STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2022
NAME OF PROVIDER OR SUPPLIER: Whitefish Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1305 E 7th St Whitefish, MT 59937	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interview and record review, the facility failed to permit 1 (#227) of 1 sampled resident to return to the facility following a facility initiated transfer when the resident was sent to the emergency room , which required the hospital to seek alternate placement for the resident. Findings include: During an interview on [DATE] at 3:51 p.m., NF3 stated resident #227 arrived through the emergency department of their facility (a local acute care facility). The resident's out of control pain was treated in the emergency department on [DATE], and she was ready to return to the facility on [DATE] from the emergency department. The emergency department physician was told by the facility they were not willing to take the resident back. NF3 said resident #227 was expecting to go back to her room at the facility after being treated in the Emergency Department. Resident #227 was then admitted to the hospital where she remained from [DATE] through [DATE], and the hospital attempted to find other living and care arrangements for the resident. NF3 said resident #227 was finally placed at another facility in town on [DATE]. During an interview on [DATE] at 3:50 p.m., NF1 said she tried to assist with getting resident #227 back into her room at the facility, but the facility refused to take her back. NF1 stated the hospital had done an amazing job of getting resident #227's pain under control, and the resident was in better shape than she had ever seen her, but the administrator and DON at the facility just would not listen. NF1 stated, They just did not want her back. NF1 said she was not informed of the Notice of Transfer or Discharge until the resident was not allowed to go back to the facility and wanted a fair hearing. During an interview on [DATE] at 3:22 p.m., staff member C stated, We could not keep her (resident #227's) pain under control. She (resident #227) did have a baclofen pump when she went to the hospital. She (resident #227) had a room for seven days with the bed hold . Initially her belongings were still in the room, even after the seven days were up. Then her boyfriend came to get them (the resident's belongings). It was a long time before he was able to get the chair though. He only had a car, so I think we had to take her power chair to the hospital. We couldn't take her (resident #227) back because we just couldn't control her pain, it definitely was not because of the pain pump because she had that before she left here. (continued on next page)

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:22 p.m., staff member L said the bed hold expired, and he told the hospital that he needed a new referral, which he received from the hospital. Staff member L stated resident #227's referral was denied because she had a baclofen pump. Resident #227's medical record showed she had the baclofen pump while she was a resident at the facility prior to going to the hospital. Staff member L stated he was, told to deny the referral by [oversight company]. Staff member L stated he had an open female bed for resident #227 but [oversight company] told him not to accept the resident because of the baclofen pump. Staff member L stated, [oversight company] would not allow us to take her back and we couldn't do anything without [oversight company]'s approval. Staff member L stated, There are a lot of reasons we deny referrals. Every referral had to go through [oversight company] first. There is no written documentation of [oversight company] telling us we couldn't take the resident it was all just verbal. Record review of resident #227's progress note, dated [DATE], showed resident #227 had a baclofen pump on [DATE]. Record review of resident #227's Emergency Department visit, dated [DATE], showed, [The facility] reports they are not willing to take her back. This document was completed and signed by NF4. Record review of resident #227's EMR reveals no instance in which staff member M concluded resident #227's needs could not be met at the facility or communicated that the facility could not meet resident #227's needs to the recieving acute care facility. Record review of a document titled Efore (sic) the State of Montana Department of Public Health and Human Services Office of Administrative Hearings, Final Agency Decision, In the Matter of Involuntary Transfer or Discharge of [resident #227], dated [DATE] showed, the facility's [DATE] Discharge Notice did not meet the requirements of the facility to provide 30 days prior notice of discharge or transfer, the facility did not meet the requirements of the facilities treating physician making the determination and communicating with the receiving facility and did not meet the requirements of the facility providing the resident with sufficient preparation and orientation in a form and manner she could understand. Record review of resident #227's EMR showed, resident #227 did not return to her room during the appeal process and did not go back to the facility at any time after her [DATE] discharge to the Emergency Department at the local hospital. Resident #227 was neither provided a proper discharge notice nor was she allowed to return to the facility.

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

44770

Based on interview and record review, the facility failed to provide Notice of Transfer or Discharge for 4 (#s 16, 44, 49, and 227) of 5 sampled residents and failed to report the transfer or discharge to the Office of the State Long-Term Care Ombudsman. Resident #16 had been transferred multiple times. Findings include:

During an interview on 3/29/22 at 3:50 p.m., NF1 said she had not been informed by the facility of the transfer or discharge for resident #s 44, 49, or 227. NF1 eventually found out about #227's discharge when resident #227 filed for a fair hearing.

During an interview on 3/30/22 at 4:48 p.m., staff member F stated the Notice of Transfer and Discharge paperwork did not exist for resident #s 44 and 49.

a. to an acute care hospital on 2/24/22. Resident #44's Notice of Transfer and Discharge was not found in the resident's EMR.

b. Record review of resident #49's Discharge MDS, with an ARD of 2/6/22, showed resident #49 was discharged to an acute care hospital on 2/6/22. Resident #49's Notice of Transfer and Discharge was not found in the resident's EMR.

c. Record review of resident #227's EMR showed resident #227 was transferred to a local hospital and discharged from the facility on 6/21/21. A Notice of Transfer and Discharge was found in resident #227's EMR, but it was not signed by the resident or documented as acknowledged.

46400

d. During an interview on 3/29/22 at 3:43 p.m., resident #16 stated she went back to the hospital for an appendectomy, and one other time since being admitted to the facility.

Review of resident #16's medical record failed to show evidence of the Notice of Transfer and Discharge to the hospital for the dates of 12/7/21, 2/21/22, or 3/10/22.

On 3/30/22, the Notice of Transfer and Discharges were requested for resident #s 16, 44, and 49. The documents were not provided by the end of the survey.

Record review of a facility document titled, Transfer and Discharge Notice, revised December 2016, showed:

. 3. A resident, and/or his or her representative (sponsor), will be given thirty (30)-day advance notice of an impending transfer or discharge from our facility.

4. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. An immediate transfer or discharge is required by the resident's urgent medical needs .

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 44770 Based on interview and record review, the facility failed to allow 1 (#227) of 1 sampled resident to return to her previous room or the first available bed after hospitalization ; and failed to ensure the medical record and discharge/transfer notification contained a valid basis for discharge for a resident who was not permitted to return. Findings include: During an interview on 3/29/22 at 3:50 p.m., NF1 said she tried to assist with getting resident #227 back into her room at the facility, but the facility refused to take the resident back. NF1 stated she was not informed of the Notice of Transfer or Discharge for resident #227 until the resident was not allowed to go back to the facility and wanted a fair hearing. During an interview on 3/30/22 at 3:22 p.m., staff member C stated, We could not keep her pain under control. She (resident #227) did have a baclofen pump when she went to the hospital . We couldn't take her back because we just couldn't control her pain, it definitely was not because of the pain pump because she had that before she left here. During an interview on 3/30/22 at 3:51 p.m., NF3 stated resident #227 arrived through the emergency department of their facility. The resident's pain was treated in the emergency department, and she was ready to return to the facility. The emergency department physician was told by the facility they were unwilling to take the resident back. NF3 stated the acute care facility had communicated with the medical director of the facility, and he agreed to accept resident #227 back into his care at the facility, but the facility administrator would not agree to take the resident back. During an interview on 3/30/22 at 4:22 p.m., staff member L said There are a lot of reasons why we deny referrals. Every referral had to go through [oversight company] first. There is no written documentation of [oversight company] telling us we couldn't take the resident it was all just verbal. Record review of resident #227's emergency department visit, dated 6/21/21, showed, [The facility] reports they are not willing to take her [resident #227] back. This document was completed and signed by NF4. Record review of resident #227's EMR showed resident #227 did not return to the facility at any time after her 6/21/21 discharge to the emergency department. Record review of a facility document titled, Resident Rights, not dated, showed, You may not be transferred or discharged from the facility, unless it is necessary for your welfare and your welfare cannot be met in the facility . If the transfer or discharge is involuntary, you have the right to 30 days' advance notice to ensure an orderly transition . Record review of a facility document titled, Bed-Holds and Returns, revised March 2017, showed: 1. Residents may return to and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy . (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. If a Medicaid resident exceeds the state bed-hold period, he or she will be permitted to return to the facility, to his or her previous room (if available) or immediately upon the first availability of a bed in a semi-private room . 6. If the resident is transferred with the expectation that he or she will return, but is determined that the resident cannot return, that the resident will be formally discharged . Refer to F622 Transfer and Discharge, F623 Notice Requirements for Transfer/Discharge, and F625 Notice of Bed Hold, for further information related to resident #227's transfer to the ER discharge, and facility refusal when she was ready to return.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41652 Based on interview and record review, the facility failed to ensure the Facility Assessment was reviewed and updated annually and as necessary. The deficient practice had the potential to affect any resident who received care and services at the facility. Findings include: Review of the Facility Assessment, dated 11/28/18, failed to show any information related to COVID-19 care and services. The assessment did not include: - COVID-19 as an infectious or communicable disease. - Isolation needs as a result of COVID-19. - Changes in staffing as a result of COVID-19. - An updated Infection Prevention and Control risk assessment which addressed COVID-19. During an interview on 4/12/22 at 10:03 a.m., staff member A was not able to explain why the Facility Assessment had not been updated since 2018, or why the assessment did not contain any COVID-19 information. An updated Facility Assessment, dated 4/13/22, was provided prior to the end of the survey.

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F 0880

Level of Harm - Actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

41652

Based on interview and record review, the facility failed to protect residents from the transmission of COVID-19 during an outbreak, and 34 residents were found to be positive for COVID-19, to include (#s 3, 4, 5, 7, 8, 9, 12, 17, 21, 22, 23, 27, 28, 37, 38, 39, 42, 45, 47, 48, 50, 51, 52, 56, 61, 62, 63, 65, 72, 75, 77, 177, 228, 229, and 230) of 49 sampled residents; failed to ensure the Infection Prevention and Control policies and procedures were based on current national standards and reviewed at least annually; failed to ensure staff were consistently screened for symptoms of COVID-19 prior to the beginning of each shift worked; and failed to implement a surveillance plan which included ongoing analysis of data and corrective action in response to identified concerns. The deficient practices increased the risk of any resident in the facility contracting COVID-19 and resulted in 34 residents being diagnosed with COVID-19 between 1/22/22 and 2/2/22. Findings include:

Transmission of COVID-19

Review of the facility's infection control surveillance line listing, dated 1/19/22 through 2/2/22, showed 34 residents (#s 3, 4, 5, 7, 8, 9, 12, 17, 21, 22, 23, 27, 28, 37, 38, 39, 42, 45, 47, 48, 50, 51, 52, 56, 61, 62, 63, 65, 72, 75, 77, 177, 228, 229, and 230) and 12 staff (C, H, I, J, P, R, S, T, U, V, and W) tested positive for COVID-19.

During an interview on 3/30/22 at 8:52 a.m., staff member C stated she had been responsible for infection control until 2/1/22 when staff member O took over the infection control responsibilities. Staff member C stated it was challenging to accomplish the tasks associated with infection control and COVID-19. She stated she was frequently assigned to work the floor and did not have time to monitor screening and testing compliance for the staff. Staff member C stated working the floor made it difficult for her to find the time to analyze surveillance data to identify any concerns or corrective action needed. Staff member C stated she had kept track of Covid-19 positive staff and residents and provided this information to the Public Health Department. Staff member C stated she had missed approximately 10 days of work in January of 2022 due to COVID-19 and no other staff at the facility contacted the Public Health Department during her absence. Staff member C stated she sent the surveillance information as soon as she returned to work on 2/2/22.

Annual Review of the Facility Policies and Procedures

During an interview on 3/31/22 at 7:34 a.m., staff member C stated she was not sure the last time the Infection Prevention and Control Program had been reviewed. Staff member C stated she would check the QAPI minutes to see when it had been done last.

Review of the facility's policy titled, Infection Prevention and Control Program, showed the policy was last revised October 2018. The policy failed to show it had been reviewed at least annually or had been revised based on current national standards, or as necessary.

A written request for documentation related to the annual review of the facility's Infection Prevention and Control Program was made on 3/31/22. No documentation was provided prior to the end of the survey.

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F 0880

Level of Harm - Actual harm

Residents Affected - Many

During an interview on 4/13/22 at 3:45 p.m., staff member N stated the facility had become aware of an issue with policies during the first part of the survey from 3/29/22 to 3/31/22. Staff member N stated there were policies provided by [oversight consultant], and the corporate office. Staff member N stated the policies overlapped and sometimes contradicted each other. Staff member N stated the facility was working on eliminating duplicate and contradictory policies.

Review of the facility's policy titled, COVID-19 Outbreak Status Procedure, dated 9/18/21, failed to show the current CMS requirements related to visitation and the frequency of COVID-19 testing. The policy showed, When a positive COVID 19 test is produced immediately close the building down to visitors . The policy failed to show CMS revised the visitation restrictions on 11/12/21. The policy showed, Continue to perform weekly testing (every 7 days or more depending on county health recommendations on positivity percentage) . The policy failed to show CMS changed the frequency of COVID-19 testing from the county positivity percentage to the county transmission rate on 9/10/21.

Staff Screening

During an interview on 3/30/22 at 10:02 a.m., staff member O stated she had become responsible for oversight of infection control in early February of 2022. Staff member O stated some of the staff had been entering the building through a back door and therefore, bypassing the screening area located at the front entrance to the facility. Staff member O stated the front desk receptionist was responsible for screening at the front entrance during office hours, and the facility was working on a system for the off hours. Staff member O stated the facility had been using an electronic kiosk for screening. Staff member O stated the kiosk had not been working recently and they had been using a paper system.

During an interview on 4/12/22 at 10:03 a.m., staff member A stated whoever was working the front desk during office hours was responsible for ensuring anyone who entered the building was screened. Staff member A stated this included staff who were entering the facility to work. Staff member A stated staff were on the honor system when it came to screening when there was no one at the front desk. Staff member A stated the facility had advertised for someone who could monitor the screening area when the office was closed but had not had any candidates. Staff member A stated staff member C should have been aware it was her responsibility to ensure staff was screening prior to every shift worked. However, staff member A was not aware if the DON at the time had told staff member C of this responsibility.

Review of the facility's staff screening logs for five full-time nurses, dated from 1/1/22 to 3/23/22, showed of 133 shifts worked, there were 63 missed staff screening entries.

Surveillance Plan

During an interview on 3/29/22 at 10:03 a.m., NF2 stated she should had been in contact with the facility regarding the status of their current outbreak which started in late October of 2021. NF2 stated she was not made aware of the extent of the residents being diagnosed with COVID-19 starting on 1/22/22 until 2/2/22. NF2 stated she received a list of 34 residents who tested positive for COVID-19 between 1/22/22 and 2/2/22. NF2 stated due to the late notification, she was not able to assist the facility with timely management of the outbreak. NF2 stated she was not aware the facility was using crisis staffing strategies by allowing staff who were positive for COVID-19 to care for residents, even those residents who were not positive for COVID-19.

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F 0880 Level of Harm - Actual harm Residents Affected - Many	During an interview on 3/30/22 at 10:02 a.m., staff member O stated she took over infection control responsibilities from staff member C on 2/1/22. Staff member O stated the facility was on outbreak status when she took over and she was still trying to get a handle on all of the issues related to infection control and COVID-19 management. Staff member O stated she monitored resident infections through reports of antibiotic use generated through the electronic medical record. When asked about surveillance, staff member O stated the facility had not had any infections since she took over. When asked about COVID-19 surveillance, staff member O stated she had not seen any surveillance related to COVID-19 and thought the information was in staff member C's office. During an interview on 3/30/22 at 2:50 p.m., staff member F stated infection surveillance was ongoing and she would provide the log as requested. Review of the infection control line listing since 11/1/21 included a list of residents and staff who tested positive for COVID-19, the date of the positive test, the type of test performed (rapid POC or PCR), and the vaccination status. No other information was found on the line listing which showed any analysis of the data. A request was made on 3/31/22 for the surveillance binder containing surveillance information, analysis, and corrective action related to COVID-19. No binder was provided. After a discussion with staff member C and staff member F, the facility was able to produce case information sheets which had been sent to the Public Health Department in response to positive COVID-19 test results. The facility was not able to produce any documents showing analysis of the information or planned corrective action associated with any identified concerns.