

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 06/05/2025
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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident, and the resident's representative, were made aware of the risks and benefits associated with the use of psychotropic medications prior to the start of treatment for 1 (#32) of 21 sampled residents. Findings include:</p> <p>During an observation on 6/4/25 at 1:05 p.m., resident #32 was ambulating from the dining room towards her room. The resident's gait was slow, and she was using a walker for support. Facility staff had to direct resident #32 towards her room.</p> <p>Review of resident #32's physician orders showed the following psychotropic medications being given to the resident:</p> <ul style="list-style-type: none"> - 2/11/25 to 3/17/25, Seroquel 25 mg once daily, as needed, for sleeplessness or agitation - 4/29/25 to 5/29/25, olanzapine 2.5 mg twice daily, as needed, for agitation; and, - 5/2/25 to current, sertraline 50 mg daily for mild dementia with psychotic disturbance. <p>Review of resident #32's EHR, accessed between 6/2/25 and 6/5/25, failed to show documentation of the risks and benefits of using the above listed psychotropic medications.</p> <p>During an interview on 6/5/25 at 7:20 a.m., staff member C stated they (the facility) were trying to, hash out a good process for completing the consent with risks and benefits before the psychotropic medication was started. Staff member C stated he was responsible for obtaining this documentation. Staff member C stated if he was out of the office, the forms did not consistently get done.</p> <p>A request was made on 6/3/25, for the consent documents for the resident's Seroquel, olanzapine, and sertraline used for resident #32. None were received prior to the end of the survey.</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observation, interview, and record review, the facility failed to fully investigate an allegation of theft to ensure no other residents were affected for 1 (#34) of 21 sampled residents. Findings include:</p> <p>During an observation and interview, on 6/2/25 at 2:35 p.m., resident #34 was in her power wheelchair having a difficult time grabbing the handle and speaking. Resident #34 stated she had several hundred dollars go missing from her purse in her drawer. She stated she told facility management, and they reimbursed her \$100.00 of the money missing, but did not tell if they found out who took the money.</p> <p>During an interview on 6/3/25 at 2:48 p.m., NF4 stated resident #34 had \$300.00 go missing from her purse in her room. NF4 stated he did not realize she had cashed a check when he transferred resident #34 from the hospital to the facility as she normally would not have that amount of cash on her person. NF4 stated she kept a purse unzipped due to it being too hard to zip shut. NF4 stated the facility informed him they would be conducting an investigation. NF4 stated other than reimbursing resident #34 for \$100.00, he did not know of the investigation conclusion. NF4 stated he did not know where the money was located currently, the facility made him bring in a lockbox.</p> <p>During an interview on 6/4/25 at 8:15 a.m., staff member J stated resident #34 initially reported the theft to her. She looked in resident #34's drawer and only found an envelope that did not match the description from the resident. Staff member J stated she told the facility administrator, and they took over investigation.</p> <p>During an interview on 6/4/25 at 8:58 a.m., staff member A stated all the information for the theft allegation by resident #34 was provided. Staff member A stated it was reported three days after it could have happened and at least 50 people could have been in and out of her room in that time. Staff member A stated they did not interview anyone that could have been in the room. Staff member A stated they did not interview or review any other residents for potentially being affected. Staff member A stated the initial allegation reported to her was \$200.00, then on interview with resident #34, it was said to be \$300.00. Staff member A stated they told resident #34's son to bring a lockbox ,but she was not sure if he brought one in. Staff member A stated they had some money in a slush fund so they gave resident #34 \$100.00. Staff member A stated she reported the allegation to the local police, and they said they doubted they would find who stole the money.</p> <p>During an interview on 6/4/25 at 12:35 p.m., staff member I stated she was in training to do allegations of abuse reporting, and worked collectively with the administrator and nurse manager ,to determine what to report and investigate. Staff member I stated resident #34's son was visiting when they were notified of the theft allegation, and she was in on the discussion notifying him.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility reported incident initially reported on 4/8/25, showed resident #34 reported the allegation of theft from her purse of \$200.00 to staff member J and another nurse. The nurses checked her room without finding the money so they reported the theft allegation to administration. Resident #34's purse was zipped shut and missing an envelope of money. Resident #34 never zipped her purse shut. Local law enforcement was notified, and both the facility and law enforcement told the resident it was unlikely to be found. No further investigation was provided as the facility did not interview any other potential victims or witnesses to determine who stole the money, who else could have missing money, or for the determination of any trending of missing items.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observation, interview, and record review, the facility failed to review and revise resident care plans for 3 (#s 13, 32, and 43) of 21 sampled residents. Findings include:</p> <p>1. During an observation on 6/2/25 at 4:07 p.m., resident #13 was sitting in her wheelchair with both feet elevated on the foot pedals. There was no evidence of a urinary catheter.</p> <p>During an observation on 6/5/25 at 7:57 a.m., staff member F and K were providing morning care for resident #13. Resident #13 had an incontinence brief on, and there was no evidence of a urinary catheter.</p> <p>Review of resident #13's physician orders, dated 5/6/25, showed an order to remove the indwelling urinary catheter.</p> <p>Review of resident #13's care plan, dated 3/11/25, accessed on 6/4/25, showed the resident had an indwelling Foley catheter due to urinary retention. The goals and interventions, dated 3/11/25, continued to show cares related to the urinary catheter.</p> <p>During an interview on 6/5/25 at 7:50 a.m., staff member B stated all nurses should be updating resident care plans. Staff member B could not explain why resident #13's care plan showed she had a urinary catheter. The care plan was not revised.</p> <p>2. During an observation on 6/3/25 at 8:46 a.m., resident #32 was seen sitting in the dining room, her walker placed behind her, and against the wall.</p> <p>During an observation on 6/4/25 at 1:00 p.m., resident #32 was seen ambulating in the hallway using a walker. An unidentified facility staff member was walking with resident #32 and gave the resident directions to her room.</p> <p>Review of resident #32's nursing progress note, dated 12/11/24, showed resident #32 sustained an unwitnessed fall while ambulating in her room. The section labeled Actioned Clinical Suggestions, was blank. The note failed to show what changes were implemented after this fall to prevent future falls.</p> <p>Review of resident #32's nursing progress note, dated 3/26/25 at 7:11 a.m., showed the resident sustained an unwitnessed fall in her room. The note failed to show any contributing factors. The resident did complain of bilateral knee pain. The section labeled Actioned Clinical Suggestions was blank. The note failed to show what changes were implemented after this fall to prevent future falls.</p> <p>Review of resident #32's nursing progress note, dated 3/26/25 at 11:17 a.m., showed the resident was found on the floor. The resident sustained a second unwitnessed fall on 3/26/25.</p> <p>Review of resident #32's nursing progress note, dated 5/31/25, showed the resident sustained an unwitnessed fall while ambulating in her room. The section labeled Actioned Clinical Suggestions, was blank. The note failed to show what changes were implemented after this fall to prevent future falls.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #32's care plan, dated 5/4/24, showed a focus of At Risk for Falls. An intervention, dated 5/3/24, included educating resident and family about safety reminders and to ensure the resident was wearing non-skid footwear. There was also an intervention, dated 2/7/25, which showed therapy was to evaluate and treat as needed.</p> <p>Review of resident #32's care plan, dated 1/28/25, showed a focus of Risk for Falls. The intervention, dated 1/28/25, was to utilize therapy recommendations for ambulation and transfers. The care plan also showed interventions, dated 2/7/25, to ensure call light was available, to alert the provider if a fall occurred, and to initiate frequent neuro (neurological) and bleeding evaluation per facility protocol.</p> <p>Review of resident #32's care plan, dated 3/27/25, showed a focus of an actual fall. The care plan failed to show the resident had falls on 12/11/24 and 5/31/25. The care plan also failed to show any new interventions implemented after the fall on 12/11/24, or the fall which occurred on 5/31/25.</p> <p>During an interview on 6/5/25 at 7:50 a.m., staff member B stated it was the responsibility of all nurses to update and revise care plans as needed. Staff member B could not explain why resident #32's care plan failed to show ongoing interventions implemented after each of the resident's falls.</p> <p>3. During an observation and interview on 6/3/25 at 8:09 a.m., resident #43 was sitting in his wheelchair, waiting for transportation to take him to a dental appointment. The resident stated he had a urinary catheter hooked up to a leg bag.</p> <p>Review of resident #43's physician orders, dated 3/5/25, showed the resident was admitted from the hospital with a Foley catheter, with output being monitored every shift, and the resident was on an antibiotic for seven days because of a urinary tract infection.</p> <p>Review of resident #43's MAR, dated March of 2025, showed the resident was given sulfamethazole-trimethoprim 800-160 mg tablet, twice daily, for seven days.</p> <p>Review of resident #43's care plan, dated 3/5/25, showed the resident had a urinary tract infection related to obstruction and urinary retention. The care plan failed to show the urinary tract infection had resolved. The care plan was not revised.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>2. During an observation on 6/5/25 at 7:57 a.m., resident #13 received morning cares from staff members F and K. Resident #13 was lying on her back in the bed. Resident #13 had a wound dressing on her right heel which was left in place. When resident #13 was turned to her right side for incontinence care, an open area was noted on her coccyx. There was no wound dressing in place. Staff member F applied moisture barrier cream, and a new incontinence brief. Resident #13 called out in pain and cried when she was moved in her bed. The crying stopped as soon as the resident was left alone.</p> <p>During an interview on 6/4/25 at 12:47 p.m., staff member G stated the wound nurse had been seeing the resident weekly, otherwise staff did the dressing changes.</p> <p>Review of resident #13's nursing progress notes showed the following:</p> <ul style="list-style-type: none"> - 3/17/25, bruising to buttocks, present on admission, no measurements documented, - 4/14/25, bruising to buttocks resolved, - 4/21/25, new pressure ulcer on coccyx, scheduled to see the wound nurse on 4/22/25, - 4/22/25, Unstageable pressure ulcer on medial gluteus and coccyx, moisture barrier cream and a dressing, change every three to four days; and, - 5/27/25, Stage III pressure ulcer to medial gluteus, wound border macerated and raised, apply moisture barrier cream after each brief change. <p>Based on observations, interviews, and record review, the facility failed to ensure residents received necessary treatment and services to prevent pressure ulcers and promote healing for 2 (#s 1 and #13) of 7 residents sampled with pressure ulcers. This practice contributed to chronic (>three months) Stage II and Stage III pressure ulcers for resident #1 and a Stage III for resident #13. Findings include:</p> <p>1. During an observation on 6/2/25 at 2:35 p.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. A neck pillow/collar was in his wheelchair.</p> <p>During an observation on 6/2/25 at 2:46 p.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward and to the left side. Neck pillow/collar was in his wheelchair.</p> <p>During an observation on 6/2/25 at 3:35 p.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. A neck pillow/collar was in his wheelchair.</p> <p>During an observation on 6/2/25 at 4:43 p.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. A neck pillow/collar was on his wound supply shelf.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During observations on 6/3/25, from 7:45 a.m. to 4:32 p.m., resident #1 was observed every 30 minutes and found to be in the same position in bed. Resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. The neck pillow/collar was in his wheelchair.</p> <p>During an interview on 6/4/25 at 10:13 a.m., staff member B stated she was aware wound documentation was not being completed and was working on a wound program, including camera use and staging (determining severity) education. Staff member B stated resident #1 was supposed to be up in his wheelchair for 2-3 hours each day for activities. Staff member B stated resident #1 did not get up in the evenings. Staff member B stated resident #1 should be turned and repositioned every two hours and should be checked and changed every two hours. Staff member B stated resident #1 did have a collar pillow to prevent pressure on his neck and ear. Staff member B stated resident #1 had a history of pressure injuries and maceration on his ear and neck area related to his positioning and moisture.</p> <p>During an observation on 6/4/25 at 10:01 a.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. The neck pillow/collar was in his wheelchair.</p> <p>During an observation on 6/5/25 at 7:10 a.m., resident #1 was in bed sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side. NF1 assessed resident #1's pressure wounds on his buttocks. NF1 stated he had three wound openings with a large area which was a Stage I pressure sore covering 13.5 cm by 8.5 cm on the right buttock and 13.5 cm by 7.0 cm on the left buttock. The openings included:</p> <ul style="list-style-type: none"> - 1.5 cm by 9.0 cm by 0 cm: Stage I - 1.1 cm by 1.0 cm by 0.1 cm: Stage II - 0.8 cm by 0.5 cm by 0.15 cm: Stage II <p>NF1 stated frequent turning and positioning were critical, along with frequent brief changes related to incontinence. Staff member L entered to assist NF1 during the dressing change. Staff member L stated the neck pillow was only used during times resident #1 was in his wheelchair. NF1 stated the pressure sores on resident #1's buttocks have waxed and waned, but the wounds were worse than the last time she evaluated them. NF1 stated it was hard to achieve compliance with turning and positioning with all the travel staff used by the building.</p> <p>During an observation on 6/5/25 at 9:20 a.m., resident #1 was sleeping on his back in his bed, with the head of the bed elevated to approximately 30 degrees. His head was tilted forward to the left side.</p> <p>Review of resident #1's Nursing Care Plan, with a revision date of 4/22/25, reflected:</p> <ul style="list-style-type: none"> - . Use soft cervical collar-type pillow to prevent left ear from resting on shoulder. Pillow should be on left side only with no pressure to ear. Ask for assist to properly position as needed. Check collar frequently to monitor for positioning, pressure areas, and to insure breathing and circulation are not compromised. [sic] <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- . [Resident #1] needs total assistance to REPOSITION ROUTINELY THROUGHOUT THE DAY/NIGHT; use turn sheet when he is in bed to prevent shearing. 2-3 hours maximum time in w/c and reposition every 2 hours in bed.</p> <p>Review of resident #1's EHR nursing progress note, dated 1/6/25 reflected resident #1 developed a new pressure wound on his buttocks. No measurements were available.</p> <p>Review of the facility provided tracker, Treatment/Svcs to prevent/heal pressure sores, dated 1/7/25 through 6/3/25, reflected:</p> <ul style="list-style-type: none"> - On 1/7/25 the report showed: . 6.8 x 5 x 0.01 increased significantly in size from previous measurement 12/13 of 4.8 x 3.6 *requested air mattress overlay for bed - On 1/14/25 the report showed: . Air mattress overlay placed 1/7/25 measurements have increased to 7.9 x 6.4 x 0.01 - On 3/11/25 the report showed: .Wound 1.5 x 2.5 x 0.1 - On 4/8/25 the report showed: . 3 x 3.5 x 0.01, scattered wounds - On 5/13/25 the report showed: . scattered wounds - On 6/3/25 the report showed: . scattered wounds-improving <p>Refer to observation on 6/5/25 at 7:10 a.m. for the most current measurements.</p> <p>Review of resident #1's Braden Scale, dated 10/15/24, reflected resident #1 was at high risk for pressure ulcers with a score of 10. A score of 12 or less reflects a High Risk.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to utilize a system for identifying root causes for falls, and failed to develop and implement individualized fall prevention strategies for 1 (#32) of 21 sampled residents. Finding include:</p> <p>During an observation on 6/4/25 at 1:00 p.m., resident #32 was seen ambulating with a walker and accompanied by an unknown staff member. The resident required verbal cues to locate her room.</p> <p>Review of resident #32's nursing progress note, dated 12/11/25, showed the resident sustained an unwitnessed fall in her room. The note failed to show any contributing factors or possible causes for the fall.</p> <p>Review of resident 32's nursing progress note, dated 3/26/25, showed the resident had an unwitnessed fall and was complaining of knee pain. The note failed to show any contributing factors or possible causes for the fall.</p> <p>Review of resident #32's nursing progress note, dated 5/31/25, showed the resident sustained an unwitnessed fall in her room. The note failed to show any contributing factors or possible causes for the fall.</p> <p>Review of resident #32's EHR, accessed on 6/4/25, failed to show any documentation in the available and provided records for the identification of the root causes for the resident's falls.</p> <p>During an interview on 6/4/25 at 10:13 a.m., staff member B stated she felt she needed further training in root cause analysis and had struggled to understand the root cause process.</p> <p>Review of resident #32's At Risk for Fall care plan, dated 2/7/25, showed the resident was at risk for falls and had interventions which included, assist resident with ambulation and transfers, call light available, notify provider if fall occurs, and initiate neurological and bleeding evaluations if a fall occurs. The careplan failed to show interventions reflective of the root cause of the fall on 12/11/25.</p> <p>Review of resident #32's Fall care plan, dated 3/27/25, showed the resident had an actual fall and interventions to monitor for changes for 72 hours and provide activities which promote exercise and strengthening. The careplan failed to show interventions reflective of the root cause of the fall on 3/26/25.</p> <p>Review of resident #32's care plan, dated 5/4/25, showed the resident was at risk for falls and had family and resident education regarding safety, ensure proper footwear, and refer to therapy, as needed, for interventions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Fall Prevention Program, with a revision date 5/14/24, showed the facility had two risk protocols. The low to moderate fall risk protocol identified basic intervention such as limiting clutter, make sure the bed is at it's lowest level and locked, adequate lighting, assistive devices in good repair, and monitoring residents for changes in gait, mobility, and balance. The high risk protocol contained all of the low to moderate risk interventions, increased frequency of rounds, scheduled ambulation or toileting assistance, therapy referrals, and interventions which addressed any unique risk factors.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have policies for dialysis care and management, policies for dialysis transportation, a contract and communication with the dialysis center providing dialysis treatment, and failed to have proper dialysis monitoring of the resident before and after dialysis appointments, for 1 (#207) of 1 sampled resident for dialysis. Findings include:</p> <p>During an observation and interview on 6/4/25 at 8:04 a.m., staff member J stated resident #207 was on dialysis and stated the resident's electronic chart would show orders for the dialysis, and resident #207 went twice a week, leaving at 10:30 a.m. Staff member J pulled up the chart of resident #207, and the orders did not show resident #207 was on dialysis, when he was to go to dialysis, or any monitoring for his dialysis. Staff member J stated she would get the order input into the chart, but knew she added the dialysis information to resident #207's care plan. Staff member J stated the facility did not transport resident #207, there was a non-emergent ambulance service setup prior to his admission. Staff member J stated she was unaware of any communication with the dialysis center or facility monitoring of resident #207 as she was under the impression dialysis managed monitoring for resident #207. Staff member J provided the hard copy chart for resident #207, in which only a form titled, Physician Certification for Ambulance Services, with the dialysis center name and reason for the ambulance transport as hip fracture and dialysis with inability to tolerate sitting up during transport, and it was signed on 5/29/25.</p> <p>During an interview on 6/4/25 at 7:39 a.m., resident #207 was observed in a reclined chair, with a bed sheet over him. Resident #207 stated he was going to dialysis that day. He stated he had been receiving dialysis treatment through a dialysis port. He stated there was transport setup for him before he left the hospital. He did not have food brought with him for lunch from the facility, but he preferred to eat after returning, rather than trying to bring food with him.</p> <p>During an interview on 6/4/25 at 8:42 a.m., NF5 stated resident #207 was going to the dialysis center for a while and had transport figured out prior to his hospital discharge as to not miss a treatment. NF5 stated resident #207 had dialysis three times a week, and dialysis did clinical assessments per their policy, and did pre and post dialysis weights as part of the process. All of the information was documented in their electronic medical records, but he was not aware of anything they sent to the facility.</p> <p>During an interview on 6/5/25 at 10:29 a.m., NF2 stated she was not aware of any policies for the facility on dialysis residents.</p> <p>During an interview on 6/5/25 at 11:04 a.m., staff member B stated the facility had no contract or policies for dialysis and had not been monitoring resident #207 for his pre and post dialysis care. Staff member B stated they admitted resident #207 without realizing they had a lot of missing parts of the process.</p> <p>Review of the entrance conference information provided by the facility, on 6/3/25, showed the facility had no policy for dialysis monitoring and management, no policy on transportation to and from dialysis, and no contract with the dialysis provider.</p> <p>(continued on next page)</p>		

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 06/05/2025
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.			
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #207's electronic medical record and hard copy chart, reviewed on 6/5/25, showed he was admitted on [DATE]. The only weight entered was on his admission day. There were no physician orders for dialysis appointments or monitoring the resident's pre and post dialysis status. There was only a care plan area showing he was on dialysis and a non-emergent transport ambulance service for dialysis.</p> <p>A request was made for the nursing monitoring, completed by the facility, for #207's pre and post dialysis status, since admission, a dialysis and transportation policy, and the dialysis contract was requested on 6/4/25. The items were not provided by the end of the survey.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to maintain proper hand hygiene for 4 (#s 14, 16, 21, and 208) of 7 observed medication passes; failed to maintain cleanable surfaces on floor mats for 2 (#s 1 and 36) of 2 sampled residents with floor mats; failed to maintain clean respiratory equipment for 1 (#36) of 6 sampled residents with respiratory equipment; and failed to properly store tube feeding supply sanitarly for 1 (#1) of 1 sampled resident with tube feeding supplies. These deficient practices had the potential to increase the risk of infections and spread of infections for all residents receiving care. Findings include:</p> <p>1. During an observation on 6/3/25 at 4:10 p.m., staff member E prepared the medications for resident #208. Staff member E entered resident #208's room without completing hand hygiene, began to assist the resident with medications by feeding her the pills with a spoon and giving her drinks of water between. Resident #208 stopped staff member E and stated she wanted the pills in applesauce. Staff member E obtained the applesauce and mixed the pills in the applesauce. Resident #208 then stated she meant to say apple juice. Staff member E then stated water was all she had available, and spoon fed the pills to resident #208. Resident #208 stopped her and said she could not take the larger pills unless they were cut in half. Staff member E exited the room, took the pill cutter out from the top drawer of the cart and put the wet pill in the pill cutter and cut it in half. Staff member E then returned to the room and administered the remaining medication. The pill cutter was not cleaned prior to use and was left on the cart after using. The pill cutter had dust/dirt in the cup holder portion of the pill cutter prior to use by staff member E. Staff member E did not perform hand hygiene when entering or exiting the room to collect the applesauce or cut the pill, and did not perform hand hygiene prior to entering the room at the beginning.</p> <p>2. During an observation on 6/4/25 at 7:33 a.m., staff member D was preparing medications for resident #21, including miconazole cream 2%. Staff member D put on gloves without completing hand hygiene, cleansed under resident #21's breasts with wound cleanser, dried the areas with gauze, and applied miconazole cream 2% to both areas under the breasts. No hand hygiene or glove changes were completed between dirty and clean tasks. Resident #21 then asked staff member D to clean and apply cream to her pannus. Staff member D used her same gloves to clean her pannus and applied cream and degloved. Staff member D then returned to her medication cart and started prepping the next resident's medications without completing hand hygiene.</p> <p>3. During an observation on 6/4/25 at 8:19 a.m., staff member D prepared medications for resident #16, including antifungal powder. During the administration of the powder, staff member D cleansed under resident #16's breasts with wet wash cloth, dried with a towel, and applied the powder. Staff member D then gave the resident a drink of the MiraLAX and stated she should keep working on drinking the MiraLAX. Staff member D degloved, gave a remaining pill in a cup to the resident by spoon and another drink. Staff member D took the dirty washcloth and towel and placed them on the food tray, left the room, placed the dirty linens in the dirty linen bin and took the tray to the food cart for return to the kitchen. Staff member D then walked to the other end of the hall to the nutrition room of the unit and washed her hands. Staff member D stated she washed her hands in the nutrition room because it was the only place to wash her hands on the unit. No hand hygiene was completed between dirty and clean tasks.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an observation on 6/4/25 at 8:43 a.m., staff member D prepared medication for resident #14, including teriparatide Pen 620 mcg-20 mcg and muscle rub cream 10-15% for the neck/shoulder. Staff member D put on gloves without completing hand hygiene, gave the injection and applied muscle rub, and degloved. Staff member D then left the room and carried the injection pen down to the medication room, then placed the pen in the refrigerator. Staff member D then returned to her medication cart and started to prep the next resident's medication. No hand hygiene was completed before or after gloving/degloving or when exiting the room.</p> <p>A review of staff member D's education file showed no hand hygiene education was located in the file.</p> <p>5. During an observation on 6/2/25 at 2:44 p.m., a bottle of tube feeding was found in the open cupboard of resident #1's room, and it had a thick chunky layer over a black liquid layer, separated from the rest of the liquid in the bottle. The bottle appeared unopened but it was unable to tell if the bottle had a rupture or leaked. The other bottles in the cupboard, the cupboard walls, and door, had dried thick areas of tube feeding liquid (dark creamy color) and was sticky.</p> <p>6. During an observation on 6/2/25 at 2:27 p.m., a suction machine was observed in the room of resident #36. The suction machine canister was 2/3 full of a white milky liquid, with a thick hardened crust around the top.</p> <p>7. During an observation on 6/2/25 at 2:47 p.m., the floor mat was next to the bed while resident #1 was sleeping. Staff member C stated resident #1 often would slide out of bed. The floor mat was cracked, dirty, had chunks missing at the corners and was not cleanable. There was a furry layer over the top from the mat top coming apart.</p> <p>During an interview on 6/3/25 at 2:52 p.m., staff member C stated the floor mats were not cleanable, and the cabinet was not cleaned. Staff member C stated he did not understand why the floor staff were not cleaning the cupboard when they saw the mess or when they used the suction machine. Staff member C stated the facility was aware the floor mats were not cleanable but had not addressed them as a priority. Staff member C stated resident #1 had a seizure the previous week and suction was used at that time, and the staff should have cleaned the canister afterwards.</p> <p>Review of the facility's policy, Hand Hygiene, dated 5/21/24, reflected:</p> <ul style="list-style-type: none"> - . Hand Hygiene Table: - . Between resident contacts. - . Before applying and after removing personal protective equipment, including gloves. - . Before preparing or handling medications; and - . When, during resident care, moving from a contaminated body site to a clean body site. <p>A request was made for a policy specific to intermittent suctioning and equipment maintenance of the suction equipment, but the facility did not have one.</p>		