| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255102 | A. BUILDING _____ B. WING _____ | R 12/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIVERSICARE OF RIPLEY** | **101 CUNNINGHAM DR RIPLEY, MS 38663** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>The State Agency (SA) conducted post-certification revisit for infection control with deficiency F- 880, related to hand hygiene and disinfecting equipment, F 689 related to hazardous chemical storage, F 695 related to dating and storage of oxygen and nebulizer tubing, and F 761 related to storage of drugs at the facility on 12/27/2021 to 12/28/2021. The SA determined that the facility was in compliance with the requirements for participation in Medicare and Medicaid related to infection control, dating and storage of tubing, storage of chemicals and drugs and no deficiencies were cited. The facility was licensed for 148 beds and had a census of 107 at the time of the survey.<br>The State Agency (SA) conducted post-certification revisit for Infection Control with deficiency F- 880, related to Hand hygiene and disinfecting equipment, F 689 related to Hazardous chemical storage, F 695 related to dating and storage of oxygen and nebulizer tubing, and F 761 related to storage of drugs at the facility on 12/27/2021 to 12/28/2021. The SA determined that the facility was, in compliance with the requirements for participation in Medicare and Medicaid related to infection control, dating and storage of tubing, storage of chemicals and drugs and no deficiencies were cited. The facility was licensed for 148 beds and had a census of 107, at the time of the survey. | {F 000} | | |

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

Electronically Signed | 01/17/2022

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.