STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275066	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GALLATIN REST HOME	1221 W DURSTON RD BOZEMAN, MT 59715

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to implement consistent screening of residents by taking their temperature every shift, intended to prevent the transmission of communicable diseases, specifically COVID-19, through early detection and management of potentially infected residents for 4 (#s, 15, 16, 17, and 18); failed to offer hand hygiene before meals for 12 (#s 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13); failed to follow proper hand hygiene techniques for 1 (#1); and failed to implement proper usage of a mask when in direct contact with a resident for 1 (#14) of 18 sampled residents. The deficient practices had the potential to affect all residents in the facility. Findings include: 1. During an interview on 6/15/20 at 11:00 a.m., staff member G stated, for every shift temperatures are taken for each resident, there are log books at the nurses station where temperatures are recorded. One black and one green log book at the nurses station. CNAs were responsible for taking the resident's temperatures. During an interview on 6/15/20 at 12:45 p.m., staff member A stated, the only place resident temperatures would be is in the binders at the nurses station; unless staff were following up on a high temperature then it might be recorded elsewhere. During an interview on 6/15/20 at 1:55 p.m., staff member I stated CNAs were supposed to record the resident's temperatures every shift. She stated the temperatures are recorded in a binder at the nurses station and has never recorded the temperatures anywhere else in the resident's medical record. A. During an interview on 6/15/20 at 2:09 p.m., resident #15 stated, Staff come in pretty often to take my temperature, but was not certain about how many times a day. Review of resident #15's Medication Administration Record [REDACTED]. April 2020 - There were 17 missed temperature recordings, out of 93 opportunities. May 2020 - There were 12 missed temperature recordings, out of 93 opportunities. June 2020 - From the beginning of June until the 14th there were 6 missed temperature recordings, out of 42 opportunities. B. Review of resident #16's Medication Administration Record [REDACTED]. April 2020 - There were 9 missed temperature recordings, out of 93 opportunities. May 2020 - There were 8 missed temperature recordings, out of 81 opportunities. June 2020 - From the beginning of June until the 14th there were 7 missed temperature recordings, out of 42 opportunities. C. Review of resident #17's Medication Administration Record [REDACTED]. April 2020 - There were 10 missed temperature recordings, out of 93 opportunities. May 2020 - There were 8 missed temperature recordings, out of 87 opportunities. June 2020 - From the beginning of June until the 14th there were 4 missed temperature recordings, out of 42 opportunities. D. Review of resident #18's Medication Administration Record [REDACTED]. April 2020 - There were 9 missed temperature recordings, out of 93 opportunities. May 2020 - There were 7 missed temperature recordings, out of 93 opportunities June 2020 - From the beginning of June until the 14th there were 5 missed temperature recordings, out of 42 opportunities. Review of facility document titled Memorandum dated, March 19, 2020 showed, As you are already aware residents/patients are getting their temperatures taken on each shift. Be aware of how they are doing. Report any concerns of coughing, shortness of breath, sore throat, or temperature at 100 or above to the Nurse immediately. 2. During an observation on 6/15/20 at 10:07 a.m., staff member B was not wearing a mask and pushed resident #14, who was in her wheelchair, to the other side of the hall so staff member B could mop that side of the hall. During an observation on 6/15/20 at 10:32 a. m., staff member B was not wearing a mask and pushed resident #14, who was in her wheelchair, to the other side of the hall so staff member B could mop that side of the hall. 3. During an observation on 6/15/20 at 11:30 a.m., staff member C and staff member D were assisting resident #1 off the commode. Staff member C applied gloves, wiped resident #1's buttocks, and applied cream. Staff member C removed her gloves, pulled resident #1's pants and brief up, moved the commode out of the way, and pulled resident #1's recliner behind her. Staff member C did not change her gloves when transitioning from clean to dirty task and did not sanitize after removing gloves and putting new gloves on. 4. During an observation on 6/15/20 at 11:45 a.m., staff members C, D, and E were distributing lunch to residents in their rooms. Staff member C delivered lunch to residents #4 and #7. Staff member C did not offer or assist either resident with hand hygiene before they started eating their meal. Staff member D delivered lunch to residents #2, #3, and #6. Staff member D did not offer or assist any of the residents with hand hygiene before they started eating their meal. Staff member E delivered lunch to residents #5 and #8. Staff member E did not offer or assist either resident with hand hygiene before they started eating their meal. During an observation on 6/15/20 at 12:10 p.m., staff member F was disturbing lunch to resident in their rooms. Staff member F delivered lunch to residents #9, #10, #11, #12, and #13. Staff member F did not offer or assist any of the residents with hand hygiene before they started eating their meal. During an interview on 6/15/20 at 12:22 p.m., resident #7 stated staff had not offered hand hygiene to him before meals. During an interview on 6/15/20 at 12:24 p.m., resident #6 stated he did not think the staff had offered hand hygiene to him before meals. During an interview on 6/15/20 at 12:40 p.m., staff member E stated she was not sure if staff had received training or education on offering hand hygiene to residents before meals. During an interview on 6/15/20 at 12:41 p.m., staff member C stated she received education on offering hand hygiene to residents before meals and that hand hygiene should be offered and encouraged. During an interview on 6/15/20 at 2:50 p.m., staff member G stated staff should be: (1) offering hand hygiene to all residents before eating meals, (2) hand hygiene should be completed between removing soiled gloves and applying clean gloves, and (3) gloves should be changed when transitioning from a clean to dirty task. Review of the facility's policy titled, Standard Precautions Infection Control, implemented 3/13/20 showed: .2. Using Personal Protective Equipment (PPE): a. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. Review of the facility's policy titled, Hand Hygiene, implemented 3/13/20 showed: - .6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. - Hand Hygiene Table showed: an x under the column titled either soap and water or alcohol based hand rub (ABHR is preferred) for the following conditions: 1) after handling contaminated objects 2) before applying and after removing personal protective equipment (PPE), including gloves 3) before and after handling clean or soiled dressings, linens, etc 4) after handling items potentially contaminated with blood, body fluids, secretions, or excretions 5) when, during resident care, moving from a contaminated body site to a clean body site Review of memorandum RE: COVID-19 Mealtime and Activity Chances (subject to change) dated 4/16/20 showed: -All staff providing resident care, passing trays, or working closely with resident will now be required to wear a procedure mask. -The following departments should be wearing masks: a. Nursing b. CNA's c. Therapy d. Housekeeping e. Activities

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.