STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265410	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BENTONVIEW PARK HEALTH & REHABILITATION	**410 WEST BENTON STREET MONETT, MO 65708**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement proper infection control practices to prevent the spread of the the coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2)) pandemic when staff failed to assure measures were in place to promote social distancing of residents in the Special Care Unit (SCU - a memory care unit) television room and failed to clean and sanitize cotton gait belts (an assistive device which can be used to help safely move a person to and from the bed or wheelchair) to reduce the possible spread of infection. The facility census was 70. 1. Record review of the COVID-19 CDC guideline titled, Infection Prevention and Control (IPC) Guidance for Memory Care Units, reviewed on 5/12/20, included the following: -Limit the number of residents or space residents at least six feet apart as much as feasible when in a common area; -Gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. Record review of facility's COVID-19 Social Distancing Policy, dated 2019, showed the following: -Stay at least six feet (about two arm's length) from other people; -Do not gather in groups; -Stay out of crowded places and avoid mass gatherings. Observation in the SCU on 6/5/20, at 10:15 A.M. and 10:25 A.M., showed the following: -The facility used a standard room as a television room for residents; -Along one wall, opposite of the television, was a recliner, a standard-sized couch, a dining chair and a green leather chair. The furniture either touched or was positioned a few inches apart; -Two residents sat on opposite ends of the couch, one resident sat on the left side and one resident partially laid on the right side. One resident sat in the recliner and one resident sat in the green chair; -The four residents sitting on the furniture were not six feet apart from each other and they did not wear masks. Staff did not attempt to redirect the residents; -Two residents stood in the room within six feet of each other while a staff member talked to the resident in the recliner. Staff did not attempt to redirect the residents to social distance. During an interview on 6/5/20, at 10:26 A.M., Certified Nursing Assistant (CNA) C said the following: -Residents gathered in the television area; -The furniture was not setup for social distancing. During an interview on 6/5/20, at 10:45 A.M., CNA D said the following: -The residents who resided in the SCU did not like to stay in their rooms and would not wear a mask; -Residents usually went to the television room or dining room; -The residents were not six feet apart in the television room; -He/she did not remind the residents to separate six feet apart, that morning; -The television room was not setup for social distancing. During an interview on 6/5/20, at 11:10 A.M., Licensed Practical Nurse (LPN) E said the following: -Staff did not offer masks to residents who resided in the SCU; -Residents did not practice social distancing in the television room; -Staff should position the furniture for social distancing. During an interview on 6/5/20, at 1:04 P.M., the DON said the following: -To abide by social-distancing rules, residents should be at least six feet apart; -Expected staff to remind the residents nicely to social distance; -On the SCU, some of the residents did not know how to socially distance; -The television room was not setup for social distancing. During an interview on 6/5/20, at 1:32 P.M., the Interim Administrator said the following: -Social-distancing was 6 feet apart; -Staff tried to encourage residents to remain six feet apart; -Staff encouraged residents to wear a mask on the SCU; -The television room on the SCU was not setup for social distancing; -Staff attended in-services on social distancing. 2. Record review of the COVID-19 CDC guideline, reviewed on 5/12/20, included the following: -Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19; -All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. Record review of the facility's Gait Belt Policy and Procedures, dated July 2013, showed no instructions for staff to wash or disinfect gait belts between residents after use. Record review of the facility's COVID-19 guideline titled Gait Belt Policy, undated, included the following information: -Gait belts are not to be shared between isolation residents at any time; -Proper sanitation of the gait belt to be done prior to exiting a resident's room who is in isolation; -Gait belt to be sanitized between use of each resident not residing in isolation. Observation and interview on 6/5/20, at 11:00 A.M., showed the following: -Physical Therapist (PT) A cleaned a cloth gait belt with a bleach wipe, and then sanitized his/her hands; -PT A said staff cleaned gait belts with a bleach wipe and allowed it to dry between each resident. Observation and interview on 6/5/20, at 11:35 A.M., showed the following: -After using a cloth gait belt on a resident, Licensed Practical Nurse (LPN) B fastened it around his/her waist. The LPN did not clean or sanitize the gait belt after resident use; -LPN B said staff used their gait belts on multiple residents during the shift. He/she washed his/her gait belt with his/her regular laundry at night rather than cleaning or disinfecting between residents. During an interview on 6/5/20, at 1:04 P.M., the DON said: -Gait belts were either facility or individually owned; -Staff applied a kill spray and allowed it to dry for five minutes between residents; -Gait belts were everywhere, which allowed staff to use a clean one while the other dried; -The DON did not know how staff cleaned their own individually owned gait belts, but thought they laundered it daily. During an interview on 6/5/20, at 1:30 P.M., the Administrator said: -The facility provided gait belts for staff, but some staff brought their own; -Staff were in-serviced upon hire for appropriate use and cleaning of gait belts; -Staff should wipe gait belts with Clorox bleach wipes between non-isolated residents; -Residents in isolation should have their own gait belt.

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