STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265696	A. BUILDING _____ B. WING _____	04/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLVIEW NURSING & REHAB	220 O'ROURKE DRIVE, PO BOX 1310 PLATTE CITY, MO 64079

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 record review the facility failed to monitor staff/visitors' body temperatures during screening for COVID-19 prior to entering the facility. This had the potential to affect all 63 residents and staff in the facility. The facility failed to monitor social distancing for 28 residents housed on the secured Academy unit. The residents residing on the unit were younger adults that received behavioral health services through a Life Skills program. The census included 63 residents. Findings include: The facility utilized the COVID-19 Screening Tool to screen every person prior to entering the facility. The screening tool contained multiple questions related to potential COVID-19 exposure outside the facility. The tool included checking the person's current body temperature to ensure the person did not have a fever and to ensure their body temperature had not been 100.4 degrees Fahrenheit (F) or greater in the last 14 days. Record review of the tool revealed that from 3/28/20 to 4/7/20 the facility failed to record the body temperature for persons entering the facility 22 times. Observation on 4/9/120 at 11:19am, Nurse Aide (NA1) sat behind the nurse's station on the secured unit. Three residents' gathered at the nurses' station waiting on each other to sign an activity form and were not [MEDICATION NAME] social distancing. NA1 did not discourage or educate the residents in regards to social distancing. At this time NA1 indicated the residents had been educated on social distancing prior and they were aware they were not supposed to gather too closely. NA1 indicated there was a taped line on the floor and the residents were supposed to stand behind the line when another resident was at the nurses' station. NA1 agreed she did not instruct the residents to do so. On 4/9/20 at 12:10pm, observation in the secured unit dining room revealed two staff members passing meal trays to residents. Three residents sat at one table together and were not [MEDICATION NAME] social distancing. Staff did not attempt to educate or separate the residents for social distancing. At 12:28pm four residents gathered in the hallway, one resident sat on the floor while three residents stood close together and visited with each other without [MEDICATION NAME] social distancing to maintain 6' distance from each other. Registered Nurse (RN1) walked past the hall but did not attempt to educate or encourage the residents from gathering closely to other residents. On 4/9/20 at 12:40pm, NA2 indicated the residents on the unit were educated on social distancing, often congregated while in the halls and during dining but it was their right not to practice social distancing. NA1 indicated the three residents always sat together during dining and the facility had not attempted any other means of dining to maintain social distancing. NA1 indicated residents often congregated in the halls and staff were to remind them of the social distancing. During an interview on 4/9/20 at 3:45pm, the Nurse Consultant, Director of Nursing (DON), and Administrator indicated the temperatures were to be checked and recorded on the tool to ensure the person did not currently have a body temperature or a history of body temperature above 100.4 F in the last 14 days. They indicated the residents received education related to social distancing while smoking, during dining, and gathering in the halls, but had not attempted any other alternatives to ensure residents maintained social distancing.

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