STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265394	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JORDAN CREEK NURSING & REHAB	**910 SOUTH WEST AVE SPRINGFIELD, MO 65802**

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 failed to maintain an effective infection control and prevention program by not assisting 13 out of 15 residents with appropriate 6 feet social distancing as per the COVID-19 Center for Disease Control and Prevention (CDC) guidelines. These residents resided in the special care unit (SCU - a memory care unit). The facility census was 84. 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 6 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 the COVID-19 Focused Survey for Nursing Homes assessment completed by the facility on 4/6/20 showed the facility stopped resident communal dining on 3/16/20. 1. Observation in the SCU on 5/20/20, at 11:55 A.M., showed: -Two staff, Certified Nursing Assistant (CNA) A and CNA B, assisted residents to the dining room and seated the residents at tables with other residents; -CNA A and CNA B served lunch to the residents. They did not attempt to socially distance any of the residents from one another; -Thirteen residents sat at four square tables in the SCU dining room; -Four residents sat at one table and three residents sat at each of the three other tables; -Residents at the same tables sat approximately 18 inches to 2 feet away from one another throughout the meal; -One resident sat in a chair with an over-the-bed table in front of him/her, next to one of the tables of residents. During an interview on 5/20/20, at 12:04 P.M., CNA A said the following: -The facility did not give the CNA any specific instruction on socially distancing residents in the SCU from one another; -Social distancing of residents in the SCU was not feasible and the residents could not follow social distancing directions; -All SCU residents were served meals at the same time in the SCU dining room. During an interview on 5/20/20, at 12:05 P.M., CNA B said the following: -Staff served meals to all of the SCU residents at the same time in the SCU dining room; -Staff cleaned the dining room tables and chairs before and after meals with disinfectant. During an interview on 5/20/20, at 12:10 P.M., Certified Medication Technician (CMT) C said the following: -He/she administered medications to the residents in the SCU. -All of the SCU residents ate meals in the dining room at the same time. -Staff could not separate the residents during meals. During an interview on 5/20/20, at 12:35 P.M., Licensed Practical Nurse (LPN) D said the following: -The SCU staff had one meal-time for all residents. -The LPN did not know how the staff could separate the residents in the SCU. -Staff tried not to break the routine of dementia residents. Observation in the SCU living room on 5/20/20, at 12:40 P.M., showed: -Four residents sat in chairs next to one another, three residents sat in recliners and one resident sat in a wheelchair. -Each resident sat within one foot of the resident adjacent to him/her. -CNA B entered the living room, but did not attempt to separate or distance any of the four residents from one another. During an interview on 5/20/20, at 12:45 P.M., the Director of Nursing said the following: -The facility educated staff to place residents six feet apart. -The residents in the SCU could not retain information about social distancing due to their dementia diagnoses. -Some of the residents in the SCU were ambulatory, and staff tried to redirect them. -Staff should seat a minimal number of residents in the dining room at one time. -The facility's goal was to maintain a six feet distance between residents, whenever possible. -Beginning on 5/18/20, the DON asked staff to read and sign the COVID-19 Focused Survey for Nursing Homes assessment. During an interview on 5/20/20 at 1:15 P.M., the administrator said the following: -The facility tried staggering the residents coming into the SCU dining room and tried spacing the residents out at separate dining tables.

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