STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275132	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITEFISH CARE AND REHABILITATION	**1305 E 7TH ST WHITEFISH, MT 59937**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to prevent the spread of infection by allowing 1 resident (#2), who was on droplet transmission precautions, to leave his room without a mask; and by re-using a single-use dressing on a wound for 1 (#1) of 8 sampled residents. Findings include: A. During an interview on 5/12/2020 at 9:15 a.m., staff member H stated resident #2 was on droplet transmission precautions because he had recently admitted to the facility. Staff member H stated all new residents are on a 14-day isolation period as a precaution to prevent COVID-19. During an observation on 5/12/2020 at 9:40 a.m., resident #2 was sitting in his wheelchair just outside of his doorway. Resident #2 was not wearing a mask. There was a sign on resident #2's doorway that showed he was on droplet precautions, and that staff should wear a mask, gown, and gloves when entering the resident's room. During an observation on 5/12/2020 at 9:45 a.m., resident #2 was wheeling himself down the hallway towards the nurses' station. During an observation on 5/12/2020 at 9:48 a.m., resident #2 was seated in his wheelchair at the nurses' station. Resident #2 was not wearing a mask. Two other residents were within 3 feet of resident #2. There were two staff members at the nurses' station; neither staff member interacted with resident #2 or the other two residents at that time. During an interview on 5/12/2020 at 9:52 a.m., staff member H stated it did occur to her that resident #2 was on droplet precautions. Staff member H added that this was concerning and something she would mention to her supervisor. Staff member H then asked staff member G to take resident #2 back to his room. During an interview on 5/12/2020 at 10:35 a.m., staff member D stated if she saw a resident who was on droplet precautions in the hallway, she would put a mask on them. During an interview on 5/12/2020 at 11:20 a.m., staff member G stated resident #2 was non-compliant with wearing a mask. Staff member G added that she would not allow resident #2 to sit by the nurses' station around other residents and staff, which has been something he likes to do. During an interview on 5/13/2020 at 9:36 a.m., staff member C stated if a resident who was on droplet precautions was outside of their room, they would have to wear a mask. If the resident were non-compliant with wearing a mask, she would expect staff to redirect the resident back to their room and educate on the reasons why they need to stay in their room and wear a mask when necessary. B. During an observation and interview on 5/12/2020 at 10:00 a.m., resident #1 asked to talk about a concern he had regarding his wound treatments. The resident was seated in a wheelchair with his left lower leg in a padded boot. There was an ace bandage around his foot. The resident pointed to a box on his bedside table which contained medical supplies for dressing a wound. There was gauze, cream, and an opened sheet of [MEDICATION NAME] antimicrobial wound dressing. The resident was handling the sheet of [MEDICATION NAME] with his hands. The opened [MEDICATION NAME] package instructions were printed on the package. The instructions read, Single use only. Resident #1 stated, This is what they are using on my heel. It is opened and it can get me infected. Resident #1 was currently on an IV antibiotic because of a history of osteo[DIAGNOSES REDACTED] in his left heel. The package was opened, it appeared to have two different pieces cut off it. The rest of the sheet was put back in the opened wrapper and placed back in the box next to the resident's bed. During an observation and interview on 5/12/2020 at 10:40 a.m., staff member E was brought to resident #1's room to see the opened wound treatment sheet. He took the opened [MEDICATION NAME] package and wadded it up in his hand. When asked if it was supposed to be thrown away, staff member E stated, Absolutely. During an interview on 5/12/2020 at 10:47 a.m., staff member D stated she would be doing some education after the situation of the opened [MEDICATION NAME] sheet. She also stated, They shouldn't be using the big sheets for that wound. Staff member D showed this surveyor a smaller silver-infused wound dressing sheet that should have been used on the resident's wound. During an observation and interview on 5/12/2020 at 11:45 a.m., resident #1 had his heel wound dressing changed. Staff member G performed the treatment. Staff member G showed the piece of the large pad which was cut off and placed on the resident's heel. The [MEDICATION NAME] was now a different color, having absorbed a lot of fluid from the wound. Staff member G stated, They should not be using the big one, cutting pieces off it (repeatedly). That is an infection control issue. Staff member G placed the smaller wound sheet on the wound, and also put a new, larger ace bandage on the resident's leg, and wrapped it all the way to the resident's knee, due to the large amount of [MEDICAL CONDITION] present.

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