STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275135	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Valley Health and Rehab	601 N 10th St Hamilton, MT 59840

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility failed to complete comprehensive resident assessments in accordance with the required timeframe of 14 days after admission for 4 (#s 2, 3, 25 and 41) of 10 sampled residents. The failure had the potential to prevent the residents from achieving their highest practicable level of function. Findings include:During an interview on 1/26/26 at 1:05 p.m., staff member A stated the MDS Coordinator worked remotely. Staff member A stated the MDS Coordinator was shared with another facility. Staff member A did not know why MDS's had been completed late.During an interview on 1/28/26 at 9:58 a.m., staff member D stated that comprehensive assessments had 14 days from admission to be closed. Staff member D stated he was aware MDSs had been closed late. Staff member D stated the facility had MDSs that were late when he started completing the MDS assessments for the facility on 12/22/25. Staff member D stated he was still working to get caught up and that it was a learning process covering two facilities.A review of resident #41's medical record showed an admission date of 10/21/25. The comprehensive assessment, with an ARD of 10/27/25, was due to be completed on 11/3/25. The comprehensive assessment was completed late on 11/4/25.A review of resident #3's medical record showed an admission date of 11/5/25. The comprehensive assessment, with an ARD of 11/11/25, was due to be completed 11/18/25. The comprehensive assessment was completed late on 11/19/25.A review of resident #2's medical record showed an admission date of 11/19/25. The comprehensive assessment, with an ARD of 11/22/25, was due to be completed 12/2/25. The comprehensive assessment was completed late on 12/6/25.A review of resident #25's medical record showed an admission date of 1/9/26. The comprehensive assessment, with an ARD of 1/15/26, was due to be completed 1/22/26. The comprehensive assessment was completed late on 1/23/26.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 2: Assessments for the Resident Assessment Instrument (RAI). 2.6 Required OBRA Assessments for the MDS. [table] RAI OBRA-required Assessment Summary. Assessment Type/Item Set. admission (Comprehensive). MDS Completion Date. No Later Than. 14th calendar day of the resident's admission (admission date +13 calendar days) .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to ensure staff followed appropriate hand hygiene when passing meal trays, increasing the risk of bacterial transmission to all residents who received meals in their rooms. Findings include:During an observation on 1/26/26 at 7:49 a.m., staff member K was passing room trays to residents in their rooms. Staff member K entered a room, delivered a meal, removed the plate cover, and set it on the cart. Staff member K grabbed another tray from the warmer and took it to another resident's room. Staff member K came out, put the plate cover on the cart in the hallway, then grabbed another tray and took it into a resident's room. Staff member K failed to sanitize in between room trays. During an interview on 1/26/26 at 8:08 a.m., staff member K stated hand sanitizer should be used before passing trays to residents and in between each tray. Staff member K said, I do not carry hand sanitizer on me; I use the one on the wall. I did not use it while doing those last few trays. During an observation on 1/26/26 at 12:52 p.m., staff member L was observed entering a resident's room with a meal tray, exiting the room, grabbing another tray, and delivering it to a resident without sanitizing their hands in between. During an interview on 1/26/26 at 4:29 p.m., staff member F stated, I would expect staff to be sanitizing between each tray while delivering them to the residents. During an observation on 1/27/26 at 12:56 p.m., staff member Q was assisting with passing room trays. Staff member Q passed multiple trays without sanitizing their hands between rooms. During an interview on 1/27/26 at 2:53 p.m., staff member Q stated, We (staff) should be sanitizing our hands after each tray while passing them to residents. I don't help pass them very often. I didn't know that was the process until yesterday. During an observation and interview on 1/28/26 at 7:50 a.m., staff member M was observed passing meal trays and not sanitizing their hands between resident rooms. Staff member M stated, You should sanitize every time you leave a resident's room. I did not sanitize when I came out of that room and grabbed another room tray. During an interview on 1/28/26 at 9:27 a.m., staff member H stated when staff were serving residents during meals they should have been performing hand hygiene between trays. Review of a facility document titled Hand Hygiene with an initiation date of 4/11/25 showed: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.Hand Hygiene Table: Between resident contacts. Review of a facility document titled Food Safety Requirements with an implementation date of 4/11/25 showed: Policy: It is the policy of this facility to procure food from sources approved or considered (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. 5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to: .c. Washing hands properly before distributing trays.d. Washing hands between contact with residents and after collecting soiled plates and food waste.

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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** Based on interview and record review, the facility failed to maintain a completed POLST (Provider Orders for Life-Sustaining Treatment), including the resident or resident representative signature showing the residents preferences for Provider Orders for Life-Sustaining Treatment in the medical record, for 1 (#33) of 22 sampled residents. This deficient practice had the potential for the resident to receive life sustaining care against her wishes. Findings include:A review of resident #33's POLST form, in her electronic health record, showed in section A, NO CPR: Do Not Attempt Resuscitation (DNAR)/Allow Natural Death (AND), was checked. The patient/legal decision maker signature/mandatory box was marked with an X, showing where the person was supposed to sign, but there was no signature of the resident or responsible party. During an interview on [DATE] at 11:23 a.m., staff member E stated she would explain the POLST to the resident or the resident's POA, during the admission process, she would then sign the person preparing the form box and instruct the resident or the resident's POA to sign the patient/ legal decision maker box.A review of a facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, with an implemented date of [DATE], showed, Policy:It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives.Policy Explanation and Compliance Guidelines:On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide a resident or resident representative with a notice of transfer/discharge, or a bed hold notice, when the resident was transferred to the hospital for 1 (#53) of 22 sampled residents. This deficient practice increased the risk that the resident would not be fully prepared for transfer. Findings include: Review of resident #53's electronic medical record showed resident #53 was transferred emergently to the hospital on [DATE], for a decline in health and abnormal behaviors. During an interview on 1/28/26 at 8:41 a.m., staff member B stated resident #53 was transferred to the hospital for further evaluation, and they (the facility) utilized the ambulance services due to his bed-bound status. Staff member B stated they would expect transfer and bed-hold notices to be completed for any resident being sent out of the facility. Review of resident #53's electronic medical record failed to show the facility provided resident #53 or their representative with a notice of transfer/discharge or notification of bed hold.During an interview on 1/28/26 at 11:56 a.m., staff member H stated they did not have the transfer/discharge and bed hold notices for resident #53, and they must not have been completed when the resident was transferred to the hospital on [DATE].

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a comprehensive resident assessment within 14 days after the facility determined there had been a significant change in the resident's physical and or mental condition for 1 (#4) of 10 sampled residents and their MDS assessments. The failure had the potential to prevent the residents from achieving their highest practicable level of function. Findings include:During an interview on 1/26/26 at 1:05 p.m., staff member A stated he did not know why MDSs had been completed late.During an interview on 1/28/26 at 9:58 a.m., staff member D stated a comprehensive Significant Change assessment had 14 days to be completed. Staff member D stated he started doing MDSs for the facility on 12/22/25. Staff member D stated the facility had multiple late MDSs when he started, and he was still catching up. A review of resident #4's medical record showed a comprehensive Significant Change MDS was scheduled, with an ARD of 11/16/25. The MDS was due for completion on 11/29/25. The MDS was completed late on 12/6/25.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 2: Assessments For the Resident Assessment Instrument (RAI). Significant Change in Status (SCSA) (Comprehensive). MDS Completion Date. No Later Than. 14th calendar day after determination that significant change in resident's status occurred (determination date +14 calendar days) .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to complete a Quarterly resident assessment in accordance with the required timeframe of 14 days after the ARD for 2 (#s 16 and 23) of 10 sampled resident assessments. The failure had the potential to prevent the resident from achieving their highest practicable level of function. Findings include:During an interview on 1/28/26 at 9:58 a.m., staff member D stated a Quarterly assessment had 14 days from the ARD to be closed. Staff member D stated he was aware of MDSs for facility residents that had been completed late, and since he started on 12/22/25, was still working to catch up on them. A review of resident #16's medical record showed a Quarterly assessment was scheduled with an ARD of 11/20/25. The Quarterly assessment was due to be completed 12/4/25. The MDS was completed late on 12/7/25.A review of resident #23's medical record showed a Quarterly assessment was scheduled with an ARD of 12/29/25. The Quarterly assessment was due to be completed 1/12/26. The MDS was completed late on 1/18/26.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 2: Assessments For the Resident Assessment Instrument (RAI). Quarterly (Non-Comprehensive) . MDS Completion Date. No Later Than. ARD +14 calendar days.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide restorative services to a resident in an attempt to prevent the resident from a deterioration in her range of motion, when she was not able to extend her arms or complete some of her own ADL care, and the facility did not follow their policies and procedures for restorative care for 1 (#5) of 22 sampled residents. Findings include:During an observation and interview on 1/25/26 at 12:31 p.m., resident #5 was in her room. Resident #5 stated she had difficulty lifting her arms. Resident #5 lifted her arms as far as she could, and her arms were only about halfway extended. During an observation and interview on 1/26/26 at 7:55 a.m., resident #5 stated, I was in PT and OT, but due to insurance, I haven't had any therapies. I try to do my own exercises. The staff don't assist with any of the exercises. I wish I had more assistance with my range of motion. I'm getting stiff in my arms. Resident #5 raised her arms to show how far she could reach, and it was only about halfway to full extension. Resident #5 stated, The staff even have to brush my hair because I can't with my arms the way they are.During an interview on 1/26/26 at 11:53 a.m., staff member N stated we (the facility) really don't have a restorative program. I think they (management) are working on one. Staff member N stated, I encourage residents with decreased range of motion to do as much for themselves as possible.During an interview on 1/26/26 at 4:06 p.m., staff member O stated she did not think the facility had a restorative program but thought they were working on one. During an interview on 1/26/26 at 4:07 p.m., staff member J stated, Yes, there is a restorative program, and it is really good. They also just hired a new full-time therapist. Staff member J stated residents with decreased range of motion would be referred to PT and OT for an evaluation. During an interview on 1/27/26 at 3:21 p.m., staff member B stated, I'm not sure if we have a restorative program. Staff member B stated, If a resident has a decreased range of motion, staff will notify the physician and obtain an order for PT and OT to evaluate the resident. During an interview on 1/27/26 at 3:22 p.m., staff member H stated, We don't have a restorative program. During an interview on 1/28/26 at 11:32 a.m., staff member P stated resident #5 was discharged from therapy 5-6 weeks ago. Staff member P said she was not sure if the aides worked with resident #5 on the range of motion. Review of resident #5's care plan, with a revision date of 10/26/25, showed: Focus: ADL, [Resident #5] has a risk for decline in ADL function related to disease processes, mobility, and mental health status.Goal: [Resident #5] will improve or maintain the current level of function through the next review date.Interventions: .Encourage to participate to the fullest extend possible.,PT/OT evaluation and treatment as per MD orders. [sic]Review of a facility document titled Prevention of Decline in Range of Motion, with an initiation date of 4/11/25, showed: Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable.Policy Explanation and Compliance Guidelines: 1. The facility, in collaboration with the medical director, director of nurses, and as appropriate, physical/occupational therapist, shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care.2. Assessment for Range of Motion.b. Resident who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion.3. Appropriate Care Planninga. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion.4. Preventative Care. b. Staff will be educated on basic, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to:. v. Assisting resident with range of motion exercises, performing passive range of motion for resident unable to actively participate. [sic]

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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 assess a resident for injury after a fall, increasing the risk of delayed treatment for 1 (#46) of 22 sampled residents. Findings include: During an observation and interview on 1/25/26 at 12:46 p.m., resident #46 was lying in bed with a neck brace on. Resident #46 talked about his recent surgery and about a fall he had after arriving at the facility. During an interview on 1/27/26 at 2:38 p.m., staff member J stated, When a resident falls, we (staff) complete neuro checks if the fall is unwitnessed. The nurse will assess the resident for injury, and then the staff will transfer the resident to a safe area. Vital signs are taken, and an assessment is completed. A risk assessment is completed post-fall.During an interview on 1/27/26 at 3:21 p.m., staff member B stated, The facility's process for a resident fall would be to leave the resident on the floor and assess them. If they are ok, assist them to a safe location. Then notify the appropriate individuals, conduct a risk management assessment and neuro checks, and send them to the hospital if needed.During an interview on 1/28/26 at 9:31 a.m., resident #46 stated, I have fallen three times since I got here. During my first fall, I pulled the (call) light and waited for 10-15 minutes for help. I tried to get into my chair and slipped. During an interview on 1/28/26 at 9:41 a.m., staff member L stated, she was not on shift when resident #46 fell the first time, and she assumed it was unwitnessed. Staff member L said, He (resident #46) was pretty unstable when he first got here. During an interview on 1/28/26 at 10:45 a.m., staff member B stated she spoke with the nurse who was on duty when resident #46 fell, and the nurse said she had completed the required neuro checks and risk assessment but could not find them. Review of resident #46's electronic medical record showed a health status note, with a date of 1/9/26, which showed: Resident was found on floor after pressing call light. CNA and RN helped resident up with Hoyer (mechanical lift) and then to the restroom. Resident then did Stand pivot transfer to bed form the wheelchair with CNA and RN assistance. No injury noted, Neuro, pain and physical assessments preformed and at normal baseline. [sic]Review of resident #46's list of assessments in the electronic medical record failed to show that a fall assessment was completed for the fall on 1/9/26. A request for resident #46's neuro checks and risk assessment for the fall on 1/9/26, was made on 1/27/26, and was not received by the end of the survey period. Review of a facility document titled Fall Prevention Program with an implementation date of 4/11/25, showed: Policy: Each resident will be assessed for all risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines:1. The facility utilizes a standardized risk assessment for determining a resident's fall risk.2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 9. When any resident experiences a fall, the facility will: a. Assess the resident.b. Complete a post-fall assessment.c. Complete an incident report.f. Document all assessments and actions.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, interviews, and record review, the facility failed to provide meals at regularly scheduled times, causing a resident to become frustrated for 1 (#31) of 22 sampled residents. Findings include:During an observation and interview on 1/25/26 at 12:56 p.m., resident #31's meal tray was delivered to his room on the Birch Hall. NF1, who was in the resident's room, said lunch meals are often served late. NF1 stated, You get used to it over time. During an observation on 1/26/26 at 12:35 p.m., NF1 came down the hall and asked staff member A where the lunch meal was. NF1 stated, Resident #31 is really wanting to lie down, and he was told he can't lie down until after lunch. He is not happy lunch is so late. During an observation on 1/26/26 at 1:07 p.m., resident #31's lunch tray was delivered to his room on Birch Hall. Resident #31 stated he was not happy with the meal, and NF1 returned it to the cart and ordered an alternative.During an observation on 1/26/26 at 1:14 p.m., staff were delivering the last lunch tray to the Birch Hall. During an interview on 1/26/26 at 4:29 p.m., staff member F stated, The lunch meal was served late. I was training a new cook. Meals are sometimes late, depending on how quickly the staff get them dished up and passed. I am down a couple of staff members who are on leave. During an interview on 1/27/26 at 2:37 p.m., staff member K stated, I can't for sure say how often meals are late, but I can say the residents sit down in the dining room for quite a while most days.During an interview on 1/27/26 at 2:38 p.m., staff member J stated meals have been served late more often lately. Staff member J said, I heard they are down two staff members in the kitchen; the meals could be late due to being short-staffed.Review of a facility document titled Meal Times, undated, showed: .Lunch: -11:30 AM: Pearl Dining Room and Pearl Room Trays,-12:20 PM: Birch and Aspen Room Trays,-12:30 PM: Big Sky Dining Room. [sic]Observations showed meals were served late which frustrated some residents. -1/25/26 at 12:56 p.m. lunch trays were being passed, 36 minutes late,-1/26/26 at 1:07 p.m. lunch trays were being passed, 47 minutes late.Review of a facility document titled Frequency of Meals with an implementation date of 4/11/25, showed: Policy: The facility will ensure that each resident receives at least three meals daily without extensive time lapses between meals.

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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 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in a sanitary manner, increasing the risk of foodborne illness for all residents receiving food from the dietary department. Findings include:During an observation on 1/25/26 at 12:11 p.m., the following items were observed in the walk-in coolers with no label or date:Freezer:-an open bag of French friesRefrigerator:-2 halves of a tomato, each wrapped in a cellophane wrap,-half of an onion wrapped in a cellophane wrap,-large pan of red Jello half empty.During an interview on 1/26/26 at 7:27 a.m., staff member F stated she directed her staff to check the received date and the expiration date when they open an item. Staff member F stated that staff should put a label and a date on any open items and on anything that was cut and wrapped in cellophane. Staff member F stated she continues to remind her staff to label open items. Staff member F pointed to a document (Use by Date Guide) on the outside of the refrigerator door and stated, I put those there as a reminder to my staff on the rules for dating open items.Review of a facility document titled Food Safety Requirements with an implementation date of 4/11/25, showed: Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.3. c. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275135	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Valley Health and Rehab	601 N 10th St Hamilton, MT 59840

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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate an individual who worked at least part time at the facility as the dedicated Infection Preventionist. The deficient practice had the potential for an ineffective infection prevention program and placed all residents in the facility at risk of infection and exposure to pathogens. Findings include:During an interview with staff member B and staff member H on 1/28/26 at 9:11 a.m., staff member B stated in addition to her Director of Nursing Role she was also the Infection Preventionist. Staff member B stated she devoted approximately five hours per week to the Infection Preventionist role. Staff member H stated staff member B started performing the Infection Preventionist role a couple of weeks ago, and every couple of weeks staff member B received regional support with those duties. Staff member B stated it (Infection Preventionist role), had been a learning process, and once she had a routine, she felt there would be adequate time for the Infection Preventionist duties. Staff member B stated, We're pushing to get there in regard to meeting the regulation for an Infection Preventionist. Staff member H stated she was aware the infection preventionist was required to be a dedicated staff member who worked at least part-time in the facility.A review of a facility-provided document, not titled, with a date range 10/16/25 to 1/27/26, showed a breakdown of staff member B's time worked. The document did not show any time designated for Infection Prevention.A review of a facility policy titled, Infection Preventionist last reviewed 8/7/25, showed: . Policy Explanation and Compliance Guidelines:1. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program.2. The facility will ensure the Infection Preventionist is adequately qualified and meets eligibility requirements: . e. Works at least part-time at the facility. [sic]