STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255139	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BATESVILLE	154 WOODLAND ROAD BATESVILLE, MS 38606

(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 A COVID-19 Focused Infection Control Survey was conducted by the State Agency (SA) on 8/10/2020. The facility was found to not be in compliance with infection control regulations and did not implement the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility was cited a deficiency at F880. The census at the time of the survey was 91 and held a license for 130.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/1/20

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

Electronically Signed | 09/02/2020

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to prevent the potential spread of Infection related to placing a contaminated scoop on the ice while passing ice to residents for one (1) of four (4) random tours of the facility. Findings include: Record review of the facility's "Equipment and Department Cleaning/Maintenance Policy" dated 04/2020, revealed the ice scoop in ice chests was not to be left in the ice while not being used, and should be cleaned daily in the dish machine. On 08/10/2020 at 11:00 AM, an observation on B-Unit revealed, Certified Nursing Assistant (CNA) #1 passing ice to the residents from the ice cart. CNA #1 was observed entering Room B30, getting the resident's water pitcher, taking the pitcher to the resident's bathroom, and filling the pitcher with water. CNA #1 exited the room and opened the ice cooler lid, removed the ice scoop from on top of the ice, filled the pitcher with ice, laid the scoop back on top of the ice, and returned the pitcher to the resident's room. CNA #1 moved the cart down toward room B28, entered the room, picked up the water pitcher, took the pitcher to the resident's bathroom, turned on the faucet, and filled the pitcher with water. CNA #1 then exited the room, opened the ice cooler top, picked the contaminated scoop up off the ice, and filled the water pitcher with ice. CNA #1 returned the contaminated scoop onto the ice,	F 880	F880 - The residents on B unit were located in our COVID free zone. However, each resident was assessed that day for fever or signs of infection with no negative variances. The Certified Nursing Assistant that was identified with the infection control practice issue received coaching and counseling on 8/10 by the Assistant Director of Nursing Services regarding the correct procedure for passing ice to residents. Completion date 9/1/2020 All residents in the center have the potential for being affected by this same practice. Center staff observed other Certified Nursing Assistants on each hall to identify other residents that might be affected to assure staff were not violating infection control practices of improper scoop storage. Completion 9/1/2020 Each ice chest will be labeled with signage that instructs staff to: 1) perform hand hygiene, 2) remove ice scoop from holder, 3) retrieve ice from chest with scoop and place in the resident's pitcher, 4) return ice scoop back to holder, and 5) repeat step 1-4 between each resident. An in-service was initiated with nursing staff after the incident and completed on 8/24/20 by the Infection Control Preventionist regarding Infection Control Practices with delivery of ice to residents	

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F 880	Continued From page 3 closed the ice cooler top, and returned the water pitcher to the resident. CNA #1 exited Room B28 and entered Room B26. CNA #1 picked up the resident's water pitcher, took it to the resident's bathroom, turned on the water faucet, filled the pitcher with water, exited the room, and opened the ice cooler top. CNA #1 picked up the ice scoop off of the ice, filled the pitcher with ice, closed the ice cooler top, and returned the pitcher to the resident's room. CNA #1 did not use hand sanitizer or wash her hands before picking up the ice scoop and did not clean the scoop before placing on the ice. An observation of the ice cooler revealed a mesh pocket, attached to the side of the cooler, with nothing inside the pocket. On 08/10/2020 at 11:25 AM, an interview with CNA #1, confirmed, she placed the contaminated ice scoop on top of the ice in the ice cooler, after filling the residents water pitchers. CNA #1 confirmed the ice scoop would be contaminated after she picked up the resident's water pitcher, turned on the water in the resident's bathroom, opened the top to the cooler, and then picked up the ice scoop. CNA #1 revealed she was trained to place the ice scoop in the pocket on the side of the cool and not on the ice. CNA #1 revealed that she did not know why she did not place the scoop in the pocket, but instead placed the scoop on the ice. CNA #1 revealed by placing the contaminated scoop on the ice, it could cause the spread of infection. On 08/10/2020 at 12:00 PM, an interview with the Director of Nursing (DON), confirmed, CNA #1 should not have placed the ice scoop on the ice, but should have placed it in the pocket on the side of the cooler. The DON revealed the staff had been trained to place any scoop in the pocket	F 880	and proper storage of the ice scoop. Completion 9/1/2020 The facility plans to monitor its performance to make sure that solutions are sustained by the nursing management team (Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Director of Clinical Education) by observing Certified Nursing Assistants passing ice and storage of scoops beginning 8/30/20 and continuing with observation on five (5) passes per week for four (4) weeks followed by two(2) passes per week for four (4) weeks. Any variance will be corrected immediately and addressed in Quality Assurance and Performance Improvement. Completion 9/1/2020	

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F 880	Continued From page 4 on the container. The DON confirmed the contaminated scoop could cause the spread of infection. Record review of an in-service, dated 01/08/2020, with a subject of Hand Hygiene, included under the subtitle of Dining, revealed, when passing ice, the scoop handle does not touch ice. CNA #1's signature was located on the sign in sheet as being in attendance.	F 880		