

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2020
NAME OF PROVIDER OF SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP 525 WEST MAIN STREET MELROSE, MN 56352	
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. Based on interview and document review the facility failed to maintain an infection surveillance program in order to identify any trends and/or potential infectious outbreaks. This had the potential to affect all 54 residents who resided in the facility. Findings include: On 10/8/20, at 1:01 p.m. registered nurse (RN)-A who was the facility's infection preventionist was interviewed. RN-A stated she would send the resident surveillance plan via email. -at approximately 1:15 p.m. received the facility's hand written surveillance for residents for May 2020, via email. The document was hand written. A summary was included. The surveillance for June, July, and August 2020, were requested but not provided. -at 2:28 p.m. RN-A confirmed she did not have infection surveillance for June, July, or August 2020. RN-A stated infection surveillance for residents was last completed for residents in May 2020. The document titled CentraCare Melrose Infection Prevention and Control Program revision date 3/2019. The policy indicated the following: -Have a system for surveillance to identify and prevent communicable disease or infection before being spread to persons in the facility. -The responsible person for the facility Infection Prevention and Control Program would direct and conduct surveillance activities. -Maintain records of infections and communicable disease, along with any incident/follow up actions. -In Long Term Care: routine surveillance of signs and symptoms of illness and/or infection are monitored.		

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.