STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING _____ B. WING _____	**04/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY MANOR HEALTH & REHAB CTR	**520 FIRST STREET NORTHEAST SARTELL, MN 56377**

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 ensure all staff received education regarding infection control practices, including following precautions and using personal protective equipment (PPE) during [MEDICAL CONDITION] (COVID-19) outbreak, in accordance with Centers for Disease Control (CDC) guidelines, for 1 of 2 residents (R1) reviewed, in contact and droplet precautions. This had the potential to affect all 152 residents residing in the facility. Findings include: R1 was admitted to the facility on [DATE] following hospitalization for pneumonia with an unspecified organism and acute [MEDICAL CONDITION]. During the entrance conference on 4/7/20 at 9:45 a.m. registered nurse (RN)-A reported, due to R1's discharge from a hospital and diagnosis, and due to the current COVID 19 pandemic, R1 was placed in contact (wearing gloves and gown when entering room) and droplet (wearing mask and eye protection when entering room) precautions upon admission to the facility. During an observation on 4/7/20, at 11:46 a.m. R1's room door was open, and on the door, was a small dark sign, directing, Before entering resident's room, please check with the nurse. A plastic bin, with three drawers, had been placed beside R1's door and contained PPE. A sign on top of the bin directed anyone entering the room, to don PPE, with pictures to show what PPE was required and how to put it on. Information technology (IT)-A, wearing a mask, approached R1's room, knocked on the open door, announced he needed to check something in the bathroom, and without donning PPE, entered R1's room. R1 stated, What? three times, and then asked IT-A to come closer because she couldn't hear him. IT-A walked to within two feet of R1, and bent down with his face close to her ear, and again stated he was there to check something in the bathroom. IT-A walked to the closed bathroom door, turned the handle with an ungloved hand, and entered R1's bathroom. The bathroom door closed and after a few moments, IT-A opened the bathroom door by the handle, and walked to exit R1's room into the hallway. IT-A was immediately stopped by surveyor and RN-A was summoned. On 4/7/20, at 11:50 a.m. IT-A stated he did not notice the sign on the door and was not aware that he shouldn't have entered R1's room without donning PPE. During an interview on 4/7/20, at 11:52 a.m. RN-A stated all staff should have completed mandatory training and staff should not enter rooms of residents that have precautions without donning PPE as directed. RN-A stated she did not know if IT-A completed the training. During a telephone interview on 4/8/20, at 11:21 a.m. RN-A, the director of nursing, and the vice president, indicated IT-A did not attend the mandatory training offered 3/10/20, however, has now completed the training. Review of the facility's undated policy, Management of Suspected or Confirmed [MEDICAL CONDITION] (COVID-19), included, All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements.

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