STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	**04/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

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 implement appropriate infection control practices related conducting employee and visitor health screenings immediately upon entrance to the facility, and ensuring appropriate social distancing was maintained according to current COVID19 federal and state government guidelines. These practices had the potential to affect all 26 residents who resided in the facility including all facility staff. Findings include: On 3/31/20, at 2:30 p.m. the facility's front, west entrance door was locked. Upon entrance, the greeting staff member did not request nor attempt to conduct a health screening of the State surveyor which would have included checking a temperature, asking and observing for signs/symptoms of illness including the novel [MEDICAL CONDITION] (Covid19). In addition, there was no thermometer in the entrance screening area. Without conducting a health screening, the staff member escorted the surveyor to a room which was located down the North wing hallway where nine residents residents. At 2:45 p.m. a staff member entered the room and requested to check the surveyor's temperature. -At 3:00 p.m. activity director (AA)-A stated visitors entered the facility through the West entrance and the staff entered the through the East door. Upon observation of the East entrance, there were no screening tools in the area in order to screen employees upon entrance. AA-A stated the staff entered through the East door and walked down to nurse's station which was through the East hallway and past nine resident rooms, to be screened prior to starting their shift. AA-A also stated the facility continued to conduct group activities such as bingo in the dining room, but were only allowing one resident to a table and limiting the group to ten residents. -At 3:15 p.m. the South resident unit was observed to be open to the Sun room sitting area which also adjoined the assisted living apartments/units (ALF). The ALF was also open to the sun room. Both the ALF tenants and the nursing home residents had free access to this area. At this time, an ALF tenant was observed seated in the sun room. -At 3:22 p.m. the director of nursing (DON) stated there were no restrictions currently in place related to the ALF tenants entering the nursing home and that after leaving the ALF, the tenants were not able to get back in through the ALF doors because they were locked to restrict visitors, therefore the ALF tenants needed to come through the nursing home in order to re-enter the ALF building. The DON confirmed this required the ALF tenants to walk though the South resident unit of the facility where eight residents resided. The DON stated the facility was not actively screening any of the ALF tenants who entered the nursing home. -At 3:30 p.m. trained medicaiton aid (TMA)-A verified the staff entered the building through the East door and had to walk to the nurse's station, through a resident unit, to have their temperature checked and health screening questions completed prior to starting their shift. Shortly there-after, eight residents were observed seated in the lobby near the nurse's station. One female resident was seated on a love seat against the wall facing the lobby and another female resident was seated in her wheelchair directly on the left side of the love seat. The residents elbows were nearly touching each others. At the same time, several staff members had walked through and past the lobby and had made no attempt to socially distance the two residents. -At 4:30 p.m. the DON confirmed the staff entered through the East door and walked through a resident unit in order to get to the nurse's station to be screened for symptoms. The DON stated the facility did not have enough staff to conduct the screenings immediately upon entrance through the East door, and prior to walking through the facility. The DON stated they had been screening staff through the adjoining hospital's emergency department, but the emergency room staff felt there was too much traffic through the hospital and had requested the facility to manage their own staff screening. The DON stated she would try to set up a self screening station at the East entrance for staff to screen before they entered the facility. In addition. the DON confirmed the two residents observed in the lobby had not maintained the required six feet separation of each other. The DON stated she thought the staff were doing a pretty good job of helping the residents maintain social distancing, but there were a few independent residents that did not understand the concept of the need for separation and she felt the staff doing what they could to ensure safe distancing was maintained. -At 5:15 p.m. residents were observed seated one to a table in the dining room maintaining six foot distancing of each other. -At 5:20 p.m. a male resident was observed seated in a wheelchair, with his eyes closed, just left of the dining room entrance/exit area. A female resident was attempting to exit the dining room at the same time as a male resident who was ambulating with his walker, was trying to enter the dining room. All three residents were observed to be approximately two feet apart from each other. The female resident conversed with the ambulatory male resident for several minutes before she continued to exit the dining room and wheeled herself to her room. The male resident continued to ambulate into the dining room and seated himself. Staff were not observed to provide verbal reminders/cues to maintain a safe distance apart from each other. The facility's health screening log was reviewed and revealed the staff had their temperature checked and were screened for shortness of breath, cough, and sore throat. The facility's Emerging Threats-Acute Respiratory Syndromes Coronavirus policy dated 3/13/20, indicated points of entry would be limited, visitor restrictions would be enforced, and the Center for Disease Control (CDC) guidelines and recommendations at that time would be followed. A policy regarding Employee Screening was requested, although not provided.

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