STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER COUNTY CARE AND REHABILITATION CENTER	**1157 HIGHWAY 17 TUSCUMBIA, MO 65082**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility staff failed to follow infection control protocols for Covid 19 when staff did not wear face mask at all times while in the facility. Then census was 53. Review of the Centers for Disease Control and Prevention (CDC) recommendation dated 5/21/20, showed in order to prevent the spread of COVID-19, facility staff are to ensure all healthcare personnel (HCP) wear a facemask or cloth face covering for source control while in the facility. Additionally, HCP includes, but are not limited to emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). 1. Observation on 05/20/20 at 09:44 A.M., showed the maintenance person wore his/her mask around his/her neck. He/She did not properly place the face mask over his/her face while in the residential hallways. 2. Observation on 05/20/20 at 10:12 A.M., showed the dietary supervisor did not wear a face mask while he/she worked in the kitchen and while he/she prepared the residents' meals. 3. During an interview on 05/20/20 at 10:18 A.M., the dietary supervisor said kitchen staff are only required to wear masks in residential areas and do not have to wear them in the kitchen while preparing food. 4. During an interview on 05/20/20 at 12:00 P.M., the administrator said kitchen staff used face masks at first and switched to different types because they were hot. She said staff do not wear face mask in the kitchen because they were told they didn't have to anymore.

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.