

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Gallatin Rest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from physical abuse by agency staff for 1 (#27); failed to ensure a resident was free from verbal abuse by agency staff for 2 (#s 39 and 60); failed to ensure a resident was free from physical and verbal abuse by another resident for 2 (#s 46 and 59); and failed to ensure a resident was free from neglect of care for 1 (#13) of 8 residents sampled for abuse. The failure placed the residents at risk for physical injury, emotional distress, diminished quality of life, and loss of dignity. Findings include: 1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed NF2 was observed grabbing resident #27 by the arm and directing the resident into a seated position. The facility investigated the incident and substantiated the allegation of abuse. During an interview on [DATE] at 12:05 p.m., staff member B stated NF2 was a travel staff member completing a 13-week contract; however, following the abuse investigation, his contract was terminated. Staff member B stated there had been previous concerns addressed with NF2's travel agency regarding lack of motivation, attitude, and insubordination. Staff member B stated NF2 had been counseled by his agency for the prior concerns. During an interview on [DATE] at 3:00 p.m., staff member N stated she observed and reported the incident involving NF2 and resident #27. Staff member N stated NF2 was attempting to prevent resident #27 from standing. Staff member N stated that when resident #27 attempted to stand, NF2 yelled at the resident to sit down, grabbed the resident by the arm, forced the resident into a seated position, and did not let go. Staff member N stated NF2 then made a hand gesture as if reaching for an imaginary handgun. Staff member N stated, I intervened by taking the wheelchair from [NF2] and wheeling resident #27 to the end of the hall for a snack. Staff member N stated there had been previous concerns regarding NF2's behavior toward residents and lack of concern for resident well-being. Staff member N stated she had previously reported concerns to staff member B, including NF2 being sarcastic and uncaring toward residents in his care. Staff member N stated she believed NF2 did not think she would report the incident because they were friends outside of work; however, my residents come first. Review of facility emails between NF2's travel agency and staff member B showed NF2 had previously been reported for concerns related to resident care and professionalism. On one occasion, NF2 was reported to have his head on a table while using his phone when he was assigned to monitor safety for a resident during a meal. On another occasion, NF2 was assisting a resident when the resident became upset and combative. Other staff intervened and removed the resident from NF2's proximity, and as the resident was being escorted away, NF2 made sarcastic comments toward the resident. Facility email communication between NF2's agency and the facility showed the agency would provide re-education on the previous concerns regarding NF2's behavior, although the email (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication did not include documentation of the facility's monitoring of NF2's behavior. NF2 received a final warning on [DATE] for lack of professionalism, and on [DATE], the abuse incident involving resident #27 occurred. Review of NF2's travel staff personnel record and email communication between the facility and NF2's agency failed to show evidence that the facility monitored NF2 for behavior and resident care improvement. Review of a facility policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated [DATE], showed, Prevention: . The facility will identify, correct, and intervene in situations in which abuse . of residents is likely to occur . 2. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed that a contract CNA had been verbally abusive to resident #39 and refused to provide care to resident #13. The reason for the refusal was that resident #13's speech was difficult to understand. The report showed the facility investigated the situation and determined verbal abuse had occurred, and the CNA's contract was terminated. The facility failed to ensure the staff member had the necessary training/oversight, and skills to address the resident's care needs and prevent abuse. During an interview on [DATE] at 8:37 a.m., resident #39 stated she remembered an incident with a CNA being verbally abusive to her. During an interview on [DATE] at 3:19 p.m., resident #13 did not remember the issue with a travel CNA from September of 2025. 3. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #46 entered resident #59's room and was overheard saying, I am going to smack and punch you. A CNA corrected resident #46 and removed him from resident 59's room. At the time, it was believed to have been only verbal abuse. Later, resident #59 was found to have a resolving bruise near his right eye. When staff interviewed resident #59, he was able to answer only yes or no questions. The resident said he had been hit by resident #46. It was determined that resident #46 struck resident #59 at some point in time. Resident #46 was moved to another hall and counseled that physical violence and verbal threats are not acceptable. During an interview on [DATE]at 9:05 a.m., resident #46 stated he did not want to talk about the incident, and he was seeing a counselor and making progress. Resident #46 stated he knew resident #59 had died. 4. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed two staff members reported an agency employee (NF3) had verbally abusive interactions with resident #60 the evening of [DATE]. NF3 went into resident #60's room to tell her to shut up multiple times. The two staff members reported NF3 told resident #60 she had a severe migraine, and resident #60 needed to Grow up, and act like an adult and stop yelling. The facility reported incident findings showed the alleged violation was verified, and NF3 was removed from duty with her remaining contract time cancelled. The findings showed resident #60 had no memory of the incident, and ongoing behaviors had not increased following the incident. The facility failed to ensure the staff member had the necessary training, skills, and oversight to ensure a resident was not treated in a manner that was abusive. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #60's electronic medical record showed an admission date of [DATE] with a primary diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance. Review of resident #60's care plan, dated [DATE], showed resident #60 had behavioral concerns displayed by refusal of care, agitation, and restlessness related to her diagnoses of dementia with behavioral disturbance, anxiety, and depression. The care plan provided interventions to interact with resident #60 by approaching and speaking calmly, and to explain a procedure before starting, giving her time to adjust. NF3 did not follow the individualized care plan interventions for resident #60's conditions by interacting with her in a verbally abusive manner. During an interview on [DATE] at 10:38 a.m., staff member A stated that the incident with resident #60 and NF3 had occurred. Staff member A stated the facility relied primarily on contract nursing staff to fill resident care needs. Staff member A stated there had been abuse training before the incident and after the incident with nursing staff, and education on the need to immediately report any alleged abuse incidents. Review of a facility policy titled Abuse, Neglect and Exploitation, revised [DATE], showed: . It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by . implementing written policies and procedures that prohibit and prevent abuse. Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse for 7 (#s 13, 27, 37, 39, 46, 55 and 59) of 8 residents sampled for abuse. The failure resulted in incomplete investigations, which did not show the evaluation of ongoing actions taken for the residents' well-being, did not identify resident-specific interventions, revise care planning, or document other measures implemented to protect residents and prevent recurrence of similar incidents. Findings include: 1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #37 and resident #55 were involved in a physical altercation without injuries. Staff intervened, separated the residents, and completed initial assessments. Resident #55 was transferred to another facility approximately six weeks after the incident. During an interview on [DATE] at 7:50 a.m., resident #37 stated, No one followed up with me, and no one told me to stay away from her (#55). Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed NF2 was observed grabbing resident #27 by the arm and directing the resident into a seated position. The facility investigated the incident, substantiated the allegation of abuse, and terminated the agency staff member; however, it did not provide evidence of any psychosocial monitoring, care planning, or revision of care post-event. During an interview on [DATE] at 1:42 p.m., staff member A stated the facility's post-incident process included educating staff as needed and, when applicable, verbally instructing staff to keep residents separated or monitor residents following an incident; however, the instructions were not documented in the electronic health record, kardex, or task list. Staff member A stated psychosocial follow-up visits or assessments were not completed for residents #27, #37, or #55 following the respective incidents and stated she did not know they were required. During an interview on [DATE] at 4:02 p.m., staff member N stated if there were instructions to monitor for behavioral changes or keep residents separated following an incident, the instructions would typically be communicated verbally during the report. Staff member N stated she was unaware whether those instructions were documented anywhere in the electronic health record and did not recall whether there were any post-event instructions for the incidents identified above. Review of the electronic health records for residents #27, #37, and #55 failed to show documentation of increased supervision, emotional support, counseling, psychosocial follow-up, monitoring of resident interactions, monitoring for behavioral changes related to the incidents, care plan revisions, or other protective measures implemented following the incidents to prevent recurrence. Review of a facility policy titled Abuse, Neglect and Exploitation, revised on [DATE], showed: . Protection of Resident . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. C. Increased supervision of the alleged victim and residents; D. Providing emotional support and counseling to the resident during and after the investigation, as needed; . G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of abuse. A request was made on [DATE] for documentation of post-incident psychosocial monitoring and evidence of measures implemented to prevent recurrence of the abuse events. No documentation was provided by the end of the survey. 2. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed that a contract CNA was verbally abusive to resident #39 and was neglectful with resident #13. The report showed the facility determined verbal abuse had occurred, and the CNA's contract was terminated. The report failed to show that the facility had attempted to determine if any other residents were affected by the contract CNA. During an interview on [DATE] at 8:37 a.m., resident #39 stated she remembered an incident with a CNA being verbally abusive to her. Resident #39 stated she felt the facility handled the situation. 3. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #46 entered resident #59's room and was overheard saying, I am going to smack and punch you. A CNA corrected resident #46 and removed him from resident 59's room. At the time, it was believed to have been only verbal abuse. Later, resident #59 was found to have a resolving bruise near his right eye. When staff interviewed resident #59, he was able to answer only yes-or-no questions. The resident said he had been hit by resident #46 but felt safe in the facility. It was determined that resident #46 struck resident #59 at some point in time. Resident #46 was moved to another hall and counseled that physical violence and verbal threats are not acceptable. During an interview on [DATE] at 9:05 a.m., resident #46 stated he did not want to talk about the incident and that he was seeing a counselor and making progress. Resident #46 stated he knew resident #59 had died. During an interview on [DATE] at 10:25 a.m., when staff member A was asked what she did to ensure no other residents were affected by the CNA's behavior, she stated, Could not tell you. I don't know that I talked to anyone. I may have asked staff to check with other residents.		