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 _____	04/09/2020

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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interview and record review, the facility failed to respond to and act on resident concerns voiced during monthly resident council meetings. This had the potential to affect all residents who attended the resident council meetings or who had interest in the council's activities, and specifically 3 (#s 1,5, and 9), of 12 sampled residents. Findings include: Review of the resident council meeting minutes provided by the facility showed several repeated concerns over six months and three resident council meetings: -October 4, 2019, residents voiced concerns that call lights were not answered for up to 45 minutes. Staff's attitude was tired or sad. The resident's showers were not being done. Staff member E responded during the meeting and stated a shower schedule would be implemented. The residents also voiced concern about the 8 p.m. snacks not being passed. There was no indication this was addressed in the resident council minutes. -November 8, 2019, residents voiced concerns that call lights were now up to an hour wait time to be answered. Residents stated the call light response time actually became worse since the last meeting in October. Residents voiced concerns that staffing was low and they wanted it fixed as soon as possible because they felt they were the ones suffering due to the effects of short staffing. Residents stated a lot of people were not being showered. Residents requested the facility keep the shower schedule and stick to it. Residents stated the 8 p.m. snacks sat at the nurses' station and were not offered. There was no indication the facility addressed this grievance. There were no resident council meeting minutes provided for December 2019, January or February of 2020. There was nothing to show the resident grievances in previous meetings had been addressed by the facility. -March 4, 2020, residents stated the call lights were still not answered for an hour or more on some halls. Residents still felt like there was not enough staff. Residents felt the staff's attitudes were poor because they were tired, and the 12 hour shifts were not working. Showers were still not completed. Residents stated the 8 p.m. snacks were not being passed. Review of the facility's plan of correction documentation from a complaint survey on 11/6/19, showed a new bath schedule was not put into place until 11/18/19. The nurses and CNAs were not trained on the schedule or documenting showers until 12/8/19. This is more than two months after residents were told a new shower schedule would be implemented. The facility failed to sustain corrections made for this complaint survey plan of correction During an interview on 4/7/20 at 6:25 p.m., resident #9, who was present at the last resident council meeting, and stated it had been a while since she had a bath. During an interview on 4/7/20 at 6:53 p.m., resident #5, who was also present at the last resident council meeting, and stated facility management just didn't get the point. Call lights take 1.5-2 hours to be answered when there is only one aide in the building. During an interview on 4/7/20 at 7:37 p.m., resident #1 stated she had not had a bath in three weeks. During an interview with staff member B on 4/9/2020 at 2:05 p.m., staff member B stated showers were not getting done and they were implementing a new shower schedule, based on a full facility, and two showers per week.
F 0677 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from emotional harm and felt neglected and scared for 1(#8), provided feeding assistance for a dependent resident for 1 (#1), dressing assistance for 1 (#10), and regularly scheduled baths/showers for dependent residents for 12 (#s 1, 2, *3, *4, 5, *6, 7, *8, 9, 10, 11, 12, 13) of 13 sampled and supplemental residents. Findings include: 1. During an observation on 4/7/20 at 7:37 p.m., resident #8 was found to be lying in her bed, she appeared uncomfortable, she was trying to reposition herself. She looked ungroomed, with matted, greasy hair. During an observation and interview on 4/7/20 at 7:37 p.m., resident #8 stated she had not had a bath in three weeks, she stated she, Had not been out of this bed in weeks. She said it took staff too much time because she was a Hoyer lift, so they don't want to get her up. She went on to say she was flaky and dirty and, I can smell my own crotch. She was lying on a dark blue air mattress with no bottom sheet. It was clear to see the skin flakes all over the mattress. She stated she asks every day to get out of bed and get a shower. She stated, I feel neglected, and scared. I could die in here and rigor mortice could set in before they find me. She said she doesn't get her brief changed often. She stated on Sunday night (4/5/20) I was changed at 10:45 p.m., the next morning I put my call light on at 7:00 a.m., the CNA said she was alone and would come back. It was Monday at 1:10 p.m. when I finally got changed. She said she was very wet with urine. Review of bathing records for resident #8, dated 4/8/20, showed her previous bath was 3/4/20, making it 35 days since she had a shower. Before that, she had a bath or shower on February 4, 7, 11, and 18. In the month of January, she had only received two showers, on the 10th and the 18th. 2. During an observation and interview on 4/8/20 at 12:15 p.m., resident #6 was lying in a recliner chair, hair was greasy with diffuse white flakes throughout hair, and the skin on the resident's face was shiny with several long chin hairs visible. During an interview on 4/8/20 at 2:00 p.m., resident #6 stated she had not showered in at least three weeks but would like to have one. Review of resident #6's Weekly Bath Record, 1/1/20 through 4/9/20, showed: -January-resident bathed four times out of nine scheduled days, -February-resident bathed three times out of eight scheduled days, -March-resident bathed on 3/3/20, -April-resident had no documentation of any baths provided. 3. During an interview on 4/7/20 at 6:52 p.m., resident #5 stated she had not been receiving showers and she was sad and stated, the facility used to be a wonderful place. During an interview on 4/8/20 at 11:05 a.m., resident #5 stated she believed her last bath was on 4/2/20 but was unsure. Resident #5 stated she had an [MEDICAL CONDITION], and the sponge needed to be changed every three days, or the skin around the stoma would breakdown. During an observation and interview on 4/8/20 at 11:12 a.m., staff member C and Q came into the room to take resident #5 to the shower. Resident #5 stated the skin surrounding the stoma was clean due to her diligence in taking care of the site, not the facility's care regarding showers. Review of resident #5 bathing record, showed the following: -March 2020, resident #5 did not receive eight out of nine scheduled showers, with one shower on 3/13/20. -April 2020, resident #5 did not receive two out of two scheduled showers, and received a shower on 4/8/20. -Resident #5 went 25 days without a shower from 3/13/20 to 4/8/20. 4. During an observation on 4/7/20 at 6:35 p.m., resident #3 lowered her bed to the low position, transferred from the wheelchair to the bed, independently without staff assistance, and laid down in the bed. Resident #3's hair was greasy and uncombed, and the resident had short, dark hairs which covered her chin area. During an observation on 4/9/20 at 3:10 p.m., resident #3 still had greasy, uncombed hair, and dark whiskers on her chin. During an interview on 4/9/20 at 4:15 p.m., NF1 stated resident #3 emptied her [MEDICAL CONDITION] bag herself and had put herself to bed on different occasions. Review of resident #3's Weekly Bath Record, January through April 2020, showed: -January-resident

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 0677 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 1) bathed six times out of nine scheduled days, -February-resident bathed four times out of eight scheduled days, -March-resident bathed two times out of nine scheduled days, -April-resident had no documentation of bathing days. 5. During an observation and interview on 4/7/20 at 6:28 p.m., resident #7 was lying in bed and had greasy hair. Resident #7 stated, I got a bath last Thursday and it had been a month before that. I'm supposed to get two baths a week. Never get one on Saturday. They are always so short on help. During an interview on 4/7/20 at 6:36 p.m., resident #7 stated there is no ADL assistance from staff to help with daily hygiene or baths. Resident #7 stated her roommate with dementia brought her a wet cloth for her face because staff had not been available to help. Review of resident #7's bathing record, dated 3/1/20 to 4/1/20, showed: -March 2020, resident #7 did not receive seven out of eight scheduled showers, with one shower on 3/18/20. -April 2020, resident #7 did not receive three out of three scheduled showers. -Resident #7 went 21 days without a shower from 3/18/20 to 4/8/20. 6. During an observation and interview on 4/7/20 at 6:05 p.m., resident #13 was feeding resident #1. Resident #13 had gloves on her hands and was sitting in her wheelchair assisting resident #1, who was lying in her bed in a hospital gown with her hair slicked back and greasy in appearance. Resident #13 stated she was not supposed to be feeding her roommate, and it was the third time she had done it. Resident #13 stated she was feeding resident #1 because there was no one to help her eat, and the staff just walk right by, even with the call light on. Resident #1 stated she had not had a shower in quite some time which made her feel terrible. During an observation and interview on 4/8/20 at 9:11 a.m., resident #1 was lying in bed, with the head of the bed raised to 45 degrees. Resident #1 stated, I have not been changed recently and on 4/5/20 I sat for two hours, without being changed, after having a bowel movement. Resident #1 stated it had been at least 12 days since she had been bathed. During an interview on 4/8/20 at 1:53 p.m., staff member I stated she had heard that resident #13 had been feeding resident #1. Review of resident #1's ADL charting, dated April 2020 from 4/1/20 to 4/8/20, showed the resident had not been assisted to eat for 12 meals of 21 total meals. Review of resident #1's ADL charting, dated March 2020, showed the resident had not been assisted to eat for 53 meals of 93 total meals. Resident #1's weight remained stable as her roommate had been assisting her to eat. Review of resident #1's bathing record, dated March 2020, showed, resident #1 received showers on 3/14/20 and 3/18/20. No other showers were documented for the month of March 2020. Review of resident #1's bathing record, dated April 2020 from 4/1/20 to 4/8/20, showed no documented showers. Review of resident #1's care plan, dated 1/1/19, showed the following: -Provide resident with total assist for bathing. -Provide resident with total assist of eating. Resident needs to be fed meals. 7. During an observation and interview on 4/7/20 at 7:40 p.m., resident #10 was sitting in a recliner in blue and white polka dot pajamas, she stated she goes three weeks between showers. Resident #10 stated she did not want to stay in her pajamas as she felt better when she gets ready for the day. Resident #10 stated there was not a lot of staff and things do not get done in a timely manner. Resident #10 stated she did not ask staff for help often, but did need it at times. During an observation and interview on 4/8/20 at 11:45 a.m., resident #10 stated she would like to put on some fresh pajamas as she had these on for 3 days, pointing at her blue and white polka dot pajamas. Resident #10 stated staff had not offered her to get dressed or showered for the day. During an interview on 4/8/20 at 9:10 a.m., staff member M stated he expected residents to be up and dressed for the day by breakfast unless the resident prefers to stay in their pajamas. Staff member M stated he had never seen a shower list for the facility and showers have been a challenge to complete and had not been completed all of the time. During an interview on 4/8/20 at 1:53 p.m., staff member I stated resident care has been affected by sparse staffing. Staff member I stated they have been trying to catch up on showers and would expect that residents are not left in their pajamas all day. During an observation on 4/8/20 at 2:20 p.m., resident #10 was sitting in her recliner in her blue and white polka dot pajamas. During an interview on 4/8/20 at 2:40 p.m., staff member O stated certified nursing assistants should be getting residents dressed. Staff member O stated the management team will be checking activity of daily living sheets to ensure cares are being completed. Review of resident #10's care plan, dated 8/16/19, showed the following: -(Name) requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting . -Provide (Name) with extensive, assist of 1 for bathing. -The residents care plan does not address the level of assistance the resident requires for dressing. Review of resident #10's dressing assistance record, showed the following: -In March 2020, resident #10 was assisted in dressing 21 times out of 62 times. No refusals were documented. Resident #10 self-performed the task three times in March 2020. -From 4/1/20 to 4/9/20, resident #10 received dressing assistance on 4/2/20. No other assistance had been documented. Review of resident #10's bathing record for 3/1/20 to 4/9/20, showed no documented shower assistance provided to resident #10. 8. During an observation and interview, on 4/7/20 at 6:44 p.m., resident #11 was lying in her bed with long whiskers on her chin, she stated she could not recall when she had a shower last. During an interview on 4/9/20 at 8:24 a.m., staff member J stated he was unsure when resident #11 had been showered last. Staff member J stated on his last shift on 4/7/20 he was too busy and unable to complete showers while trying to figure out the facility as it was his first day at the facility. Review of resident #11's bathing record, dated 3/11/20 to 4/9/20, showed no documented showers since her admission on 3/11/20. 9. During an observation on 4/7/20 at 6:25 p.m., resident #9 was in her room, it smelled of body odor in the room. During an interview on 4/7/20 at 6:25 p.m., resident #9 stated it had been a while since she had a bath and it had been about two weeks. Review of resident #9's bathing record, dated March 2020, showed one documented shower on 3/13/20. No other showers had been documented for the month of March 2020. Review of resident #9's bathing record, dated 4/1/20 to 4/9/20, showed no documented shower for resident #9. Review of resident #9's care plan, dated 5/9/19, showed, Provide at least two showers weekly to promote good hygiene. 10. During an observation and interview on 4/8/20 at 12:08 p.m., resident #4 was sitting in the wheelchair, with visibly greasy, uncombed hair. Review of resident #4's Weekly Bath Record, February through April 2020, showed the last time the resident was bathed was 2/8/20. The records showed no documentation for bathing in the months from 3/1/20 to 4/9/20. 11. During an observation on 4/8/20 at 2:00 p.m., resident #2 was lying in bed with visibly greasy, uncombed hair. Review of resident #2's Weekly Bath Record, January through April 2020, showed: -January-resident bathed two times out of four scheduled days, -February-resident bathed six times out of eight scheduled days, -March-resident had no documentation of bathing, -April-resident had no documentation of bathing. 12. During an interview on 4/9/20 at 8:30 a.m., resident #12 stated that she had not received a shower since admission on 3/23/20. She did say she would like a shower. Review of resident #12's shower record from 3/23/20 to 4/9/20, showed no documented showers. During an interview on 4/8/20 at 2:34 p.m., staff member N stated showers had not been getting done due to staffing shortages. Staff member N stated certified nursing assistants are responsible for giving showers and nurses are responsible to oversee to ensure showers are given. During an interview on 4/9/20 at 2:05 p.m., staff member B stated showers had not been completed. Staff member B stated she had just implemented a new shower schedule. Staff member B stated certified nursing assistants are responsible for giving showers. The floor nurses, and the director of nursing, are ultimately responsible to ensure showers are getting completed. During an interview on 4/9/20 at 3:45 p.m., staff member A stated showering had been identified as a concern since last fall. Staff member A stated the facility is trying to find a solution to ensure showers are being completed through education and a catch up shower day during the week for management oversight. Staff member A stated the director of nursing is responsible for monitoring of showers. Staff member A stated the showers for the day are gone over during morning meetings and stand ups. Review of the facility policy titled, Activities of Daily Living, undated, showed: -Assistance is provided to residents who need extensive or total assistance with maintenance of nutrition, grooming, and personal and oral hygiene. Review of facility policy titled Bath, Shower/Tub, revised February 2018, showed: -The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. (sic)
F 0684 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received the necessary care and services, by performing timely skin assessments to identify and monitor for any altered skin integrity that lead to unidentified skin breakdown for 3 (#s 1, 2, and *4); and failed to identify skin breakdown that lead to pain for 1 (#*6) of 12 sampled residents. This failure had the potential to affect residents at risk for skin breakdown residing in the facility. Findings include: 1. During an observation and interview on 4/8/20 at 12:15 p.m., resident #6 stated while roommate was being interviewed, I have sores. Resident #6 was assisted by staff member D to stand with a walker, which was located against the wall. The resident's wheelchair was observed against the wall without any cushion on the seat. Staff member D removed resident #6's incontinence brief and the resident's bilateral buttocks had an unidentified, open area on

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) each cheek, surrounded by a five inch by three inch dark purple, non-blanchable area. Resident #6 stated her pain was rated at a five on a scale of one to ten. During an observation and interview on 4/8/20 at 2:30 p.m., resident #6 had reddened areas in her groin and wanted to show staff member D the areas under her breasts. Under both breasts the areas were bright red and resident #6 stated they itched bad. During an interview on 4/8/20 at 2:33 p.m., resident #6 stated she had not told anyone about her bottom and it was not being treated by anyone. The resident's last documented day of bathing was 3/3/20. During an interview on 4/8/20 at 2:52 p.m., resident #6 stated, regarding the cushion for the wheelchair, Haven't had in quite a while. Review of resident #6's Annual MDS, with an ARD of 9/11/19, showed: -Section G, Functional Status, one person, physical assist for transfer, dressing, toilet use, and personal hygiene, -Section H, Bladder and Bowel, always incontinent of urine, -Section I, Active Diagnoses, Hearth Failure, Hypertension, Diabetes Mellitus, Arthritis, [MEDICAL CONDITION], Non-Alzheimer's Dementia, [MEDICAL CONDITION] or [MEDICAL CONDITIONS] Disorder or [MEDICAL CONDITION], Depression, [MEDICAL CONDITIONS], -Section M, Skin Conditions, resident is at risk for developing pressure ulcers/injuries, resident does not have any unhealed pressure ulcers/injuries, pressure reducing device for chair. Review of resident #6's Order Summary Report, dated 4/9/20, showed: -[MEDICATION NAME] Powder apply to groin/breast topically as needed for rash ensure areas are dry before apply. Start date of 11/11/18. There were no physician orders for a pressure relieving device to the wheelchair or monitoring. Review of resident #6's Medication Administration Record, [REDACTED]. Review of resident #6's Weekly Skin Check, dated 1/27/20, showed: -Skin condition: redness, -Other Redness to Rt side of face near temple that is pre-existing. Scabbing present to coccyx, barrier cream applied, -Groin Redness, [MEDICATION NAME] powder applied, -Face Redness to Rt side of face near temple that is pre-existing, -Other Redness below bilat breasts and abdominal fold, [MEDICATION NAME] powder applied, -Other Scabbing present to coccyx, barrier cream applied. Review of resident #6's Weekly Skin Check, dated 2/24/20, showed: -Other skin issue: scab to bilateral buttock, -Resident has scabs to bilateral buttock with blanchable purple surrounding the areas. This nurse applied a [MEDICATION NAME] for protection, -Clinical Suggestions: Skin evaluated for signs of breakdown. Review of resident #6's Weekly Skin Check, dated 3/9/20, showed: -Left buttock-Blanchable purple/redness to buttock, -Barrier cream applied and encouraging offloading as often as possible. 2. During an observation and interview on 4/8/20 at 12:08 p.m., resident #4's skin surrounding her eyes was red and swollen. Resident #4 stated, They hurt. During an observation and interview on 4/8/20 at 2:36 p.m., resident #4's skin surrounding the eyes was more swollen than when it was observed at 12:08 p.m. Resident #4 was itching the eyes and stated the right eye hurts. During an observation on 4/8/20 at 2:40 p.m., staff member D transferred resident #4 from the wheelchair to the bed. Resident #4 did not have a cushion on the seat of the wheelchair. After a urine soaked, incontinence brief was removed, it was observed resident #4 had bilateral, bright red areas on her buttocks. Resident #4 had a small open area on the left buttock, approximately one half inch by one half inch. During an observation and interview on 4/8/20 at 2:45 p.m., resident #4 rolled on to her back from a left sided lying position and vigorously began rubbing her vaginal area with both hands and stated It itches. Resident #4 had reddened, excoriated, bilateral, open areas to her upper thighs near the groin. Review of resident #4's Annual MDS, with an ARD of 11/2/19, showed: -Section G, Functional Status, one person, physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene, -Section H, Bladder and Bowel, always incontinent of urine and bowel, -Section I, Active Diagnoses, Diabetes Mellitus, [MEDICAL CONDITION] Disorder, [MEDICAL CONDITION], Non-Alzheimer's Dementia, [MEDICAL CONDITION] Disorder or [MEDICAL CONDITION], Depression, [MEDICAL CONDITION]. Review of resident #4's Order Summary Report, dated 4/8/20, showed: -No orders were documented for any skin treatment or increased monitoring of skin conditions except the new orders initiated on 4/8/20, for the treatment of [REDACTED]. after cares, -Roho cushion to wheelchair, check for proper inflation and ensure in good repair, every day shift, start date of 11/13/18. Review of resident #4's Treatment Administration Record, 1/1/20 through 4/8/20, check for pressure relieving cushion, showed: -1/1/20-1/31/20 no documentation for nine out of 31 scheduled days, -2/1/20-2/29/20 no documentation for 12 out of 29 scheduled days, -3/1/20-3/31/20 no documentation for 12 out of 31 scheduled days, -4/1/20-4/8/20 no documentation for three out of eight scheduled days. Review of resident #4's Nursing Progress Notes, dated 3/4/20, showed: -Other Skin Issue: redness, -Resident has non-yeast related redness to groin, MBC applied. -Skin is intact with no areas of concern at this time. There were no clinical suggestions listed. Review of resident #4's Nursing Progress Notes, dated 2/19/20, showed: -Other Skin Issue: redness to groin, MBC applied. -Resident has redness to groin, MBC applied. Skin is intact with no other areas of concern at this time. -Clinical Suggestions: Evaluated, addressed the cause of moisture. Review of resident #4's Weekly Skin Check, dated 4/1/20, showed: -No skin conditions or changes, ulcers, or injuries, -Skin is clean, dry, and intact. Review of resident #4's Weekly Skin Check, dated 2/5/20, showed, no skin conditions or changes, ulcers, or injuries. 3. During an observation on 4/8/20 at 10:00 a.m., resident #1 had a small open area on the coccyx, with a six inch by six inch, dark purple, blanchable area surrounding the coccyx that bled when it was wiped with a moistened, disposable wipe. Review of resident #1's Re-entry MDS, with an ARD of 11/8/19, showed: -Section G, Functional Status, two plus persons physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene, -Section I, Active Diagnoses, [MEDICAL CONDITION], Hypertension, Diabetes Mellitus, [MEDICAL CONDITIONS] Disorder or [MEDICAL CONDITION], Anxiety Disorder, Depression, Dysphagia, Tinea Unguium, Age-Related [MEDICAL CONDITION], and Muscle Weakness. Review of resident #1's Order Summary Report, dated 4/8/20 showed, Is to be up in wheelchair M,W,F x 3 hours. The order was started on 12/18/19. Review of resident #1's Treatment Administration Record, 1/1/20 through 4/8/20, regarding orders for the resident to be up in the wheelchair, showed: -1/1/20-1/31/20 no documentation for five out of 14 scheduled days, -2/1/20-2/29/20 no documentation for two out of 12 scheduled days, -3/1/20-3/31/20 no documentation for six out of 13 scheduled days, -4/1/20-4/8/20 no documentation for two out of four scheduled days. 4. During an observation on 4/8/20 at 2:00 p.m., resident #2 was lying on her back, barefoot, with heels in direct contact with the bed. There were no heel protectors or heel lifts observed. Resident #2's right heel was reddened, boggy, and non-blanchable when staff member D pressed on it. A blister was present with depressed skin in the middle of the reddened area. Resident #2 had an undressed, small, open area on the coccyx, a non-blanchable, reddened area on her left buttock, and a dark purple, non-blanchable, tiny, non-raised rash, in a line pattern, on the left buttock. The facility had not identified the type of the skin injury to the foot or that it was avoidable. During an interview on 4/8/20 at 2:20 p.m., staff member D stated the facility did not have a wound nurse, they did not think they needed one. Review of resident #2's Admission MDS, with an ARD of 1/23/20, showed: -Section G, Functional Status, two plus persons physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene, -Section H, Bladder and Bowel, always incontinent of urine, -Section I, Active Diagnoses, [MEDICAL CONDITION] Fibrillation or Other [MEDICAL CONDITION], Hypertension, Diabetes Mellitus, [MEDICAL CONDITIONS], [MEDICAL CONDITIONS], Encounter for Other Orthopedic Aftercare. Review of resident #2's Order Summary Report, dated 4/8/20, showed: -Apply [MEDICATION NAME] then place a silicone border dressing. Change Tue, Thur, Sat. one time a day every Tue, Thu, Sat for wound care to coccyx. -Order started on 3/21/20, There were no documented physician orders for any skin checks. Review of resident #2's Treatment Administration Record, for March and April 2020, showed: -March's record from 3/21/20-3/31/20 showed the dressing to the coccyx was changed on two of the five scheduled days, with three days not done, -April's record from 4/1/20-4/8/20 showed the dressing to the coccyx was changed on one of the three scheduled days, with two days not done. Review of resident #2's Braden Scale Observation/Assessment, dated 1/16/20 and 1/23/20, showed the resident was at risk, with a score of 16. Review of resident #2's Braden Scale Observation/Assessment, dated 1/30/20, showed the resident was at risk, with a score of 17. Review of resident #2's Weekly Skin Check, dated 1/23/20, showed: -Right trochanter (hip) surgical wounds, -Right arm bruising from broken arm. Review of resident #2's Weekly Skin Check, dated 1/30/20, showed no new skin conditions since the last documented skin check. No skin checks were documented after 1/30/20. During an interview on 4/9/20 at 8:08 a.m., NF3 stated only residents that have identified wounds are assessed during a visit and only the residents under the care of NF4. NF3 stated there is not a specific wound care nurse, all nurses report wounds. NF3 stated, I feel all wounds are always avoidable. During an interview on 4/9/20 at 8:14 a.m., NF3 stated, I depend on nursing staff to identify the wounds so I can then assess them for treatment. During an interview on 4/9/20 at 2:16 p.m., staff member B stated, She knows there are skin problems. We are getting ready to do a skin sweep to identify problems and do education. Staff member B stated NF3 does wound assessments every Thursday and only looks at the people the nurses have identified. During an interview on 4/9/20 at 2:56 p.m., staff member D stated she was not sure if there was a policy on when and whom to report skin changes to. Staff member D stated Braden Scales help identify risks and allow precautions to be put in place before skin issues happen. Staff member D stated weekly skin assessments help prevent skin issues. Staff member D stated the resident's provider should always be notified of any changes in skin condition. During an interview on 4/9/20 at 3:19 p.m., staff member C stated any changes in skin condition should be reported to the nurse on that hall as soon as possible. During an interview on 4/9/20 at 3:27 p.m., staff member G stated any skin issues are reported to the medical doctor by

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	275132	A. BUILDING _____ B. WING _____	04/09/2020

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.

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) calling them or writing a note, depending on the severity. Staff member G stated monitoring staff to ensure they are implementing care planned interventions is the responsibility of the nurse on the unit.
F 0690 **Level of harm** - Minimal harm or potential for 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.** Based on observation, interview, and record review, the facility failed to ensure that necessary, timely assistance was provided for bowel incontinence, which lead to the resident lying for a long duration of time on a soiled incontinence pad for 1 (#1) of 12 sampled residents. Findings include: During an observation and interview on 4/8/20 at 9:11 a.m., resident #1 was lying in bed, with the head of the bed raised to 45 degrees. Resident #1 stated, I have not been changed recently and on 4/5/20 I sat for two hours, without being changed, after having a bowel movement. During an observation and interview on 4/8/20 at 9:49 a.m., staff member D rolled resident #1 on to her left side and the incontinence underpad, was adhered to the resident's buttocks. A large area of dark brown liquid stain was observed on the underside of the pad before the pad was removed from resident #1's buttocks. Staff member D peeled back the incontinence pad and a partially dried large bowel movement was smashed into resident #1's peri area and between the legs. Resident #1 was not wearing a brief and stated that was her choice. Staff member D did not comment on the situation with resident #1, draped the resident with a privacy sheet, left the room to seek the aid of an additional staff member, and gather supplies to clean resident #1. During an interview on 4/8/20 at 9:55 p.m., resident # 1 stated that no one had checked on her since shift change that morning, at 6:00 a.m. During an observation on 4/8/20 at 10:00 a.m., staff member D and staff member H continued to clean resident #1's feces with difficulty. The feces was hard to wipe off of the skin, and the liquid had dried to an eight inch diameter area on resident #1's buttocks. Neither staff member D or H were able to remove all the discolored areas on resident #1's buttocks. Review of resident #1's Nursing Progress Notes, dated 3/11/20 at 11:45 p.m., showed, Resident started complaining as soon as this SN came on shift that her SP catheter was leaking and that she was soaked. Resident is bed bound and really needs 2 person assist with changes. Daytime nurse reports that resident is sitting wrong and that she is pulled up in the bed catheter would stop leaking. I am not sure if CNA or nurse completed that task before they went off shift. This SN was left alone on 2 halls without a CNA from 8-930 PM right when residents need changed and put to bed. This SN was called to this residents room and told she was soaking wet and that she had told day nurse and CNA on a few occasions and catheter was not changed and she was soaked from her bottom to her shoulders, resident reports she had been wet all day (sic). Review of resident #1's Nursing Progress Notes, dated 3/21/20 at 5:06 a.m., showed, SN and CNAs went to re position resident for comfort, resident reports she was not repositioned all day. While re positioning we found a XXXL BM under resident clear up to her pubic bone and into her vagina that had been there long enough to dry (sic) .
F 0691 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care needs were met, leading to skin excoriation surrounding the [MEDICAL CONDITION], and to include a physician's orders [REDACTED].#3) of 12 sampled residents. Findings include: During an observation on 4/9/20 at 3:10 p.m., staff member D wheeled resident #3 to her room, to evaluate the resident's [MEDICAL CONDITION]. On resident #3's abdomen, on the lower left side of the adhered [MEDICAL CONDITION] bag, was an opened area with reddened and excoriated skin. The reddened area extended two inches beyond the tape holding the [MEDICAL CONDITION] bag to the abdomen. Resident #3's abdomen, on the right side of the [MEDICAL CONDITION] bag, had a speckled rash, that extended out beyond the tape. During an interview on 4/9/20 at 4:15 p.m., NF1 stated resident #3 emptied her [MEDICAL CONDITION] bag herself on different occasions. Review of resident #3's Admission MDS, with an ARD of 8/28/19, showed: -Section C, Cognitive Patterns, BIMS of 9 (moderate impairment), -Section G, Functional Status, one person, physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene, -Section G, Balance during Transitions and Walking, Surface-to-surface transfer (transfer between bed and chair or wheelchair) not steady, only able to stabilize with staff assistance, -Section H, Bladder and Bowel, frequently incontinent of urine, -Section H, Bladder and Bowel, Appliances, box not checked for Ostomy (including [MEDICATION NAME], [MEDICAL CONDITION], and [MEDICAL CONDITION]), -Section I, Active Diagnoses, Cancer, [MEDICAL CONDITION], Hypertension, [MEDICAL CONDITION] Reflux Disease, [MEDICAL CONDITIONS], Other Fracture, Non-Alzheimer's Dementia, [MEDICAL CONDITION] Status. Review of resident #3's Order Summary Report, dated 4/9/20, showed no orders for any monitoring or changing of the [MEDICAL CONDITION] bag. Review of resident #3's Treatment Administration Records, for the months of January through April 2020 showed no interventions or parameters for changing the [MEDICAL CONDITION] bag. Review of resident #3's Nursing Progress Notes, dated 3/21/20, showed, Resident room mate reports resident [MEDICAL CONDITION] bag has stunk all day and she alerted staff, reports that staff took her away to another bathroom and 'cleaned her up' brought her back and she still stunk. The room was very odoriferous. Resident had pulled the appliance apart and this was not cleaned up causing wafer to become soiled, roommate reports they knew she was not clean and even commented she had a whole in the bag but did nothing about it. This SN had no choice but to replace appliance again the second time in 3 days, resident is very excoriated and some bleeding noted under wafer. SN did use powder and skin barrier to make a shield for her skin last time and it is showing improvement. SN did this technique again to try and prevent further damage. Will continue to monitor and assess (sic). There was no documentation of any continued monitoring or assessment. Review of resident #3's Progress Notes from 1/1/20 through 4/8/20 showed no documentation mentioning any status of the resident's [MEDICAL CONDITION], other than on 3/21/20. Review of resident #3's Weekly Skin check, dated 1/3/20, showed, Redness below and around stoma site has been present since admission. Review of resident #3's Weekly Skin Check, dated 1/24/20, showed, Redness below and around stoma site has been present since admission. Review of resident #3's Weekly Skin Check, dated 1/31/20, showed no skin conditions or changes, ulcers, or injuries. Review of resident #3's Skin Only Evaluation, dated 2/7/20, showed a lower back faint rash.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, interview, and record review, the facility failed to ensure sufficient staffing and montioring and supervision to ensure cares were provided to residents who reside in the facility for 3 (#s 4, 6, and 8) of 12 sampled residents resulting in breakdown and pain and feelings of neglect. This failure had the potential to affect all the residents in the facility. Findings include: A. During an observation and interview on 4/7/20 at 7:37 p.m., resident #8 was found to be lying in her bed, with matted, greasy hair. She did not appear groomed. She said she had not had a bath in three weeks. She said she was left in wet briefs for long periods of time because she had to be lifted with a Hoyer lift, and it takes staff too long. She stated that staff rarely checked on her and she felt neglected and scared. During an interview on 4/7/20 at 6:21 p.m., staff member R stated the facility typically staffs the night shift with one CNA on each end, but a lot of the time there is only one CNA for the the building. Staff member R stated there were always two nurses in the building. Review of the facility time clock information for direct care nursing staff for the last week of March and the first week of April 2020, showed there was never more than two CNAs on the night shift between 3/28/20 and 4/6/20. On 3/27/20, there were four CNAs but two of them left work at 10:00 p.m. Six times between 3/27/20 and 4/6/20 there was only one CNA on the night shift, for an average resident census of 60-65 residents, based on the facility assessment. B. During an observation and interview on 4/8/20 at 12:15 p.m., resident #6 was lying in her room, her hair and face appeared greasy and ungroomed. She stated she had not had a shower for three weeks. Resident #6 also had skin breakdown which had not been identified by the facility. This breakdown was causing the resident pain. During an interview on 4/9/20 at 12:37 p.m., staff member A, stated he was notified about cares such as ADL assistance and showers not being completed. Staff member A stated it had been ongoing for the last nine months, since he had been at the facility. Staff member A stated two CNAs was not good enough, four CNAs was the baseline. He stated the facility had one CNA on the night shift schedule. Resident council minutes provided by the facility also supported the identified concerns about staffing. In October of 2019,

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) residents voiced concerns about the time it took for call lights to be addressed, and showers were not given. In November of 2019, residents said the wait time for call lights worsened, and they stated again, that a lot of residents were not given showers. It was in this meeting that residents stated staffing was low. In March of 2020, residents again voiced concerns that there was not enough staff, and showers were not being given C. During an observation and interview on 4/8/20 at 2:36 p.m., resident #4 had skin breakdown with no orders for treatment. The resident stated the skin issue around her eyes hurt, and she itched in her groin area. The resident was also found with a urine soaked brief. The Whitefish Care and Rehab Facility Assessment, updated on 3/10/20, showed the following: -Part 2: Services and Care We Offer Based on our Residents' Needs, showed general care areas such as activities of daily living, bowel/bladder, skin integrity, pain management, and psycho/social support, among the list of the types of support/care the facility was supposed to provide to the residents. -Part 3 of the the facility assessment showed the resources (staff) needed to provide competent support and care. -Average daily census range was 60-65. Their direct care staff members, CNA per resident ratio was 1:15 for the night shift, and 1:20 for the day shift. This would mean they needed four CNAs on the night shift, and three on the day shift. The facility assessment showed the staffing plan was to be subject to adjustment to meet the care and safety needs of the resident thus maintaining the quality of life. These adjustments were shown to not have happened, as the basic ADLs of the residents were not met.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to post daily nurse staffing information that included the total number of staff, the actual hours worked by nursing staff providing direct care, and resident census in a readily accessible place for residents and visitors to review, and retain nurse posting data for the required timeframe of 18 months. Findings include: During an interview on 4/9/20 at 9:06 a.m., staff member A stated he could not find the nurse staffing postings. Staff member A stated the posting was usually posted in the back hallway and was not sure where they went after that. Staff member A stated he could not find the blank master copy of the document and was in the process of making a new one. A request for the daily staff posting was made on 4/8/20. No documentation was provided by the facility prior to the end of the survey.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on observation, interview, and record review, the facility administration failed to manage the facility in such a way to provide and maintain residents with the highest practicable well-being and to ensure basic care needs and activities of daily living were met through adequate staffing availability, and staff who were competent to provide necessary care. This failure had the potential to affect all the residents in the facility. Findings include: During an observation on 4/7/20 from 6:33 p.m. to 6:49 p.m., a resident's call light was activated to evaluate the response time. During this time, a staff member glanced into the room, and continued to walk up the 400 hall way, without stopping to check on the residents. After waiting, another staff answered the call light at 6:49 p.m. During an interview on 4/7/20 at 6:21 p.m., staff member R stated the facility typically staffs the night shift with one CNA on each end, but a lot of the time there is only one CNA for the building. Staff member R stated there were always two nurses in the building. During an interview on 4/9/20 at 12:37 p.m., staff member A, stated he was notified about cares such as ADL assistance and showers not being completed. Staff member A stated it had been ongoing for the last nine months, since he had been at the facility. Staff member A stated his goal was to have a one to ten CNA to resident ratio. He stated the facility had a continuous advertisement out for staff. He stated the facility gets about 2 applications per week for CNAs. During an interview on 4/9/20 at 2:05 p.m., staff member B stated nurses should be able to provide incontinent care along with their medication pass. She stated that her idea of being properly staffed, provided there was two nurses on shift, would be four CNAs during the day, and two CNAs at night. The Whitefish Care and Rehab facility assessment, dated 2/26/20, as being reviewed with the facility QAPI committee, and dated 3/10/20 as the most recent update, showed their average daily census range was 60-65. Their direct care staff members, CNA per resident ratio was 1:15 for the night shift, and 1:20 for the day shift. This was directly opposed to what staff member B stated staffing should be. The facility assessment showed the staffing plan was to be subject to adjustment to meet the care and safety needs of the resident thus maintaining the quality of life. These adjustments were shown to have not happened, as the basic ADLs of the residents were not met, per the previous interviews with staff members A and B. Record review of the facility census, dated 4/7/20, showed a census of 56 residents. Review of the facility time clock information for direct care nursing staff for the last week of March and the first week of April 2020, showed there was never more than two CNAs on the night shift between 3/28/20 and 4/6/20. On 3/27/20, there were four CNAs but two of them left work at 10:00 p.m. Six times between 3/27/20 and 4/6/20 there was only one CNA on the night shift, for an average resident census of 60-65 residents, based on the facility assessment. Refer to F677-ADL Care Provided for Dependent Residents for lack of the provision of resident care.