STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255219	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR WALK HEALTHCARE CENTER	**570 NORTH SOLOMON STREET GREENVILLE, MS 38703**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the staff failed to prevent the spread of infection as evidenced by failure to appropriately handwash or use hand sanitizer, social distance,and use disposable dining utensils during resident mealtime for four (4) of four (4) facility departments observed during the survey. (Nursing, Dietary, Housekeeping, and Maintenance). Finding include: Review of the facility's policy titled, Coronavirus-(COVID-19- Interim Policy for Suspected or Confirmed Coronavirus (COVID-19),undated, revealed it is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiological Risk for the COVID-19 and to adhere to Federal and State/Local recommendations (to include, for example: Admissions,Visitation, Precautions: Standard, Contact, Droplet, and/or Airborne precautions, including the use of eye protection). The policy revealed in the event of an outbreak, institute outbreak management protocols to include hand hygiene using alcohol based hand sanitizer before and after removal of Personal Protective Equipment (PPE), including gloves. The facility will re-educate employees and reinforce strong hand- hygiene practices, cough etiquette, respiratory hygiene, transmission based precautions, and appropriate utilization of PPE's as indicated. Review of the facility policy titled, Infection Control Guidelines for All Nursing Procedures, revised August 2012, revealed its purpose was to provide guidelines for general infection control while caring for residents. The general guidelines reveal Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. Findings include: An observation, on 8/10/20 at 11:20 AM, revealed storage of opened and unopened boxes of unused Personal Protective Equipment (PPE) lining the walls in room [ROOM NUMBER]. Approximately two (2) feet from the PPE, in the center of the room, was an open red bag lined cardboard trash receptacle. The red bag contained clear packaging bags, face shields, masks, gowns, and shoe covers. An observation, on 8/10/20 at 12:10 PM, during the serving of the resident's lunch meal revealed the facility was not utilizing disposable trays, plates, utensils, or beverage containers. An observation during the lunch meal tray pick-up, on 8/10/20 at 12:40 PM, revealed Certified Nursing Assistant (CNA) #1, entered room [ROOM NUMBER] wearing a gown, face mask, and black gloves. She exited the room and put the lunch tray on the cart, lifted the top off of the tray, wrote down the intake, and then entered room [ROOM NUMBER] and picked up that tray. CNA #1 did not change her gloves between rooms. An observation, on 8/10/20 at 1:03 PM, revealed CNA #2 entered room [ROOM NUMBER]. An observation, on 8/10/20 at 1:04 PM, revealed CNA #3 entered room [ROOM NUMBER]. This surveyor followed the CNAs into room [ROOM NUMBER] and observed CNA #2 and CNA #3 removing contaminated PPE and placing it in the open red bag lined cardboard receptacle and then donning clean PPE stored in room [ROOM NUMBER]. An interview, on 8/10/20 at 1:05 PM, with CNA #2 and CNA #3 revealed that neither one of them had thought about what they were doing. An observation, on 8/10/20 at 1:10 PM, revealed Dietary Staff #2, Housekeeper #1, Housekeeper #2, and Housekeeper #3 sitting together at a table in the dining room talking and eating, not socially distanced. An interview, on 8/10/20 at 1:12 PM, with Dietary Staff #2 confirmed they were not at least six (6) feet apart and this could cause possible spread of germs. An interview, on 8/10/20 at 1:13 PM, with Housekeeper #1 confirmed they were not complying with social distancing and this could spread germs. She stated they had meetings about social distancing. An interview, on 8/10/20 at 1:14 PM, with Housekeeper #3, confirmed she did not think they were six (6) feet apart. She stated they had in-services on handwashing and being six (6) feet apart. An observation, on 8/10/20 at 1:25 PM, with the Administrator revealed Maintenance Staff #4 entering and exiting rooms on the 100 hall, touching the side rails and name plates at the doorway and reaching up and leaning against the door facings with gloved hands. Maintenance Staff #1 did not change gloves between rooms. An interview, on 8/10/20 at 1:33 PM, with the Administrator revealed staff cannot wear the same gloves when they are touching something in one room or area and go into another room. An interview, on 8/10/20 at 1:35 PM, with the Administrator confirmed that a red bag container with contaminated PPE was in room [ROOM NUMBER] where clean PPE was stored. He stated that was not good, that it meant everything was contaminated. The Administrator stated staff had cross-contaminated by coming out of the rooms. He stated PPE should be taken off inside the resident room. An interview, on 8/10/20 at 2:00 PM, with the Administrator revealed that meals should be served on Styrofoam and thrown away in the resident rooms. An interview, on 8/10/20 at 2:05 PM, with the Dietary Manager, in the presence of the Administrator, revealed they were using regular trays, plates, silverware and glasses because she didn't think they had any isolations. She stated she usually gets a list every week of the COVID residents, but did not get one this week. The Administrator confirmed that the Dietary Manager should have gotten a list. An interview, on 8/10/20 at 3:00 PM, with CNA #1, confirmed that her gloves were dirty when she picked up lunch trays and touched the dirty tray, the pen and the paper. She stated that it was so hard to remember to change everything, especially bonnets and shoe covers. She confirmed she had gone in and out of resident rooms without changing her gloves. An interview, on 8/10/20 at 3:08 PM, with CNA #3 confirmed PPE should be taken off in the room before you leave the room. She stated that not doing this can cause cross-contamination. An interview, on 8/10/20 at 3:15 PM, with CNA #2 revealed that they can change their PPE in two areas. They change it before they come out of the room or in room [ROOM NUMBER]. She stated that it is cross-contamination when you come out of the room. She stated that they had been instructed to do this in an in-service but it changes. An interview on 8/10/20 at 3:35 PM, with the Director of Nursing (DON) revealed staff should take off PPE in the room because you are contaminated and should not be wearing contaminated PPE in the hall and going into a clean room and changing their PPE. She confirmed the red bag trash should not be in the room with clean PPE. She stated that she monitors staff to be sure they wear only N-95 masks and her Assistant Director of Nursing makes rounds and monitors the staff. An interview, on 8/10/20 at 3:55 PM, with the DON, revealed she felt there was confusion with passing the meal trays. She confirmed they should have been on Styrofoam and thrown away. She confirmed that she assisted with passing the trays and totally failed by not noticing the meal was on regular trays. The DON stated that she has to get a plan, that being on the medication cart, she can't monitor her staff. She stated that this was very disappointing and somebody didn't do what they should. An interview, on 8/10/20 at 4:18 PM, with the Environmental Director, confirmed his staff had training and education on COVID. He stated they should sit at different tables in the dining room to be six (6) feet apart and if they are not, it's a problem. Record review confirmed Housekeeping Staff #1, #2, and #3, and the Dietary Manager had received in-service education related to Infection Control and Prevention and limiting movement in and out of the facility on 3/10/20, 3/23/20, 4/2/20, and 5/2/20. Record review confirmed CNA #1, CNA #2, and CNA #3 had received in-service education related to PPE and COVID-19 precautions and infection control prevention on 3/10/20, 3/23/20, 4/2/20, 5/2/20 and 5/21/20.

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.