STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENDIVE MEDICAL CENTER N H	202 PROSPECT DR 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to properly implement adequate infection control precautions for communal dining and group activities and ensuring social distancing measures were in place, and documenting staff screening for an elevated temperature, and the absence of symptoms; the facility failed to provide training for staff on COVID-19 infection control guidelines for resident care; and the facility failed to ensure staff were using proper hand hygiene when serving meals, and not offering hand hygiene to residents when delivering room trays, for 3 (#2, #3, and #5) of 5 sampled residents. The deficient practices had the potential to affect all residents in the facility. Findings include: 1. During an observation on 5/19/20 at 7:26 a.m., the May calendar of activities showed activities were being held. No restriction on the number of residents allowed to attend, or the need for social distancing was seen on the calendar. During an interview on 5/19/20 at 7:41 a.m., staff member C stated she had not received any guidance related to social distancing for residents, or the need to modify dining and activities, as part of strategies intended to decrease the risk associated with Covid-19 During an observation on 5/19/20 at 10:15 a.m., residents were in the dining room for brunch. Residents were seen sitting together, at square tables, with less than three feet between residents sitting at the same table, and social distancing was not observed for these residents at these tables. The tables in the dining room were at least six feet apart. None of the residents observed were wearing a facemask prior to entry into the dining room. During an interview on 5/19/20 at 1:32 p.m., staff member A stated she understood the CMS guidance for communal dining and group activities was a recommendation, not a requirement, unless Covid-19 was present in the county or community. Staff member A stated the facility would, Take that step if Covid-19 came to the community. Staff member A stated the facility was [MEDICATION NAME] social distancing in the dining room by having the tables spread at least six feet apart. 2. During an observation and interview on 5/19/20 at 8:23 a.m., staff member D was seen performing the temperature and symptom screening for all persons entering the building. This screening was performed on all staff, visitors, residents, and hospital patients. Staff member D was not seen documenting the name, temperature result, or the absence of respiratory signs and symptoms. Staff member D stated she had not been instructed to document any of the screening information for staff, vendors, or visitors. Staff member D stated if someone entering the facility had a temperature greater than 100.4 degrees Fahrenheit or respiratory symptoms, they were asked to leave the building immediately, or were referred to the urgent care clinic for additional follow-up. During an interview on 5/19/20 at 1:31 p.m., staff member B stated staff were not documenting any Covid-19 screening information for staff, visitors, or venders. Staff member B stated, I don't believe they are logging that information unless a problem is noted, and I believe if they had a temperature or issue, they would be turned away and contacted. During the Exit Conference on 5/19/20 at 4:30 p.m., staff member A stated the screening information had been documented when only the Extended Care Unit was required to screen all staff and visitors. Staff member A stated on March 20,2020 the entire organization began screening, the documentation of Extended Care Unit staff and visitors stopped. 3. During an interview on 5/19/20 at 8:26 a.m., staff member L stated she did not think the facility had any in-service training for infection control that was related to Covid-19 infection control procedures. During an interview on 5/19/20 at 12:10 p.m., staff member J stated there was not a plan in place at the moment for training on Covid-19 related to processes for infection control. Staff member J stated, Covid-Crazy makes things get pushed to the side. They will be incorporating a process in June. During an interview on 5/19/20 at 12:13 p.m., staff member K stated the facility had not given any formal training to staff related to Covid-19 infection control procedures. Staff member K stated the facility still needed to develop the training, and wanted to wait until the CDC had more guidance on Covid-19. On 5/19/20 at 9:46 a.m., documentation of education, to include content and attendee list, since January 1, 2020 was requested. None was received prior to the end of the survey. 4. During an observation on 5/19/20 at 10:02 a.m., staff member G was assisting resident #3 to get up for lunch. After brushing the resident's hair and assisting her to her wheelchair, staff member G took resident #3 to the dining room. Staff member G did not offer or assist resident #3 with hand hygiene prior to her meal. During an observation on 5/19/20 at 10:05 a.m., residents were being taken into the dining room for brunch. No hand hygiene was being offered to residents before they entered the dining room, or before they received their meal in the dining room. During an interview on 5/19/20 at 10:10 a.m., staff member C stated, Hand hygiene is performed for residents before they come into the dining room. During an observation on 5/19/20 at 10:21 a.m., staff member M was setting up meal trays for the residents during brunch. Staff member M pulled her facemask down with her hand under her chin, to talk to a staff member. She then pulled the mask back up over her nose and mouth with her hand and continued to place food items on the trays for residents. No hand hygiene was performed. During an observation on 5/19/20 at 10:42 a.m., staff member G delivered the room tray to resident #2. Hand hygiene was not offered or provided to the resident prior to eating her meal. During an observation and interview on 5/19/20 at 10:46 a.m., staff member G delivered the room tray to resident #5. Hand hygiene was not offered or provided to the resident prior to eating her meal. When asked when hand hygiene should be offered to residents, staff member G stated she should have offered it before the meal, but forgot. During an interview on 5/19/20 at 2:39 p.m., staff member N stated dietary staff receive hand hygiene training upon hire during on-boarding, and then yearly after that. Every six months an informal training is completed on hand hygiene. Staff member N stated, I give daily reminders for hand hygiene in huddles. Our last formal training for dietary staff on hand hygiene was in October of 2019. We were going to have a training in January, but it was postponed.

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.