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 _____	09/01/2020

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

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility and staff failed to: - Ensure COVID-19 negative residents were not roomed with COVID-19 positive residents for 4 (#20, #43, #44, #45) - Failed to ensure housekeeping staff were dedicated to their appropriate assignments within the facility, to not include COVID-19 isolation rooms, and the non isolation unit areas, in one day's shift, putting all residents at risk if the staff member entered their room and failed to use proper precautions. - The facility failed to ensure the housekeeping staff were following proper PPE precautions for infection control for 1 (#22) - Failed to ensure staff were correctly donning and doffing PPE, and applying PPE prior to entering a COVID-19 positive resident's room, for residents 5 (#6, #22, #48, #49, #50) - Failed to ensure staff were using proper PPE, with adequate training, to include N95 masks, when COVID-19 infected residents were present in the facility - Failed to ensure the correct infection control precaution signage was present throughout the facility, based on the residents isolation needs for residents 10 (#15, #19, #22, #24, #27, #28, #34, #36, #39, #48) - Failed to ensure residents and visitors were adhering to proper visitation precautions to prevent the spread of infection for 1 (#6) - Failed to ensure a COVID-19 positive resident was not within six feet of a COVID-19 negative resident for 2 (#21 and #47) - The facility failed to protect residents from infection, and in total, residents #1 through #43 had positive or presumptively positive (tested /Pending with symptoms) COVID-19 test results as of [DATE]. Residents #1, #3, #9, and #10 were deceased , and residents #14, #31, and #38 were hospitalized as of [DATE]. These deficient practices directly contributed to the spread of the COVID-19 infection within the facility, due to unsafe infection control practices utilized by staff, for the 50 sampled and supplemental residents. Immediate Jeopardy Announcement On [DATE] at 5:35 p.m. an Immediate Jeopardy was announced to the Administrator and Director of Nursing. The Immediate Jeopardy situation was related to F880 - Infection Control, for all residents within the facility. The onsite survey investigation discovered infection control concerns related to resident safety and the spread of COVID-19, as shown above in the facility failures. The Immediate Jeopardy was cited at the Severity and Scope of an L, and upon removal of the immediacy of the deficient practice, would be lowered to an I. The facility did not remove the immediacy prior to the end of the survey on [DATE]. As of [DATE] an acceptable plan to remove the immediacy has not been received by the State Survey Agency. Findings include: 1. Rooming COVID-19 Positive Residents with COVID-19 Negative Residents During an interview with staff member I on [DATE] at 3:59 p.m., staff member I stated they had combined COVID-19 positive and COVID-19 negative residents in the same room. Staff member I reviewed her resident listing and stated rooms [ROOM NUMBERS] each had two residents, and the residents were a combination of COVID-19 positive and negative test results. Residents #44 and #45 were in room [ROOM NUMBER], and residents #43 and #20 were in room [ROOM NUMBER]. 2. Housekeeping Staff Assignments and Proper PPE Precautions During an observation and interview with staff member D on [DATE] at 2:15 p.m., staff member D stated she was cleaning more since COVID-19 had started in the facility, using an approved cleaner or bleach on lights, rails, tables, and everything that residents touch. Staff member D stated, We normally have a housekeeper on COVID-19 (unit), but there was a call-in today so I'm doing the whole building. Staff member D was wearing an N95 mask and stated her mask was definitely snug. During an observation on [DATE] at 2:31 p.m., staff member D applied her PPE (gown and gloves) outside resident #22's room. Staff member D rolled up the reusable gown sleeves to her elbows so that her skin was showing and then put gloves on and entered the resident's room. The resident's room had a droplet precaution sign on the door. During an interview on [DATE] at 2:51 p.m., staff member D stated she did not remember the last time she had any PPE training, hand hygiene training, or training related to COVID-19. Staff member D stated, I think maybe I had training on hand hygiene ,[DATE] months ago, I don't know. I am so tired, I can't even think. We are all working off of no energy. 3. Staff Donning and Doffing PPE During an observation on [DATE] at 2:13 p.m., staff member E exited resident room [ROOM NUMBER] and resident #6 was in the room. Staff member E doffed her reusable gown outside of the resident's room and placed it in an unlabeled clear plastic bag. Staff member E stated, I had to come outside the room to put the gown in a bag because there wasn't anywhere to put it in the resident's room. During an observation on [DATE] at 2:15 p.m., staff member G stepped out of resident room [ROOM NUMBER] into the hallway wearing full PPE and then stepped back into the resident's room and doffed her gown and gloves into the Biohazard bag in the resident's room. Staff member G then walked out of the resident's room and left the resident's door open. Resident #6 was in the room. The resident's door had signage showing the resident was on droplet precautions. During an observation on [DATE] at 2:20 p.m., staff member E walked into resident #6's room without a gown or gloves on. The staff member walked out of the resident's room and did not perform hand hygiene, and then grabbed a disposable gown and donned gloves and gown, and then entered resident's room. Resident #6 was in the room. The resident's door had signage showing the resident was on droplet precautions. During an observation on [DATE] at 2:25 p.m., resident #49 was outside his room [ROOM NUMBER] with a protective face covering. Staff member E walked past and did not instruct the resident to go back into his room. During an observation on [DATE] at 2:31 p.m., staff member D applied her PPE (gown and gloves) outside resident #22's room. Staff member D rolled up the reusable gown sleeves to her elbows so that her skin was showing and then put gloves on and entered the resident's room. The resident's room had a droplet precaution sign on the door. During an observation on [DATE] at 2:36 p.m., staff member E doffed PPE inside resident #48's room [ROOM NUMBER], and then left the room and did not perform hand hygiene. Staff E touched her face-shield and mask, grabbed a new isolation gown, put it over her head, and then sanitized her hands. Staff E then entered resident #6's room [ROOM NUMBER]. During an interview on [DATE] at 2:38 p.m., staff member E stated, I have had handwashing training, training on putting on and taking off PPE and how to use a face shield. There was a lady here last week doing the training. During an interview on [DATE] at 3:00 p.m., staff member B stated anyone showing any symptoms of COVID-19 were on droplet precautions, but the whole facility was on isolation precautions. Staff member B stated the expectation for staff was to wear all PPE face shield or eye protection, a mask, a gown and gloves, and for them to doff their PPE inside the resident's room and change PPE between residents. Staff member B stated, It's been taking around ten days for the results of the COVID-19 tests to come back to the facility. During an interview with staff member B on [DATE] at 3:05 p.m., staff member B stated the facility had provided PPE training to the staff and recently held training during the week of [DATE]th. During an observation on [DATE] at 3:44 p.m., staff member J walked into resident room [ROOM NUMBER] wearing a surgical mask and a face shield but no gloves or a gown. The signage on the door showed keep door closed, and there was a Biohazard bag inside the room. Staff member J left the resident's room [ROOM NUMBER] and did not perform hand hygiene. Staff member J then entered into resident #50's room [ROOM NUMBER] and did not don a gown or gloves. Staff member J removed a food tray from the resident's room and left the resident's room. No hand hygiene was performed upon staff member J leaving the resident's room. There was no door signage on room [ROOM NUMBER] showing if the resident was on isolation precautions. During an interview on [DATE] at 3:45 p.m., staff member J stated I don't know who is on precautions honestly. I never wear PPE when I go into a resident's room because I'm not in there for

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

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) very long. During an interview with staff member F on [DATE] at 3:45 p.m., staff member F stated she had worked at the facility since the end of [DATE]. Staff member F stated there was COVID-19 in all areas of the facility except for the 300 hall. Staff member F stated she had received PPE training and had completed skills checkoffs for donning and doffing PPE when she started in April. During an interview on [DATE] at 4:02 p.m., staff member I stated most of the residents on the 100 and 400 wings have COVID-19 and tested positive and they are not in the COVID-19 wing because they had milder symptoms. Staff member I stated, This information is what I am going off of, I heard it last Thursday. During an interview with staff member J on [DATE] at 4:10 p.m., staff member J stated, I gown up sometimes, but I have a lot to do, and most of the time I don't gown, the DON made us for awhile, changing gowns on and off. Staff member J stated he had been working at the facility for the past three to four weeks and he had read PPE trainings. During an interview with staff member H on [DATE] at 4:11 p.m., staff member H stated, They gave us PPE, donning/doffing and hand washing training last week. During an interview on [DATE] at 4:13 p.m., staff member H stated she was trained last week on donning and doffing PPE. Staff member H stated, I always wear a gown, gloves, face shield or mask. Then I always take it off after I am done in each resident's room. During an interview with staff member B on [DATE] at 4:19 p.m., staff member B stated he had been doing surveillance in the facility with infection control and when they first started surveying staff, No one was complying. Staff member B stated he had not been documenting the infection control auditing of the staff. Staff member B stated, How do I get staff to comply with infection control? My staff is very young and the battle is hard, it's retention vs. compliance. Staff member B stated last week they had infection control training for the staff. During an observation on [DATE] at 4:31 p.m., staff member H was observed going into room [ROOM NUMBER] without a gown or gloves. During an observation on [DATE] at 4:45 p.m., staff member J donned PPE with a face shield, a surgical mask, a gown and gloves. Staff member J entered room [ROOM NUMBER] and then exited the room without doffing his gown or gloves. Staff member J went over to the food cart that was in the hallway and touched two food trays that had not been delivered to residents yet. Staff member J then went back into room [ROOM NUMBER], doffed his gown and gloves and left the resident's room. A review of the facility's COVID Cluster Line List, dated [DATE], showed residents #1 thru #43 had positive or presumptively positive (tested /Pending with symptoms) COVID-19 test results as of [DATE]. Residents #1, #3, #9, and #10 were deceased , and residents #14, #31, and #38 were hospitalized as of [DATE]. For COVID-19 testing, the first staff member tested positive on [DATE]. The first resident began displaying signs of symptom of the COVID-19 infection on [DATE]. 4. Isolation Mask Use During an interview on [DATE] at 2:05 p.m., staff member B stated the staff not working on the COVID-19 wing are to wear the surgical mask, and a face shield or eye protection. Only the staff working on the COVID-19 wing are to wear the N95. During an interview with staff member B on [DATE] at 3:05 p.m., staff member B stated he started working at the facility in [DATE]. Staff member B stated the facility provided masks to the residents, and the facility staff were using surgical masks. During an observation and interview with staff member H on [DATE] at 3:59 p.m., staff member H was wearing a duck bill N95 mask that was gaping open at the nose and sliding down off the staff member's nose, and not being worn properly. Staff member H stated she was just back to work that day after being off work with COVID-19 for the past three weeks. 5. Infection Control Precaution Signage During an observation on [DATE] at 2:25 p.m., resident #19 in room [ROOM NUMBER] was in her room with the door open. The signage on the door showed droplet precautions. During an observation on [DATE] at 2:25 p.m., resident #39 was in room [ROOM NUMBER], and the door was open. Door signage showed droplet precautions. During an observation on [DATE] at 2:26 p.m., resident #22 was in room [ROOM NUMBER] and the door was open. Door signage stated droplet precautions. Resident #48 was in room [ROOM NUMBER] and the door was open. Door signage showed droplet precautions. During an observation and interview on [DATE] at 2:46 p.m., staff member D stated there was COVID-19 in the hall, past the double doors, and past room [ROOM NUMBER]. No infection control or other signage was present on the closed double doors. During an observation on [DATE] at 3:38 p.m., resident #15 was in room [ROOM NUMBER] and the door was open. Door signage showed droplet precautions. During an observation on [DATE] at 3:40 p.m.: - Resident room [ROOM NUMBER], 102, 103, 104, 105, 106, 112, 403, 402, 404, and 410 did not have any signage showing that the residents were on isolation precautions. - Resident room [ROOM NUMBER] had signage on the door which showed Contact Precautions, and the door was left open. - Resident room [ROOM NUMBER] had signage on the door which showed Contact Precautions, and the door was left open. During an observation on [DATE] at 4:07 p.m., staff member H stated residents in rooms 402A/B (residents #36 and #24), 403A/B (residents #34 and #27), 404A/B, 406A/B, 409A, 410A, and 112A all had COVID-19. Staff member I stated residents in rooms 101A/B, 102A, 103B, 104A, 105B, 106A, 109A, and 112B all had COVID-19. Review of the facility's COVID Cluster Line List dated [DATE], showed resident #15, in room [ROOM NUMBER], had tested positive for COVID-19, and resident #28 in room [ROOM NUMBER] was presumptive positive for COVID-19. 6. Window Visitor Precautions During an observation on [DATE] at 2:31 p.m., resident #6 was seated in a wheelchair in her room, and was talking through an open, screened window with a male visitor on the outside of the building. Neither resident #6, nor the male visitor on the outside of the window, were wearing a protective face mask. During an observation on [DATE] at 2:33 p.m., staff member E donned a gown and gloves outside resident #6's room. Staff member E entered resident #6's room and closed the open window, as requested by resident #6, after the male visitor on the outside of the window had walked away. Staff did not provide safety interventions for the visit. 7. COVID-19 Positive Resident Within Six Feet of COVID-10 Negative Resident During an observation on [DATE] at 3:40 p.m., residents #21 and #47 were outside of their rooms by the nurses' station on the 400 wing. They were both in wheelchairs sitting next to each other closer than 6 feet. Staff members H and I were at the nurse's station, within sight of residents and did not intervene. During an observation on [DATE] at 3:42 p.m., resident #21 was wearing her surgical mask below her chin. During an observation and interview on [DATE] at 3:46 p.m., staff member H stated that resident #21 had tested positive for COVID. She stated the resident does not stay in her room, so they allow her to be by the nurses' station. Staff member H stated resident #47 had tested negative for COVID. Residents #47 and #21 were sitting in wheelchairs, closer than 6 feet apart from each other by the nurses' station. During an interview on [DATE] at 4:02 p.m., staff member I stated most of the residents on the 100 and 400 wings have tested positive for COVID. Staff member I stated they are not in the COVID wing because they have milder symptoms. Staff member I stated, This information is what I am going off of, I heard it last Thursday. During an observation on [DATE] at 4:05 p.m., resident #21 was seated in a wheelchair located near the nurses' station in the 400 hall and was wearing a mask that had fallen down off the resident's face. Staff member I told resident #21 to pull her mask up on her face. Staff member I stated they had tried everything to keep resident #21 in her room, but the resident refused to stay in her room and continued to roam through the halls in her wheelchair, not properly wearing her mask. Staff member I stated resident #21 had tested positive for COVID-19. During an observation and interview on [DATE] at 4:13 p.m., resident #47 was wearing a protective face mask, and was seated in a wheelchair near the nurses' station on the 400 hall. Resident #47 stated she was at the facility for rehab on her leg, and had been tested twice for COVID-19, and was negative both times. A record review of Progress Notes for nursing for resident #3 showed on [DATE]: Residents POA called to speak with nursing about residents condition with the SOB (shortness of breath), LOW 02 (low oxygen), Covid-19 positive and contested lungs . Decision made to send resident to ER (emergency room) for eval and treatment .Resident left facility around 4:15 (p.m.) tonight via ambulange .02 stats low at 80% . A record review of Progress Notes for nursing for resident #9 showed on [DATE]: CNA alerted this nurse that the PT (patient) was not breathing. This nurse assessed Pt (patient) immidiately (sic). Pt not breathing. Apical pulse was absent for 60 seconds. This nurse attempted to contact POA to notify,m POA did not answer. This nurse left a voicemail for POA to contact facility as soon as possible. This nurse contacted MD (medical doctor), verbal order to release body . A record review of Progress Notes for nursing for resident #10 showed on [DATE]: .Resident is COVID positive. Resident 02 stats continued to drop throughout the day and resident wouldn't allow me to keep the oxygen placed on her face. Later when assessing the resident 02 sats were t (sic) 78% .Resident had a spiked temp of 102.2. MD notified Family notified hustand wanted resident sent to ER for eval and treatment . A record review of Progress Notes for nursing for resident #38 showed on [DATE]: Resident had a decrease in LOC (level of care) would open eyes when calling resident's name but would not keep eyes open. O2 SAT (oxygen saturations) at 86% with oxygen on via NC (nasal cannula. Temp of 100.6. MD notified of change in condition. Resident went to the hospital via ambulance .spoke with (responsible party) of change in condition and of resident going to hospital. Review of the facility's COVID-19 Management policy, showed: I. Infection Control - Resident with known or suspected COVID-19 will follow Standard, Contact and Droplet Precautions with an N-95 or higher-level respirator if available. - Visual alerts and signs will be posted at the entrance and throughout the facility to provide residents and healthcare staff about hand hygiene, respiratory hygiene and cough etiquette. V. Immediate identification and Management of potentially affected residents - The facility will make every effort to designate a unit or a wing, with dedicated healthcare staff to house suspected and positive COVID-19 residents. When a resident is identified as having COVID-19 like

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) symptoms, he/she will be moved to a single, isolation room, with the door closed. - If there is a sustained community transmission or case(s) of COVID-19 in the facility, the facility will restrict residents to their room unless there is a medical necessity to leave their room. In such cases, residents will wear face masks, practice hand hygiene, limit movement in the facility and maintain social distancing (6 feet away from others). VII. Education - The facility will provide education to staff on COVID-19, including but not limited to signs and symptoms, transmission, screening criteria, etc. Review of the Whitefish Care and Rehabilitation Emergency Operations Plan, dated [DATE], showed: - Infectious Disease - Initial Actions - Limit exposure between infected and non-infected persons, consider isolation of ill persons.