STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275144	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTERN MONTANA VETERANS HOME	**2000 MONTANA AVE GLENDIVE, MT 59330**

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 the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 and to prevent the potential spread of infections. Specifically, the facility failed to: Implement infection control precautions for communal dining and group activities to ensure adequate social distancing was in place during dining and in the activity room. Follow infection control standards by not having proper signage for rooms designated as transmission-based precautions for 2 (#s 17 and 33) of 7 sampled residents. Dispose of potentially contaminated items safely from a room designated with transmission-based precautions for 1 (#17) of 7 sampled residents. Follow hand hygiene standards by not providing or offering hand hygiene to residents prior to meal service for 4 (#s 7, 16, 47, and 64) of 7 sampled residents, to prevent the spread of COVID-19. These deficient practices had the potential to affect all residents in the facility. Findings include: 1. During an observation on 5/20/20 at 8:25 a.m., there were two residents sitting at the same round table in the activity room. The residents were less than three feet apart, and were not wearing facemasks. There were no other residents in the activity, and social distancing was not in place for the two residents. During an interview on 5/20/20 at 8:35 a.m., staff member F, who was working in the secure unit, said facility education provided had stressed hand hygiene and facemasks, but did not expect residents to wear masks or maintain social distancing. During an interview on 5/20/20 at 9:20 a.m., staff member J stated residents were still eating in the dining room together, and there were only about two people who would usually receive room trays. During an observation on 5/20/20 at 10:05 a.m., there were 28 residents observed in the dining room. Social distancing was not observed for residents eating in the dining room. One of the tables, which seated four residents, had four residents who required assistance while eating. These residents had less than three feet between them, and no masks were being worn by residents in the dining room. During an observation on 5/20/20 at 10:18 a.m., there were multiple tables with two to four residents sitting together. The residents sitting at the same table were two to three feet apart. No residents were observed wearing a facemask upon entering or leaving the dining area. 2. During an observation on 5/20/20 at 8:27 a.m., resident #33's room on D wing, was designated as a transmission-based precautions room, and the room did not have signage identifying what type of precautions were necessary. The sign on the door to the room showed PPE must be worn at all times: gown, gloves, mask, face shield. During an observation on 5/20/20 at 8:45 a.m., a sign on resident #17's room read, get your ppe on. A dresser was observed next to the room with hand sanitizer on top and gowns and gloves inside. There was no signage that showed what type of PPE was to be donned before entry. During an interview on 5/20/20 at 9:00 a.m., staff member L stated the resident was in isolation for two weeks because he left the facility and went out of town for an appointment. Staff member L stated staff members are supposed to wear a gown, mask, and gloves when they enter the room. During an observation and interview on 5/20/20 at 9:28 a.m., staff member K stated she was going to shower resident #17. Staff member K realized she did not have a face shield that was assigned to her, so she used a staff members that had not been used before. Staff member K took out a disposable gown and gloves from the dresser next to the resident's room. Staff member K realized she did not have towels for the resident. Staff member K placed the gloves back in the drawer and laid the gown on top of the dresser and left to get towels. A staff member saw the gown laying on top of the dresser and threw it away, and the gloves remained in the drawer. During an observation and interview on 5/20/20 at 9:37 a.m., staff member K returned with towels for resident #17 in isolation. She stated she was just going to put the shower supplies in the resident's room to shower him later. She sanitized her hands, got a new gown out of the isolation dresser next to the resident's room, as well as gloves, properly donned PPE and entered the room. Staff member K exited the resident's room with her PPE still on. Staff member K then doffed her PPE in the hallway, outside of resident #17's room. Staff member K then walked the PPE, without putting it in a garbage bag, across the hall, behind the nurses station, and threw the PPE away in the regular trash can, although the resident was in isolation precautions. During an interview on 5/20/20 at 9:45 a.m., staff member K stated a couple weeks ago staff member B did an in-service on PPE, which she attended. Staff member K stated there were stations set up, and they were trained how to properly don and doff PPE. During an interview on 5/20/20 at 2:02 p.m., staff member C stated the facility was working on revising the signs for Contact/Droplet precautions due to changes in PPE availability. 3. During an observation on 5/20/20 at 10:37 a.m., room trays were delivered to residents #s 7 and 47. The CNA delivering meal trays did not offer or provide hand hygiene to either resident. Both residents were in bed when the meal trays were delivered, and ate their meals while in bed. Review of resident #7's Quarterly MDS, with an ARD of 2/25/20, showed he required extensive assistance of one for bed mobility and personal hygiene. Transfers out of bed occurred only one to two times during the assessment period. Review of resident #47's Quarterly MDS, with an ARD of 4/28/20, showed he required extensive assistance of one for bed mobility and personal hygiene. Resident #47 was totally dependent on staff for transfers out of bed. During an observation on 5/20/20 at 10:45 a.m., resident #64 was assisted to a sitting position on the edge of the bed, and his tray was placed on his bedside table. The CNA who delivered the meal tray did not offer or provide hand hygiene to resident #64 prior to eating his meal. Review of resident #64's Annual MDS, with an ARD of 5/12/20, showed he required extensive assistance of one for bed mobility, personal hygiene, and transfers out of bed. During an observation on 5/20/20 at 10:47 a.m., a CNA delivered a room tray to resident #16. The CNA who delivered the meal tray did not offer or provide hand hygiene to resident #16 prior to eating her meal. Review of resident #16's Significant Change MDS, with an ARD of 3/10/20, showed she required extensive assistance with bed mobility and was totally dependent on staff for transfers out of bed. Resident #16 required limited assistance of one for personal hygiene. During an interview on 5/20/20 at 9:45 a.m., staff member K stated a couple of weeks ago she had attended an in-service on hand hygiene, provided by staff member B. During an interview on 5/20/20 10:50 a.m., staff member I stated she provided hand hygiene to residents upon awakening in the morning, and after toileting. Staff member I stated she knew hand hygiene should be more often, but that was the best she could do.

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.