STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	**04/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE VIEW SENIOR LIVING	**250 FIFTH STREET EAST TRACY, MN 56175**

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to cancel group activities and ensure employees were actively screened at the point of entry for symptoms of COVID-19 according to Centers for Disease Control (CDC) and Centers for Medicare and medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 42 residents. Finding include Observation and interview on 4/6/20 at 12:10 a.m., with the social service director (S) identified the main entrance of the facilty for was used for visitors and the south entry door for staff. All staff were to go to the nurses station to be screened. The nurses station was located in the central area of the facilty next to the dining area and day room. 14 residents were seated at dining tables for lunch. 1 resident was being assisted with eating. The facilty had not discontinued group activites but tried to limit group activities to less than 10 residnets at at time while [MEDICATION NAME] social distancing. Observation on 4/6/20 at 1:30 p.m., of the south entrance identified the exterior door opened to a short corridor. A time clock was located on the wall outside the kitchen. That corridor led to the dining area. The dining area was central to the building and was adjacent to the main entrance, the TV area, and the nurse station. Observation on 4/6/20 at 2:25 p.m., dietary assistant (DA)-a entered the facility through the designated doorway and walked to the nurse station. DA-A took his own temperature and recorded the information on the staff COVID-19 screening sheet and proceeded to the kitchen to begin his shift. Interview on 4/6/20 at 2:25 p.m., with the director of nursing (DON) identified staff were expected to have the nurse screen actively staff for symptoms of COVID-19 at the start of the shift. No formal audits had been completed to identify if the screening process was being followed by staff. Observation on 4/6/20 2:30 p.m., identified 10 residents were seated throughout the dining tables in the dining room, and TV area playing BINGO. Interview with the administrator on 4/6/20, at 3:20 p.m. identified he received CMS memos and was aware of the guideline to cancel all group activities and actively screen staff at the point of entry. The facilty had not canceled group activities at the present time to have less disruption to their daily routines, however, group activities were to be limited to 10 residents to ensure they were socially distanced. Review of the 3/19/20, COVID-19 Employee Screening guidelines identified all employees were to be screened for fever and acute respiratory illness prior to clocking in for their shifts by a team member. There was no mention that was to occur at the point of entry. Review of the 3/19/20, New Updates on the COVID-19 Procedures policy identified group activites were to be limited to 10 residents and were to be spaced six feet apart. There was no indication the policy had been updated in accordance with CDC and CMS guidance to cancel all group activities.

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