STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 12/29/20. The facility was not in substantial compliance with Infection Control. The facility was not following infection control safety practices and guidance recommended by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) during a COVID-19 pandemic and F880 was cited. The census at the time of the survey was 55, with a license for 66 beds.	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		1/22/21

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

Electronically Signed | 01/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 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. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 2 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 interview, staff in-service record review, and facility policy review, the facility failed to prevent the likelihood of the spread of COVID-19 as evidenced by failure to use proper hand hygiene between residents for three (3) of six (6) employees observed delivering lunch trays. Findings include: Review of facility policy titled, "Infection Control Program", dated February 1, 2008, revealed, "the facility will establish and maintain an Infection Control Program focused on preventing the transmission of infectious disease in the long-term setting", with the purpose to, "decrease the risk of infection for residents and staff, monitor for the occurrence of infections and implement control measures, identify and correct improper infection control practices, and to insure compliance with federal and state infection control guidelines." An interview with the Director of Nursing (DON) on 12/29/2020, at 9:20 AM, revealed the facility's census is 55. The DON stated the facility currently has 15 COVID-19 positive residents. An observation on 12/29/2020, at 11:25 AM, revealed lunch trays being delivered to the resident's rooms. Observation of Certified Nursing Assistant (CNA) #1 revealed delivery of trays to residents in two (2) different rooms and hand hygiene was not performed between the residents.	F 880	1. Failure to prevent the likelihood of the spread of COVID-19 as evidenced by the failure to use proper hand hygiene between residents for three Certified Nursing Assistants was reported by the Mississippi State Department of Health on 12/29/2020 during a Covid Infection Control Survey conducted in facility. Certified Nursing Assistant #1, Certified Nursing Assistant #2 and Certified Nursing Assistant #3 were provided one on one education immediately regarding facility policy to hand wash or sanitize between each resident while providing care. 2. All residents in facility have the potential to be affected by the alleged deficient practice. 3. Handwashing/Sanitizing Policy and Procedure inservice was started on 12/29/2020 by Director of Nursing for staff to be completed 1/20/2021. Current and newly hired staff will also complete a Handwashing/Sanitizing Competency and Post-test to ensure understanding of the policy and procedure. Competency and Post-test will be also be completed annually by staff. Approximately sixteen hand sanitizer wall stations will be added to the facility to provide staff with easier access to sanitizer, ordered 1/19/21 and will be installed upon delivery. Seventeen additional two liter hand sanitizer pump	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 3 An interview on 12/29/2020, at 12:00 PM, with CNA #1, revealed she was aware she should have washed her hands or used hand sanitizer between each resident. CNA #1 stated she has been in-serviced on hand hygiene and infection control and she was aware of the importance of hand hygiene to prevent the spread of infections. An observation on 12/29/2020, at 11:25 AM, revealed lunch trays being delivered to the resident's rooms. Observation of Certified Nursing Assistant (CNA) #2, revealed delivery and set up of meal trays to multiple residents in different rooms and hand hygiene was not performed between the residents. An interview on 12/29/2020 at 11:50 AM, with CNA #2, revealed she was aware she should have used hand sanitizer or washed her hands between each resident. CNA #2 stated she has been in-serviced on hand hygiene and infection control and she was aware of the importance of hand hygiene to prevent the spread of infections. An observation on 12/29/2020 at 11:35 AM, revealed lunch trays being delivered to the resident's rooms. Observation of Certified Nursing Assistant (CNA) #3, revealed delivery and set up of meal trays to multiple residents and hand hygiene was not performed between the residents. An interview on 12/29/2020 at 11:35 AM, with CNA #3, revealed she is aware she should have used hand sanitizer or washed her hands between each resident's tray delivery and set up. CNA #3 stated she had been in-serviced on hand hygiene and infection control and she was aware	F 880	bottles were added throughout facility by Director of Nursing on 12/29/2020 for staff to use. 4. Director of Nursing will make rounds beginning 12/30/20 during meals alternating between breakfast, lunch and dinner to ensure staff are using proper Handwashing/Sanitizing Policy and Procedure between each resident three times a week x four weeks then as needed. Any non-compliance will be immediately addressed and results will be brought by the Director of Nursing to the Quality Assurance and Prevention Committee monthly for review, revision and or resolution of the plan. Housekeeping supervisor will monitor the hand sanitizer wall stations once a week for four weeks beginning 12/30/20 then once a week every two weeks for four weeks then monthly thereafter to ensure stations are refilled timely. Any non-compliance will be immediately addressed and findings will be brought by the Housekeeping supervisor to the Quality Assurance and Prevention Committee monthly for review, revision and or resolution of the plan. Director of Nursing will monitor the hand sanitizer pumps weekly for four weeks beginning 12/30/20 then every two weeks for four weeks then monthly thereafter to ensure pump bottles are refilled timely. Any non-compliance will be immediately addressed and findings will be brought by the Director of Nursing to the Quality Assurance and Prevention Committee monthly for review, revision and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 4 of the importance of hand hygiene to prevent the spread of infections. An interview on 12/29/2020 at 4:00 PM, with the Director of Nursing (DON), confirmed the staff are to wash their hands or use hand sanitizer between each resident and the failure to do this increases the potential spread of infection. DON stated the staff has been in-serviced on hand hygiene, COVID-19, and infection control guidelines. The DON confirmed the facility failed to follow infection control guidelines. An interview on 12/29/2020 at 4:00 PM, with the Administrator, confirmed the importance of hand hygiene to prevent the spread of infections. The Administrator stated the staff has been in-serviced on hand hygiene, COVID-19, and infection control guidelines. The Administrator confirmed the facility failed to follow infection control guidelines. Record review of an in-service attendance record titled "Handwashing and Hand Hygiene", dated 10/26/20, presented by the Assistant Director of Nursing, confirmed CNA #1, CNA #2, and CNA #3 attended.	F 880	resolution of the plan. Facility Infection Preventionist will continue to monitor these processes and solutions once a month thereafter to ensure continued compliance. Infection preventionist will monitor this by making infection control rounds including checking handwashing/sanitizing by staff and checking hand sanitizer wall stations once a month and will report findings to the Quality Assurance and Prevention Committee monthly for review.	