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 _____	**10/21/2020**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to safely dispose of, and properly sanitize and handle potentially contaminated personal protective equipment, upon leaving resident rooms, and the rooms were identified to have droplet transmission-based precautions in place, for 3 (#s 1, 2, and 3) of 6 sampled residents. Findings include: During an observation on 10/21/20 at 9:00 a.m., rooms 111 (resident #1) and 116 (residents #2 and 3) it was noted facility staff had posted droplet/contact precaution signs on the doors of the rooms. Outside of the rooms was an isolation cart, and a large 32 gallon garbage can. Resident room [ROOM NUMBER] and 116 were double occupancy rooms, which had the isolation precautions in place for each resident in the room. During an observation and interview on 10/21/20 at 9:19 a.m., staff member C stood outside resident #2 and 3's door and stated I don't know what is going on with this room. Staff member C was wearing a face shield and surgical mask. Staff member C donned a gown and gloves and entered the room. Staff member C exited the room wearing her face shield, surgical mask, gown, and gloves. Staff member C took off her gown and gloves outside resident #2 and 3's room, she then threw it away in the trash can outside the room, and then she applied hand sanitizer. Staff member C removed her face shield and laid it down on the isolation cart, without a protective barrier in place, and sanitized the inside of the shield with hand sanitizer. She stated I'll go change my mask now I have to go get one, there isn't any in the isolation cart. Staff member C did not dispose of her gown and gloves inside resident #2 and #3's room, did not put down a barrier when setting her face shield on the isolation cart to clean it, and there was not surgical masks in the isolation cart for her to use as required. During an interview on 10/21/20 at 9:30 a.m., staff member C stated she had infection control training a couple months ago on how to correctly don and doff PPE. She stated there was normally a spray bottle on top of the isolation cart to sanitize her face shield, and usually there were surgical masks in the isolation cart, however that day there were not. During an observation on 10/21/20 at 10:45 a.m., staff member D was delivering a room tray to resident #1 who was on droplet and contact precautions. Staff member D donned PPE and entered the resident's room. Staff member D doffed her gown and gloves inside the resident's room, carried the gloves and gown outside the resident's room, and threw the PPE away in the garbage can outside the resident's room. Staff member D then applied hand sanitizer. Staff member D did not sanitize her protective eye glasses, did not change her surgical mask prior to leaving the area identified to have precautions in place, and did not dispose of her gown and gloves inside resident #1's room. During an interview on 10/21/20 at 10:53 a.m., staff member D stated she would normally discard the PPE in a trash can inside the resident's room, however there wasn't a trash can inside the resident's room. Staff member D stated she does not usually change her surgical mask after being in a resident's room who is on precautions unless she knows the resident tested positive for COVID-19. During an interview on 10/21/20 at 4:20 p.m., staff member B stated staff are to discard PPE outside the resident's rooms in the trash can so there is not a trash can in the resident's room which could be a fall hazard. Review of the facility's training diagram on how to correctly don and doff PPE showed: .Gown and Gloves . 2. Cross arms and grip gown on shoulders. Pull and break gown in controlled fashion. 3. Roll the gown towards your hands. Remove the gloves with the gown. Dispose of the gown and gloves. 4. Sanitize hands. Face Shield 5. Do not touch face. 6. Remove the face shield by the strap over your head without touching your skin. 7. Sanitize hands. EXIT patient room .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE