dakota but is aware that he doesn't have anywhere to live). [sic]Despite the resident expressing a desire to discharge closer to family in North Dakota, the facility failed to implement and reassess discharge planning interventions to pursue potential placement options.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop a comprehensive, person-centered care plan that included enhanced barrier precautions for a resident with an indwelling urinary catheter for 1 (#81); and failed to include PTSD triggers and interventions on a resident's comprehensive care plan for 2 (#s 53 and 57) of 25 sampled residents. The deficient practice increased the risk for transmission of multidrug-resistant organisms for resident #81 and made it difficult for staff to assist in managing the residents' environment and identify what residents suffered from PTSD and their triggers for residents #53 and #57. Findings include: 1. During an observation on 3/10/26 at 12:10 p.m., resident #81 was observed lying in bed in his room with an indwelling urinary catheter in place. Review of resident #81's comprehensive care plan with an admission date of 7/24/24 showed: Focus: CATHETER: [Resident #81] has Indwelling Catheter r/t Neurogenic bladder and this was initiated: 12/9/24. The Goal showed, [Resident #81] will show no s/sx of Urinary infection through review date, which was initiated 12/9/24. Further review of the care plan showed it did not include enhanced barrier precautions as an intervention to address infection prevention associated with the resident's indwelling urinary catheter. During an interview on 3/12/26 at 9:22 a.m., staff member B stated enhanced barrier precautions should be reflected on the individual care plans for residents currently on enhanced barrier precautions. Review of the facility's policy titled, Comprehensive Care Plan, not dated, showed: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standard of quality. 3. The Comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. [sic] 2. During an interview on 3/10/26 at 8:41 a.m., resident #57 stated, I was started on Prozac for my anxiety, but no one from the facility has talked to me about my diagnosis of PTSD. I would say my anxiety is part of my PTSD, especially when I feel like I can't move due to being paralyzed three years ago. During an interview on 3/10/26 at 9:06 a.m., resident #53 stated, No one ever listens to the fact that I have severe PTSD, I'm claustrophobic, and it gives me high anxiety. Resident #53 stated he would go to the woods to manage his anxiety when he lived on his own. Resident #53 stated that staff had never talked to him about his PTSD and any associated triggers, such as confinement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/26 at 1:36 p.m., staff member E stated, We [facility staff] care plan a diagnosis of PTSD (for the resident with it) and any identified triggers associated with it. It's all based on getting to know the resident. I plan on doing a deep dive into the care plans. I noticed they aren't very comprehensive, and that is due to the previous staff. During an interview on 3/11/26 at 2:54 p.m., staff member N stated she was only aware of two people who had PTSD. Staff member N stated this was resident #53 and another resident who had a military history. Staff member N stated she did not know resident #57 had a history of PTSD. Staff member N stated she would look in the Kardex in Point Click Care (electronic health record system) to see if someone had PTSD and what their triggers were. Staff member N stated she knew resident #53's triggers included any surprise moments, such as knocking on the door loudly, or quietly approaching the resident. Staff member N stated she did not know resident #53 was claustrophobic, but thought that might be the reason he was moved to a private room. Resident #53's comprehensive care plan, with a revision date of 12/12/25, failed to show identified triggers associated with behaviors or interventions specific to assisting staff in mitigating or preventing behaviors, anxiety, or stress associated with his diagnosis of PTSD. Resident #57's comprehensive care plan, with a revision date of 3/9/26, failed to show identified triggers associated with behaviors and interventions specific to assisting staff in mitigating the behaviors associated with her diagnosis of PTSD. Review of a facility document titled Trauma Informed Care, undated, showed: Policy: . and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the residents care plan.7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as. depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.8. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. [sic]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update care plan interventions for 2 (#s 4 & 37) residents with new foley catheters; and failed to ensure a resident's family members were involved in the care planning process for 1 (#81) of 25 sampled residents. This failure limited the resident's representative involvement in resident #81's care and treatment decisions. Findings include:1. During an observation and interview on 3/11/26 at 3:07 p.m., resident #4 pointed to her catheter drainage bag hanging from the side of her bed and stated she had a catheter put in after her most recent surgery. Review of resident #4's urology note, dated 2/18/26, showed she was seen for acute urinary retention post hospitalization. Review of resident #4's care plan, revision date 4/30/25, showed, Urinary incontinence: [Resident #4] has urge/stress bladder incontinence . Interventions included ensuring the resident had an unobstructed path to the bathroom and an established voiding pattern. There were no care plan updates acknowledging resident #4's new urinary catheter. During an interview on 3/12/26 at 10:00 a.m., staff member B stated there had been a new division of workload, implemented not long ago, where staff would get an assigned hallway, and for those residents on the halls, they would address the resident care plans and updates. 2. During an observation and interview on 3/10/26 at 9:51 a.m., resident #37 had a Foley catheter bag attached to the underside of his wheelchair. He stated he had the Foley for a while. Review of resident #37's 5-day MDS, with an ARD of 10/25/25, showed he had an indwelling catheter. Review of resident #37's historical and current care plans, dated October 2025 through March 2026, failed to show the resident had a urinary catheter or that urinary catheter interventions were in place, until 3/3/26, which was approximately five months after the MDS showed the resident had a catheter. 3. During an interview on 3/11/26 at 1:06 p.m., NF3 stated the first time the facility reached out to him directly for anything was for a care plan meeting for his brother scheduled on 2/26/26. NF3 stated the facility was going to call him for the meeting. NF3 stated that he and his brother waited for the call, but the facility never called. During an interview on 3/11/26 at 2:12 p.m., staff member E stated she called and invited family to attend care conferences by phone. When asked why resident #81's family had not been involved in the care planning process, she reported that family invitations were based on the resident's cognitive level, and stated that resident #81 did not want his family involved. During an interview on 3/11/26 at 3:29 p.m., resident #81 stated he wanted his family involved in his care. Resident #81 said staff had not asked him if he wanted family to be involved, and resident #81 assumed his family was involved. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #81's electronic health record showed he was admitted to the facility on [DATE]. Review of resident #81's Comprehensive MDS, with an assessment reference date of 2/13/26, showed the resident had a Brief Interview Mental Status (BIMS) score of 15, cognitively intact. Review of resident #81's social service progress note, dated 2/3/26 at 3:28 p.m., showed Resident and family was notified of care conference of 2/26/26 at 2 p.m. [sic] Review of resident #81's care conference summary, dated 2/26/26, showed the meeting date and time were 2/26/26 at 1:00 p.m. There were no family members listed as participants in the meeting. Review of the facility's policy titled, Comprehensive Care Plans, not dated, showed, .Policy Explanation and Compliance Guidelines: . 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: . e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: . v. Family members, surrogate, or others desired by the resident.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and address the needs of residents with PTSD, to include their psychosocial well being related to past traumatic events, for residents' who displayed and or voiced concerns related to trauma, and or who had a diagnosis of PTSD, in an attempt to assist the residents' and staff in being able to meet the needs of the residents (refer to F656 Comprehensive Care Plan), for 3 (#s 53, 57, and 102) of 25 sampled residents. Resident #53 voiced being upset that no one listened to him about his trauma. Resident #57 stated his behavior was stemming from past trauma related to a significant injury, and resident #102 was often angry. Findings include: 1. During an interview on 3/10/26 at 8:41 a.m., resident #57 stated, No one from the facility has spoken to me about my PTSD or any triggers I have. I have had trauma in my life and became paralyzed three years ago. I would say that my screaming behavior was in response to my anxiety of past trauma and not being able to do things for myself since I'm paralyzed. I was just put on more medicine. During an observation and interview on 3/10/26 at 9:06 a.m., resident #53 was sitting on his bed and appeared upset and short of breath. Resident #53 stated, I have COPD, and it is hard to breathe. I have issues, that's why I'm here. No one listens to the fact that I have severe PTSD. I'm claustrophobic, and it gives me high anxiety. Resident #53 said when living alone, he would handle his symptoms by going into the woods. Resident #53 also mentioned he had other triggers the staff had addressed, such as being startled. Resident #53's room was noted to be clean and organized with bare walls and not homelike. During an interview on 3/10/26 at 9:11 a.m., staff member O stated resident #53 was a tough case. Staff member O stated, We try to accommodate his needs, but he gets angry a lot. During an interview on 3/11/26 at 1:36 p.m., staff member E stated the process for Trauma Informed Care is to evaluate the resident, complete a PASARR screening, trauma-informed assessment, care plan for PTSD, and We now have the option for psych visits. Staff member E stated if a resident had a diagnosis of PTSD, she would talk to the resident and get to know them. Staff member E stated, Our [the facility] trauma evaluations suck, that's why it's important to get to know the residents. Staff member E stated PTSD triggers should be identified and care planned. Staff member E stated to meet the resident's needs, she would go and sit with them, and it would depend on the resident and what would help them. Staff member E stated she would assist residents with arranging counseling services if they chose to utilize them. Staff member E stated, PTSD interventions are monitored by behavior charting, and I watch the nurses charting; I also check in with our more problematic residents daily. If I identify a change in the resident's behaviors, I would report that to the Director of Nursing. The only training I've had at the facility is the normal mandated in-service training. Staff member E stated having no additional behavior training provided besides their own formal education, and staff member E was not aware resident #53 was claustrophobic, so that was not addressed for the resident. Staff member E stated that resident #53 will utilize psych services when he allows it, and staff member E would go and talk to resident #57 but did not identify any triggers for her PTSD. She stated #57's major issues were that she thought she was magic. During an interview on 3/11/26 at 2:54 p.m., staff member N stated she had behavioral health training during staff in-services. Staff member N stated she only knew of two people with PTSD on the 300 hall. Staff member N stated resident #53 and another resident. Staff member N stated she did not know resident #57 had PTSD. Staff member N stated she would look in the Kardex in Point Click Care (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a resident's triggers if they have PTSD. Staff member N stated she knew resident #53 did not like to be startled but did not know he was claustrophobic. Staff member N stated, I did not know resident #53 was claustrophobic, but that would make sense as to why he was moved into a room by himself. Review of resident #53's Trauma Informed Care Evaluation, with a date of 12/17/25, failed to show any triggers for resident #53's PTSD. Review of resident #57's Trauma Informed Care Evaluation, with a date of 2/23/26, failed to show any triggers for resident #57's PTSD. Review of social service progress notes failed to show identification of any triggers for residents #53 and #57. A request was made on 3/12/26 for Psychology progress notes for resident #53, and the facility stated they did not have any due to him declining services. 2. During an observation and interview on 3/9/26 at 3:28 p.m., resident #102 was in his room with NF4 and was yelling loudly. Multiple staff members entered the room and attempted to calm resident #102 but were unable to understand what he wanted or was saying. NF4 stated she thought he was angry because he wanted to go home. NF4 stated she attempted to explain to him that he could not safely go home yet and he became angrier. NF4 stated resident #102 needed speech therapy because he could not be understood since his stroke. NF4 stated his wife had dropped him off at the emergency room and left, not returning since. NF4 stated resident #102 was abandoned, and he was angry and hurt. NF4 stated that resident #102 did not understand why he could not go home. NF4 stated she was working with staff member E to figure out what to do next. During an interview on 3/11/26 at 3:20 p.m., staff member E stated resident #102 had a Trauma score of 30 and a PHQ9 (tool used to assess presence and severity of depression) score of 24 (very high), and she was not sure what to do. Staff member E stated she was going to notify the Director of Nursing and figure out a plan but had not notified her yet. Staff member E stated the Director of Nursing usually notifies the physician. Review of resident #102's Trauma-Informed Care Evaluation, dated 3/6/26, reflected a score of 30. The instructions showed, .A positive screen is a total score of >/- 14. Notify the resident's primary care physician and interested party of a positive screen. Review of resident #102's PHQ9 assessment, dated 3/6/26, reflected a score of 24. The PHQ9 Total Severity Score scale for a score of 20-27 was equal to severe depression. Review of resident #102's baseline care plan did not reflect a trauma care plan or trauma interventions to prevent re-traumatization. Review of resident #102's Comprehensive care plan, dated 3/11/26, did not reflect a trauma care plan or trauma interventions to prevent re-traumatization. Review of a facility document titled Trauma Informed Care, undated, showed: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences (continued on next page)

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	275132	A. Building B. Wing	03/12/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. 7. [NAME]-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. 8. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization.10. In a situation where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. [sic]

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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. Based on interview and record review, the facility failed to ensure a physician signature was obtained for a POLST (Montana Provider Orders for Life-Sustaining Treatment) directive prior to activating the order on the resident's EHR for 1 (#102) of 25 sampled residents. This deficient practice had the potential to result in a POLST being implemented during an emergency without a physician's order. Findings include: Review of resident #102's EHR screen reflected that resident #102 had a code status of Do Not Resuscitate: Comfort-focused. Review of resident #102's POLST, dated 3/5/26, reflected that staff member F had prepared a POLST for Do Not Resuscitate: Comfort-focused Treatment but had not been signed by the physician. The section labeled Physician / APRN / PA Signature showed that the section was mandatory. During an interview on 3/10/26 at 4:07 p.m., staff member B stated she was not aware that a POLST should be signed by the physician. Staff member B stated that the state she practiced in prior did not require a physician's signature to be valid. Review of the facility policy, Residents' Rights Regarding Treatment and Advance Directives, no date, did not reflect instructions for completing the POLST form with mandatory sections.

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	275132	A. Building B. Wing	03/12/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure a resident who was being discharged from Part A Medicare services and continued living in the facility was fully informed of which services would and would not be covered for 1 (#86) of 3 residents sampled for beneficiary notices. Findings include: Review of resident #86's medical record showed her Medicare A services ended on 1/20/26. Resident #86 received and signed CMS form 10123 but did not receive CMS form 10055. Resident #86 is a current resident at the facility. During an interview on 3/12/26 at 9:05 a.m., staff member L stated resident #86 had not been given the form (CMS 10123 ABN) because her initial plan had been to go home. After some discussion with family it was decided that she would be staying in the facility long term. Staff member L stated, We had the conversation yesterday should we have given her the ABN after her discharge plan changed and decided yes. Going forward that is our process.

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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. Based on interview and record review, the facility failed to ensure the staff and residents were aware of the process for filling out and filing grievance forms, failed to promptly investigate grievances, and failed to follow up with resident representative grievances for 2 (#s 40 and 53) of 25 sampled residents. This practice had the potential to affect anyone wanting to file a grievance or who had filed a grievance. Findings include:During an interview on 3/10/26 at 9:06 a.m., resident #53 stated he was missing multiple items of clothing, and he had spoken to facility staff about it. Resident #53 stated the facility never provided him with a form to fill out, and the facility did not offer to replace the missing clothes. Resident #53 stated, The laundry department is terrible, and I never get my clothes back after they take them to wash them.During an interview on 3/11/26 at 11:27 a.m., NF6 stated he had called staff member E about six months prior and spoke to her about some missing items of his dad's. NF6 stated he had been trying to coordinate a meeting with staff member E for quite some time and was not getting a response. NF6 stated he wanted to meet with staff member E to assist in creating a new inventory list for his dad so they could keep better track of his belongings. NF6 stated his dad was missing a gold cross necklace, a winter coat, and a couple of other items. NF6 stated he was sad these items were missing, and he now felt like he couldn't leave personal belongings at the facility. NF6 stated, It bothers me that I can't leave things there [the facility] to make him feel at home. During an interview on 3/11/26 at 1:36 p.m., staff member E stated she would initiate the grievance process when a family member verbalized a concern. Staff member E stated she does follow up with residents after they have filed a grievance, but she could be better at following up with families on the results of the grievances. Staff member E stated she did not fill out a grievance form for resident #53 when he told her of his concerns about missing clothing. Staff member E stated she did speak with laundry on his behalf, and they were trying to find his missing clothing. Staff member E stated the process for residents missing items would be to fill out a grievance form, find out details of the missing item, relay information to specific departments, contact the family, and start the process to replace or reimburse the resident/resident representative for the item. During an interview on 3/12/26 at 9:05 a.m., staff member K stated he would tell the nurse right away if a resident reported they were missing something, and then he would call the administrator. Staff member K could not identify who the grievance official was. Staff member K stated if a resident was missing something, staff should fill out a lost and found form, which is kept at the nursing station. Review of the facility's grievance logs for the past 12 months showed residents #40 and #53 were not listed on the grievance logs for their missing items. Review of a facility document titled [Facility Name] Grievance Form with a date of 1/26/26, showed resident #40's representative filed a concern about missing items with the facility. The form was not signed by the grievance official, and the section for resolution showed the resolved line was blank, so it was incomplete.Review of a facility document titled Resident and Family Grievances, undated, showed: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal.1. Social Services Director has been designated as the Grievance Official.2. 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; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations.8. Grievances may be voiced in the following forums:a. Verbal complaint to a staff member or Grievance Official.b. Written complaint to a staff member or Grievance Official.c. Written complaint to an outside party.d. Verbal complaint during resident or family council meetings. 9. A grievance may be filed anonymously. 10. Procedure: .d. ii. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance.e. The (continued on next page)

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	275132	A. Building B. Wing	03/12/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. i. Missing/Lost items will be reported as a grievance. [sic]

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure documentation of the need for an antipsychotic was reflected in the medical record and to complete attempted gradual dose reductions for a resident receiving an antipsychotic for a diagnosis of dementia for 1 (#60) of 25 sampled residents. This deficient practice had the potential to result in resident #60 remaining on an antipsychotic unnecessarily. Findings include: Review of resident #60's physician order for quetiapine fumarate (antipsychotic), dated 2/19/26, reflected resident #60 was receiving quetiapine 25 mg at bedtime, related to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, mood disturbance, and anxiety. Review of resident #60's History and Physical, dated 1/20/26, reflected that resident #60 had been started on quetiapine during a hospital admission from 1/7/26-1/13/26, prior to his admission to the facility on 1/26/26. Review of resident #60's Informed Consent for Psychoactive Medications, dated 2/18/26, reflected resident #60's representative had given verbal consent for quetiapine at bedtime on 2/23/26. During an interview on 3/11/26 at 11:45 a.m., staff member B stated resident #60 should not be on an antipsychotic for a dementia diagnosis. Staff member B stated the facility did not have any supporting documentation for resident #60's need for an antipsychotic, any gradual dose reductions, and the monthly medication review, dated 2/22/26, did not include the concern with the quetiapine. Review of the facility's policy, Use of Psychotropic Medications, no date, reflected:- .For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. - . 12. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the Ombudsman was notified of a resident discharge for a resident who left against medical advice for 1 (#98) of 25 sampled residents. This failure increased the risk that the resident would not have access to independent advocacy and oversight during the discharge process. Findings include:During an interview on 3/10/26 at 2:41 p.m., resident #98 reported it was his choice to leave the facility against medical advice. Resident #98 stated it was cold outside, he was eating poorly and he feared his safety when he discharged .During an interview on 3/10/26 at 3:13 p.m., NF1 stated she was not notified of resident #98's discharge from the facility.During an interview on 3/11/26 at 8:26 a.m., staff member A stated resident #98 left the facility against medical advice. Staff member A stated, The Ombudsman was not notified in this case.Review of resident #98's progress notes showed the following nursing notes:-12/9/25 at 7:00 p.m., Note text: Resident left facility previous shift did not sign out and has not returned. ADON (assistant director of nursing) and Administrator notified. Awaiting resident return at this time. Admin attempting to contact resident a this time [sic] -12/10/25 at 12:00 a.m., Note text: Resident did not return to facility. [Staff member A] states resident is AAO x4 and is independent with decision making. [Staff member A] state resident is now considered AMA.[sic]Review of a facility's document titled, Discharge Against Medical Advice Form, dated 12/10/25 at 12:00 a.m., showed the resident was advised to contact a personal representative or emergency services for further medical care and acknowledged leaving the facility against medical advice. The document stated the resident assumed the risks and consequences associated with leaving the facility. The form also suggested the resident was informed that if he did not return by midnight, the departure would be considered an AMA discharge. The resident signature line on the form was left blank.A request was made for Ombudsman notification for resident #98's discharge. The facility reported they were unable to find a record of Ombudsman notification for resident #98.Review of the facility's policy titled, Transfer and Discharge (including AMA), not dated, showed, . 5. The facility will maintain evidence that the notice was sent to the Ombudsman.

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	275132	A. Building B. Wing	03/12/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to complete a baseline care plan within 48 hours for 1 (#102) of 25 sampled residents. This deficient practice resulted in staff difficulty communicating with resident #102, causing frustration and anger for resident #102. Findings include:During an observation and interview on 3/9/26 at 3:28 p.m., resident #102 was in his room with NF4, and he was yelling loudly. Multiple staff members entered the room and attempted to calm resident #102 but were unable to understand what he wanted or was saying. NF4 stated she thought he was angry because he wanted to go home. NF4 stated she attempted to explain to him that he could not safely go home yet, and he became angrier. NF4 stated resident #102 needed speech therapy because he could not be understood since his stroke. During an interview and review of resident #102's CNA Kiosk information on 3/11/26 at 10:25 a.m., staff member H showed this surveyor that resident #102 did not have a baseline care plan for communication needs available. Staff member H stated that the use of the kiosk and the pocket sheet (paper sheets CNAs use showing each resident's needs) was how the CNAs knew what care the resident needed. Staff member H stated he tried to have resident #102 point to things when communicating, but it was often difficult to figure out what he needed when he was angry or frustrated.During an interview on 3/11/26 at 10:28 a.m., staff member J stated resident #102 was not interested in a writing board, so the facility was working on making a picture board for him to point to things he might want. Staff J stated that resident #102 was difficult to understand when he became frustrated and would get angry when the staff could not understand what he was saying. Staff member J stated the resident's inability to manage his anger was related to his brain cancer diagnosis.Review of resident #102's Nursing Note, dated 3/5/26, reflected resident #102 was admitted to the facility on [DATE] with confusion, verbal aggression, and speech aphagia (inability to swallow).Review of resident #102's Speech Therapy Evaluation and Plan of Care, dated 3/6/26, reflected that resident #102 had a communication level of 4, meaning unintelligible most of the time, even to known listeners.Review of the facility policy, Baseline Care Plan, with no date, reflected:1. The baseline care plan will:a. Be developed within 48 hours of a resident's admission.,2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. Interventions shall be initiated that address the resident's current needs, including any health and safety concerns.Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.

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	275132	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to consistently implement fall prevention interventions for a resident with previous fall(s) and poor safety awareness for 1 (#77) of 25 sampled residents. This deficient practice placed resident #77 at risk of additional falls. Findings include: During an observation and interview on 3/9/26 at 2:43 p.m., resident #77 was in bed lying flat on his back with his call light clipped to the foot of the bed, resting. Resident #77 stated there were a couple of people who shouldn't work at the facility. He stated, They would leave you sitting in a pile of shit. Yesterday, they (CNAs) kept saying they would come back to change me from 10:00 a.m. in the morning until 8:00 p.m. at night and never changed me. They ignore call lights because you rang it too many times. I saw it happen to another resident across the hall, too. Resident #77 stated he did not know how to work the bed remote and could not reach his call light. Resident #77 stated he had a couple of falls since he had been in the facility but did not remember what he was trying to do when he fell. There was no floor mat observed in the resident's room related to fall safety. During an observation on 3/10/26 at 3:09 p.m., resident #77 was in bed resting. The call light was attached to the foot of the bed, out of reach for resident #77. There was no fall mat on the floor or observed in the room. The resident's bed was not in a low position but was at the height of the surveyor's hip. During an observation on 3/11/26 at 7:40 a.m., resident #77 was in bed sleeping. The call light was clipped to the mattress, at the foot of the bed, hanging between the mattress and the footboard. The call light was not within reach of resident #77. There was no floor mat observed or present in the resident's room.During an interview on 3/11/26 at 7:50 a.m., staff member F stated the call light for resident #77 should not be attached to the foot of the bed. Staff member F stated, I don't know why someone did that; that should never happen. Staff member F then moved the call light and clipped it to resident #77's shirt. Staff member F stated he was not aware of a fall mat being used for resident #77, for the floor, and had not seen one in the resident's room. During an observation on 3/11/26 at 11:28 a.m., resident #77's call light was attached to the end of the mattress again, at the foot of the bed, and resident #77 was in the shower.During an observation on 3/11/26 at 3:14 p.m., resident #77's call light was clipped at the foot of the bed. Resident #77 stated, I just pissed myself now, and can't reach my call button or the urinal. The resident's bed was at the height of the surveyor's hip, not in a low position.During an interview on 3/11/26 at 3:18 p.m., staff member A stated the call light should not be attached to the foot of the bed unless the resident is up in their chair and needed to be able to reach it from the chair. Staff member A stated that the call light needed to be within the resident's reach. Staff member A stated that a request was made for the floor mat to be placed in resident #77's room, which was for fall safety.Review of resident #77's Interdisciplinary Post Event Note, dated 2/12/26, reflected that resident #77 was found on the floor. The root cause was attributed to the resident's poor bed mobility, independent of staff assistance, confusion, and illness. An intervention put into place at the time of the event was to place the call light within reach. Additional interventions added included treatment of current illness, and an additional check by the nurse each night shift.Review of resident #77's Interdisciplinary Post Event Note, dated 2/13/26, reflected that resident #77 was found on the floor next to his bed. Interventions put into place included a larger bed, a floor mat next to his bed, and the bed to be placed in the lowest position.Review of resident #77's Interdisciplinary Post Event Note, dated 2/17/26, reflected that resident #77 was attempting to remove the blankets to cool off, and he became tangled in the blankets, falling on the floor. The fall interventions included placing the bed in a low position, having the fall mat in place, increased checks, and a fan was added to the room.Review of resident #77's fall care plan, initiated 2/16/26, reflected interventions including a call light within reach, prompt response to call the light, to place the bed in a low position, to have the fall mat at bedside, and a fan in his room. Review of the facility policy, Accidents and Supervision, no date, reflected:- 3. Implementation of Interventions-using (continued on next page)

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	275132	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes:- . e. Ensuring interventions are put into action .- . 4. Monitoring and Modifications- . Ensuring that interventions are implemented correctly and consistently.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and record review, the facility failed to ensure medically related social services were provided to meet resident needs by failing to implement discharge planning services and failing to assist with securing Social Security benefits for 1 (#81) of 25 sampled residents. This deficient practice resulted in resident #81 remaining in the facility without progress toward his expressed discharge goal of returning to North Dakota and without receiving Social Security income needed to meet personal financial needs, causing the resident to rely on family members for financial support. Findings include:1. During an interview on 3/10/26 at 8:45 a.m., resident #81 reported he was from North Dakota and desired to be discharged back to North Dakota because his family lived there and he had no support system in Montana.During an interview on 3/11/26 at 1:51 p.m., NF8 stated it had been resident #81's goal to return to North Dakota. NF8 stated, The facility kept telling us they were working on it. NF8 further reported he had spoken with staff member A during a visit during the previous year about the resident's desire to return to North Dakota. During an interview on 3/11/26 at 2:12 p.m., staff member E stated referrals related to resident #81's request for placement in North Dakota were sent earlier in the day after the State Survey Agency asked about the discharge planning efforts. Staff member E reported she did not know what actions, if any, had been taken previously to address the resident's request to discharge to North Dakota.During an interview on 3/11/26 at 3:29 p.m., resident #81 stated he requested them to investigate placement in North Dakota since he was admitted . Resident #81 stated staff reported they were looking into discharge options, and it's brought up at every quarterly meeting, but he had not heard any updates.2. During an interview on 3/10/26 at 8:45 a.m., resident #81 stated he had been receiving social security funds of $30 per month, but suddenly stopped receiving the money and did not know why.During an interview on 3/11/26 at 1:06 p.m., NF3 reported that resident #81 received Social Security payments, but he no longer received the funds. NF3 reported he had been sending cash because the resident no longer received his Social Security income.During an interview on 3/11/26 at 2:12 p.m., staff member E stated that the facility billing office completes applications for Social Security benefits, and staff member E did not assist with anything financial. Staff member E said resident #81 received $30 per month, and he purchased cigarettes and other personal items.During an interview on 3/11/26 at 2:32 p.m., staff member P recalled resident #81 had been getting Social Security funds. Staff member P stated he came to the facility and was receiving social security funds, however no social security funds were received by the facility once the resident was admitted . Staff member P stated she gave resident #81 the number for Social Security to find out what was going on related to his funds. Staff member P stated she assisted resident #81 with the Social Security disability application, and it was her first time completing the application. She had no experience with the disability application process. Staff member P stated the resident was denied during the first application for disability, and there was no further follow-up. When staff member P was made aware of the need for follow-up, she stated she would have called Social Security with resident #81, and it could have been something as simple as a change of address needed. Staff member P stated that resident #81 will be owed a significant amount of money because the resident was admitted to the facility in 2024.During an interview on 3/11/26 at 3:01 p.m., staff member E stated she could assist residents with applying for financial assistance and generally would assist residents with Social Security disability applications, although she believed the business office typically handled those responsibilities at this facility. Staff member E further stated she was unaware resident #81 was no longer receiving Social Security funds or that family members had been sending him money and stated, I thought that was a Medicaid thing. When asked why she thought resident #81 fell through the cracks related to financial needs, she replied, The people before me didn't do much.During an interview on 3/11/26 at 3:29 p.m., resident #81 said he spoke to the business office about not receiving his Social Security funds. Resident #81 (continued on next page)

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	03/12/2026

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

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported that the staff had asked him to follow up with Social Security, but he was unable to get through by phone. Resident #81 said the staff then stated they would assist him with the process, and the staff never followed up.Review of the Social Services Director job description, not dated, showed: .The Social Services Director will facilitate residents' safe transition back into the community through interdisciplinary discharge planning and arrangement of community-based services and follow-up care. The Director will also assist resident and their representatives in locating and accessing financial, legal and other community resources. [sic]