STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365269	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY COURT	1076 COSHOCTON AVE MOUNT VERNON, OH 43050

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], The Department of Health and Human Services, Center for Medicare and Medicaid (CMS) Memo QSO ,[DATE]-ALL, dated [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), record reviews, review of a facility investigation timeline, review of facility policy and procedures, observations and interviews with staff, the facility failed to implement effective and recommended infection control practices including adequate implementation of personal protective equipment (PPE) to prevent the transmission of COVID-19 in the facility. This resulted in Immediate Jeopardy when Resident #44 was re-admitted to the facility on [DATE] from the hospital and staff did not use appropriate PPE per CDC guidelines while the resident was on quarantine guidelines. Actual harm occurred when staff did not implement the appropriate infection control practices during care of Resident #44 who resided on Unit #1 (non-COVID unit) and tested positive for COVID-19. Residents #11, #18, #21, #35, #46, #48, #53, #56, #60 and #63, who also resided on Unit #1 subsequently tested positive for COVID-19. Residents #48, #60 and #63 were hospitalized due to complications related to COVID-19. Resident #60 expired in the hospital on [DATE] but had not been tested . Resident #11 expired in the facility on [DATE] as a result of COVID-19 complications. Three additional residents, Residents #20, #30 and #61, who resided on other units were also hospitalized due to COVID-19 complications. During the survey on [DATE] and [DATE], the facility had 26 of 59 residents (Residents #2, #7, #8, #12, #15, #16, #18, #20, #21, #23, #29, #32, #34, #35, #36, #44, #46, #48, #53, #55, #56, #60, #61, #62, #63, and #64) who also tested positive for COVID-19 as a result of the facility not implementing and/or following appropriate quarantine measures and not utilizing proper PPE when caring for these residents. Observations on [DATE] at 12:43 P.M. during the facility tour determined inadequate infection control practices including a staff member, Licensed Practical Nurse (LPN) #19, who was observed with a surgical mask over the N95 mask. She exited the room of Resident #30 who was exhibiting symptoms of COVID-19, wearing the same PPE she had worn in that room and she was observed passing the next meal tray to Resident #22. Resident #30 was subsequently hospitalized with a positive COVID-19 diagnosis. This finding had the potential to affect all 35 residents in the facility residing on Units #2 and #3 including Residents #1, #3, #4, #6, #9, #10, #13, #14, #17, #19, #22, #24, #25, #26, #27, #28, #31, #33, #37, #38, #39, #40, #41, #42, #43, #45, #47, #49, #50, #51, #52, #54, #57, #58, #59. Additional staff interviews on [DATE] at 5:39 P.M. confirmed COVID-19 test results were obtained for ten additional residents on the non-COVID unit including Residents #13, #17, #19, #25, #30, #40, #50, #51, #52 and #59. Residents #17, #19, #40, #50, #51 and #59 were positive for COVID-19 and moved to the COVID unit on [DATE]. Once a COVID-19 unit was established, staff were observed exiting the unit without removing PPE worn in the unit. On [DATE] at 4:36 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when Resident #44 was readmitted to her room on Unit #1 and was placed in quarantine or shelter in place precautions. Facility staff caring for Resident #44 did not utilize the appropriate full PPE, including an N95 mask, goggles/face shield, gown and gloves during provision of care and then provided care for other residents in the facility. Ten additional residents on Unit #1 subsequently tested positive for COVID-19. A total of twenty-seven residents tested positive for COVID-19, six residents were hospitalized with complications related to COVID-19, one resident expired in the hospital and one resident expired in the facility with complications related to COVID-19. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction action: On [DATE], all staff in the facility were tested by the National Guard for COVID-19. The results were not obtained until [DATE]. Twelve staff members tested positive for COVID-19. On [DATE], the facility developed a COVID-19 unit utilizing resident Rooms #105 to #114. The unit was separated from the other facility areas by fire doors which were closed. The donning and doffing station for the unit was located at the front entrance. On [DATE], the COVID-19 unit was expanded to include resident Rooms #105-#,[DATE]. On [DATE] the DON placed signs on the second set of doors at the back of the of the COVID-19 unit for staff to not use these doors and the sign indicated, NOT AN EXIT. Only one entrance and exit were to be used by the donning and doffing room. On [DATE] and [DATE], 28 additional residents were tested for COVID-19. All tests were sent to the local health department. Ten of the residents tested had signs and symptoms of COVID-19. Those residents were placed on transmission-based precautions. On [DATE], Registered Nurse (RN) #20 and Licensed Practical Nurse (LPN) #57 began COVID-19 testing for all residents residing on Units #2 and #3, the two non-COVID units. As of [DATE] six additional residents tested positive for COVID-19 including Residents #17, #19, #40, #50, #51 and #59. On [DATE], the Medical Director contacted the DON and was updated on the COVID-19 status of residents and development of the COVID-19 unit along with policy and procedures for appropriate use of PPE. On this same date, the Medical Director (MD) did rounds with the DON and recommended testing all remaining residents in the facility who had not been tested for COVID-19. He also recommended additional staff education on use of PPE and signs and symptoms of COVID-19. An audit was completed on [DATE] by the DON of all resident rooms to ensure compliance of PPE outside of resident rooms and signs on doors indicating the use of PPE on the doors. At this time, all residents in precautions or quarantine status, but not COVID-19 positive, were moved to Unit #3. All residents COVID-19 positive were moved to Unit #1 and all other residents were moved to or remained on Unit #2. As of [DATE], all facility staff were required to wear full PPE in house, which included N95 masks, eye coverings, gowns and gloves, regardless of where they were working. This procedure would continue until the facility had no COVID-19 positive residents. Staff would continue to be screened each shift. On [DATE], the facility implemented new policy and procedures regarding the use of transmission -based precautions and infection control titled, COVID Positive Residents: Screening and Management and COVID-19 Infection Control - Staff and COVID-19 Return to Work. The DON or Infection Control/Designee began in-servicing all staff on [DATE] on appropriate infection control including the procedure for donning and doffing PPE and the above new policies and procedures, including quarantine procedures, use of PPE on various units and entering and exiting the dedicated COVID-19 unit. In-servicing would be completed by [DATE]. Staff not in-serviced by that date would not be permitted to work until in-servicing was completed. On [DATE] the DON in-serviced four STNAs, three LPNs, one housekeeper, one cook and one dietary aide. On [DATE] the DON in-serviced two LPNs, one RN, one housekeeper and the Activity Director. The DON confirmed the in-services were ongoing. The DON confirmed on [DATE] the Local Health Department was aware of the additional six residents who tested positive for COVID-19 including Residents #17, #19, #40, #50, #51 and #59. The DON and Administrator were in-serviced by the Corporate Clinical Nurse on [DATE] on the need to ensure that all residents in the facility would be placed on droplet precautions in accordance with the facility policy. The DON or infection preventionist or designee would conduct daily observations of staff on all units to ensure staff were using PPE appropriately, donning and doffing appropriately and disposing of PPE appropriately. The observations would be performed for the next four weeks. The DON and infection preventionist would monitor all newly diagnosed residents and newly admitted residents or readmitted residents to ensure they were placed in the appropriate transmission-based precautions according to their diagnosis. On [DATE], interview with the DON at 3:38 P.M. verified all staff in-services had been completed this day at 3:00 P.M. The Quality Assurance and Performance Improvement

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) (QAPI) committee would review the plan by [DATE] and revise the plan as needed Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the CDC guidelines for Nursing Homes and Long-Term Care Facilities revised [DATE] confirmed for new admissions and readmissions whose COVID-19 status was unknown, Health Care Providers (HCP) should wear an N95 or higher-level respirator, eye protection including goggles or a face shield that covers the front and sides of the face, gloves and a gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for fourteen days after their admission. Review of the Levering Management Policy for Caring for a Patient with Suspected Coronavirus Infection Control Preparedness Plan form dated [DATE] confirmed staff were to maintain adherence to standard, contact and airborne precautions including the use of eye protection when caring for COVID residents. Review of Resident #44's undated facility timeline authored by the DON indicated on [DATE] the resident developed severe abdominal pain and was sent to the emergency room for evaluation and treatment. The resident had a cholecystectomy (gallbladder removal) and returned to the facility on [DATE] on a Level #1 protocol. A Level #1 surveillance protocol was for any resident that went out of the facility and returned with no known exposure to COVID-19. The facility also called a Level 1, a shelter in place status (quarantine). PPE included a surgical mask and gloves anytime a HCP entered the room with handwashing required after leaving the room and changing the surgical mask when leaving the room. Resident #44 was placed in her previous room on Unit #1(general population) upon return to the facility, without a roommate, and was placed on Level #1 precautions for fourteen days. The facility did not have a COVID unit set-up at that time. The facility's undated timeline indicated on [DATE], Resident #44 was tested for COVID-19 at the community hospital for preparation for an upcoming surgery on [DATE] for a nasal polyp removal. On [DATE] at approximately 12:30 P.M., the DON received a phone call from the local health department confirming Resident #44 was positive for COVID-19. On [DATE], Resident #44 was placed on Level #4 protocol which indicated the resident had tested positive for COVID-19 but was asymptomatic. Resident #44 had exhibited no symptoms up to this point and PPE involved a head cover, goggles or face shield, N95 mask, gown and shoe covers for any HCP entering her room. Staff removed the PPE at the door to her room and COVID-19 assessments were completed every four hours on the resident including monitoring of vital signs. Observation on [DATE] at 8:20 A.M. with the DON in attendance, and subsequent interview with LPN #21, revealed LPN #21 exited the COVID-19 unit through the back door wearing a mask, gown, face shield, and gloves and went onto Unit #3 (a non-COVID unit). At the time of the observation, the DON indicated the COVID-19 unit had two doorways, one at each end of the unit, but only the main entrance was to be used to enter and exit the unit. The back door was not to be used, though it was connected to the rest of the facility (the facility was shaped as a square). The DON indicated there were no donning/doffing PPE stations at the back door of the unit, it was only at the front entrance of the unit. LPN #21 confirmed she had worn the same PPE into the non-COVID-19 unit that she was wearing in the COVID-19 unit. LPN #21 also verified there were no PPE don/doff station at the back door where she exited the unit. She said she had doffed her COVID contaminated PPE on the COVID-19 unit in resident room [ROOM NUMBER]. She then donned new PPE outside of room [ROOM NUMBER] and exited the back door of the unit, after walking past resident Rooms #123, #124, #125, #126, and #127 onto Unit #3 (a non-COVID unit). After confirmation, LPN #21 removed her contaminated PPE in Resident #59's room and donned new PPE. Resident #59 later tested positive for COVID-19 on [DATE] at 9:19 A.M. Interview on [DATE] at 10:29 A.M. with Registered Nurse (RN) #15 revealed staff would constantly use the back door of the COVID-19 unit as a shortcut to move medications and papers but she did not specify where the staff would doff and don PPE. She stated the staff were doing this until [DATE], when they were instructed not to. She further stated that during Resident #44's quarantine that started [DATE], she remembered staff wearing masks, gown and gloves into the resident's room. Interview on [DATE] at 9:19 A.M. with RN #27 revealed she did not know staff could not use the back door of the COVID-19 unit as a shortcut until [DATE] when she was instructed not to use it. Interview on [DATE] at 9:30 A.M. with RN #25 revealed when Resident #44 was first quarantined, after her readmission to the facility on [DATE], the staff were only required to wear a mask and gloves for protection. She said they weren't required to wear a gown until a few days later. She did not mention the use of any other PPE used during the resident's quarantine period. Interview on [DATE] at 12:28 P.M. with State tested Nursing Assistant (STNA) #37 revealed when she worked with Resident #44 during the 14-day surveillance period after her readmission to the facility on [DATE], the only PPE she was required to wear was a mask, gown and gloves. Observation on [DATE] at 12:30 P.M. revealed Resident #26 had a white sign on the door which indicated the resident was to shelter in place and a PPE cart was outside the resident's door. The resident's room did not have a sign on the door for staff direction on contact precautions or to see the nurse prior to entering as required, which was confirmed by LPN #19 at that time. Interview on [DATE] at 12:38 P.M. with RN #20 indicated Resident #30 was symptomatic of COVID-19 with symptoms including cough, congestion, low oxygen level and poor appetite. RN #20 verified Resident #30 was to be tested on [DATE]. RN #20 also confirmed Resident #30 had a PPE cart outside the resident's room but did not have a sign on the door for contact precautions as required. Observation on [DATE] at 12:43 P.M. revealed LPN #19 entered Resident 30's room carrying the resident's lunch meal tray. LPN #19 wore a N95 respirator mask covering her mouth and nose with a surgical mask over the top of the respirator mask. She delivered Resident #30's tray, cut up the resident's food, washed her hands and then left the room. The N95 mask and surgical mask were still in place when the nurse exited the room. Interview with LPN #19 at the time of the observation confirmed she should have changed her surgical mask upon exiting the room and should have worn an isolation gown when in the room. LPN #19 confirmed she was not aware the resident was displaying positive COVID-19 symptoms and said if she did, she would have worn the appropriate PPE. LPN #19 also confirmed Resident #30's door did not have a sign confirming the appropriate PPE to be worn during care of the resident. The nurse indicated she was working as a nursing assistant. Interview on [DATE] at 12:55 P.M. with the DON revealed residents who were admitted or readmitted from the hospital prior to the first COVID-19 positive resident should have a shelter in place protocol and staff were to stay six feet from the resident when appropriate, wear gloves and a surgical mask. The DON also indicated as of [DATE], the facility upgraded the policy to include gowns. The DON also indicated staff were supposed to change the surgical masks and gowns when coming out of a shelter in place room, remove gloves and wash their hands. On [DATE] at 1:06 P.M. the DON indicated Resident #44 had dedicated staff beginning [DATE] which included STNA #37, LPN #5 and LPN #17. The DON confirmed after [DATE], the resident no longer had dedicated staff as more positive residents were identified. The DON confirmed Resident #44 went to the hospital on [DATE] and returned to the facility on [DATE] and was put on precautions for fourteen days. The DON revealed staff were required to wear surgical masks and gloves when caring for Resident #44 prior to the confirmed COVID-19 diagnosis. The DON verified Resident #44 was tested for COVID-19 on [DATE] and the results came back on [DATE] which were positive. The DON also confirmed after the facility was aware of the positive results, the staff were required to wear PPE including an N95 mask, gown, gloves, goggles/face shield, shoe covers and should complete COVID-19 assessments, use disposable utensils and disposable meal trays. Interview on [DATE] at 1:30 P.M. with LPN #5 revealed staff had worn just a surgical mask and gloves for caring for Resident #44 when she returned from the hospital and prior to her testing positive for COVID-19. LPN #5 confirmed she was assigned as dedicated staff for Resident #44 until [DATE]. She said then more residents were identified as having COVID-19 on [DATE]. Interview on [DATE] at 2:25 P.M. with the DON confirmed the facility started moving residents to Unit #1, to make a dedicated COVID-19 unit, the morning of [DATE]. The DON verified the COVID-19 unit was not started until the day following confirmation that Resident #44 was positive for COVID-19. The DON confirmed additional residents were tested for COVID-19 and on [DATE] Residents #2, #7, #12, #16, #34, #36, #48 and #61 tested positive. On [DATE], Residents #15, #21, #23, #55 and #57 tested positive. On [DATE], Residents #29, #32, #46, #56 and #60 tested positive. On [DATE], Resident #63 was sent to the hospital for nausea, vomiting, an elevated temperature and shortness of breath and suspected COVID-19. On [DATE], Residents #8, #11, #18, #20, #35 and #53 tested positive and on [DATE] Resident #62 tested positive. The DON confirmed Resident #60 expired in the hospital on [DATE] but he was unable to report what was the actual cause of the resident's death. The DON confirmed STNA #41 was the first staff member who was reported as COVID-19 positive. STNA #41 went to an urgent care on [DATE] and was tested for COVID-19. STNA #41 obtained her positive results on [DATE]. The DON confirmed STNA #41's last date of work was completed on [DATE] and she had worked on Unit #1 with Resident #44. Interview on [DATE] at 2:37 P.M. with STNA #41 confirmed she exhibited symptoms including cold chills, body aches and cough on [DATE] and went to the local emergency room (ER) and was treated for [REDACTED].#41 indicated she did not get better and went back to theER on [DATE] and was tested for COVID-19 which came back positive on [DATE], the same day because the ER had rushed the results. STNA #41 confirmed her last day worked was [DATE] on Unit #1. She said she only wore a surgical mask and gloves when entering Resident #44's room

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) to care for her while she was in quarantine. Interview on [DATE] at 9:56 A.M. with the Medical Director confirmed Resident #44 was the first COVID-19 positive resident in the facility and he did not believe the resident was tested for COVID-19 in the hospital prior to the resident being returned to the facility on [DATE]. The Medical Director also confirmed admissions or readmissions required PPE including an N95 mask, gown, gloves and goggles. The Medical Director confirmed his last visit to see Resident #44 was on [DATE] and he brought his own N95 mask to utilize in the facility. The Medical Director also indicated he strongly suggested the facility test all residents currently residing in the facility for COVID-19. Interview on [DATE] at 1:06 P.M. with the Administrator confirmed on [DATE] when Resident #44 was readmitted to the facility, the facility had approximately 100 N95 masks. The Administrator verified that more N95 masks were purchased on [DATE] and [DATE]. The Administrator said the infection preventionist was on a medical leave the last few weeks and he was unaware of the current CDC guidance in which staff were to wear gown, gloves, N95 masks and goggles for new admissions or readmissions for fourteen days if their COVID-19 status was unknown upon admission or readmission. The Administrator also confirmed all other residents were tested for COVID-19 as of [DATE]. Interviews on [DATE] at 2:04 P.M. with RNs #94 and #95 confirmed they both worked at different facilities and were sharing the role of infection preventionist at this facility. They indicated the infection preventionist at this facility had been gone for approximately three weeks. Both nurses indicated they had visited the facility once since starting in this position, before the first resident tested positive. They indicated neither of them had not been involved in implementing any interventions since Resident #44 was readmitted or since she tested positive. Interview on [DATE] at 5:39 P.M. with LPN #12 confirmed ten residents whose COVID-19 test results were reviewed by the DON on [DATE] at 11:00 P.M. including Residents #17, #19, #40, #50, #51 and #59 who resided on the non-COVID-19 part of the facility had tested positive for COVID-19. Residents #13, #25, #30 and #52 tested negative for COVID-19. The COVID-19 positive residents were not moved to the COVID-19 unit the following day, [DATE]. Interview with the DON on [DATE] at 8:30 A.M. confirmed the facility had not used dedicated staff to care for Resident #44 while she was in her 14-day shelter in place (quarantine) status when she was readmitted on [DATE] until she tested positive on [DATE]. The DON verified the staff on Unit #1 provided care to Resident #44 and the other residents on that unit without wearing the appropriate full PPE. Review of the undated Census Positive Residents form provided by the facility confirmed Resident #44 was tested on [DATE]; Residents #2, #7, #12, #16, #34, #36, #48 and #61 were tested on [DATE]; Residents #15, #21, #23, #55 and #64 were tested on [DATE]; Residents #29, #32, #46, #56, and #60 were tested on [DATE]; Resident #63 was tested on [DATE]; Residents #8, #11, #18, #20, #35 and #53 were tested on [DATE]; and Resident #62 was tested on [DATE]. The facility confirmed all twenty-seven residents tested positive for COVID-19. Further review of the undated Census Positive Residents form revealed Resident #44 who tested positive for COVID-19 on [DATE] resided on Unit #1 and ten other residents who resided on Unit #1 including Residents #11, #18, #21, #35, #46, #48, #53, #56, #60 and #63 have since tested positive for COVID-19. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's Surveillance Observations form dated [DATE] confirmed the resident was on a Level #4 surveillance which confirmed the resident exhibited COVID-19 symptoms and facility staff were to maintain isolation and use PPE. The resident expired in the facility on [DATE] due to complications of COVID-19. Review of Resident #17's medical record revealed the resident was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #17's Surveillance Observations form dated [DATE] at 8:00 P.M. indicated the resident was on Level #2 which indicated the resident had been exposed to a known COVID-19 person. Gloves and masks were required before entering the room. Review of Resident #17's progress note dated [DATE] at 9:38 A.M. indicated a message was left for family and the resident was aware of the positive COVID swab and a room change to the COVID unit. Review of Resident #18's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #18's Surveillance Observations form dated [DATE] indicated the resident was on Level #3 surveillance which confirmed the resident had tested positive for COVID-19 but was not symptomatic. Isolation was to be maintained and PPE used. Review of Resident #19's medical record revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #19's Surveillance Observations form dated [DATE] at 8:00 P.M. indicated the resident was on Level #4 which indicated he had symptoms of COVID-19 and had probably been exposed and was presumed positive. Isolation was to be maintained and PPE used. Review of Resident #19's progress note dated [DATE] at 9:42 A.M. indicated the resident's family was notified of a positive COVID swab and room change to the COVID-19 unit. Review of Resident #20's medical record revealed the resident was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #20's Surveillance Observation form dated [DATE] indicated the resident was on Level #4 surveillance which confirmed the resident exhibited COVID-19 symptoms. Staff were to maintain the resident's isolation and use PPE. Review of Resident #20's progress note dated [DATE] at 2:01 A.M. confirmed the resident was sent to the emergency room for evaluation and treatment on [DATE] for shortness of breath, declining condition. Resident #20 was admitted to the intensive care unit (ICU). The resident returned to the facility on [DATE] and was readmitted to the COVID-19 unit. Review of Resident #21's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #21's Surveillance Observations form dated [DATE] indicated the resident was on Level #3 surveillance which indicated the resident tested positive for COVID-19 but was not symptomatic. Isolation was to be maintained and PPE was to be used. Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #30's Surveillance Observations form dated [DATE] at 08:00 A.M. indicated the resident was on Level #4 surveillance which indicated the resident had symptoms of COVID-19. Isolation was to be maintained and PPE used. Review of Resident #30's progress note dated [DATE] at 9:45 P.M. indicated the nurse received a call and the resident was being admitted to the hospital. The resident had tested positive for COVID-19. Review of Resident #35's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #35's Surveillance Observations form dated [DATE] indicated the resident was on Level #4 surveillance which indicated the resident exhibited COVID-19 symptoms. Isolation was to be maintained and PPE used. Review of Resident #40's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #40's Surveillance Observations form dated [DATE] at 8:00 P.M. indicated the resident was on Level #2 surveillance which indicated the resident had been exposed to a known COVID-19 person. Gloves and masks were required before entering the room. Review of Resident #40's progress note dated [DATE] at 3:28 P.M. indicated the resident's family was notified of a positive COVID swab and the resident's room was changed. Review of Resident #46's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #46's Surveillance Observations form dated [DATE] indicated the resident was on Level #3 surveillance which indicated the resident had tested positive but was not symptomatic. Isolation to be maintained and PPE used. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #48's Surveillance Observations form dated [DATE] revealed the resident was on Level #4 surveillance which indicated the resident exhibited COVID-19 symptoms. Staff were to maintain isolation and use PPE. Review of Resident #48's progress note dated [DATE] at 11:19 A.M. indicated the resident continued to remove his oxygen and the physician was notified. New orders were obtained to send the resident to the emergency room . The resident had not returned to the facility at the time of the survey. Review of Resident #50's medical record revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #50's Surveillance Observations form dated [DATE] at 8:00 P.M. indicated the resident was on Level #2 surveillance as the resident had been exposed to a known COVID-19 person. Gloves and masks were required before entering the room. Review of Resident #50's progress note dated [DATE] at 9:31 A.M. indicated the family was notified of a positive COVID-19 swab and the resident was moved to the COVID-19 unit. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #51's Surveillance Observations form dated [DATE] at 8:00 P.M. indicated the resident was on Level #2 surveillance stating the resident had been exposed to a known COVID person. Gloves and masks were required before entering room. Review of Resident #51's progress note dated [DATE] at 9:26 A.M. indicated the resident's family was notified of a positive COVID swab and the resident was moved to the COVID-19 unit. Review of Resident #53's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #53's Surveillance Observations form dated [DATE] indicated the resident was on Level #4 surveillance which verified the resident exhibited COVID-19 symptoms. Isolation was to be maintained and PPE was to be used. Review of Resident #56's medical record revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #56's Surveillance Observations form dated [DATE] indicated the resident was on Level #3 surveillance indicating the resident tested positive for COVID-19 but was not symptomatic. Isolation was to be maintained and appro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365269	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY COURT	**1076 COSHOCTON AVE MOUNT VERNON, OH 43050**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3)