STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A197	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JNH-JAQUITH INN	**3550 HIGHWAY 468 WEST- PO BOX207/BLDG 78 WHITFIELD, MS 39193**

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, and facility policy review, the facility failed to prevent the likelihood of the spread of COVID-19 virus as evidenced by lack of proper hand hygiene, lack of wearing a mask, and contamination of meal trays and pantry items for three (3) of three (3) tours of the facility. Findings include: Review of the facility's, Pandemic Coronavirus Disease (COVID-19) Infection Prevention Practices policy, dated May 2020, revealed its purpose provides infection prevention guidelines to control/prevent pandemic Coronavirus disease (COVID-19) in patients, residents, employees, and visitors. The policy/plan revealed A. Basic infection prevention principles for preventing the spread of pandemic COVID-19 at (Name of)State Hospital (Initials of state hospital): (1) Minimize chance for exposure, e. All employees entering the (Initials for state hospital) campus are required to wear appropriate face masks at all times. Review of the facility's Hand Hygiene policy, dated April 2019, revealed it is the policy of (Initials for name of state hospital) that all employees will use proper hand hygiene techniques to prevent the spread of infectious diseases to include: H. After touching objects that may be contaminated with disease causing microorganisms and O. After contact with inanimate objects in the vicinity of the patient/resident. Review of the facility's Personal Items policy, not dated, revealed personal items should be stored outside the food service area of the pantry. An observation, on 8/17/20 at 11:28 AM, revealed a single glove hanging on the handrail on the south side hallway near the exit door. Direct Care Trainee (DCT) #1 picked the glove up with her bare hand and put the glove in the garbage can in room [ROOM NUMBER]. She did not wash her hands or use hand sanitizer. She then stood in the hallway touching her clothes and putting her hands inside her pockets and then entered rooms [ROOM NUMBERS] touching the doorknob and door facing. An interview, on 8/17/20 at 11:35 AM, with DCT #1, revealed she should have disposed of the glove in the red garbage can and she should have put on a glove to pick it up. She confirmed she did not wash her hands or use hand sanitizer after she threw the glove away. She stated that she just wasn't thinking. She stated that what she did spreads germs. The DCT #1 stated she has hand sanitizer in her pocket and always uses it, but confirmed she did not use it after she disposed of the glove. An interview, on 8/17/20 at 12:15 PM, with the Director of Nursing (DON), revealed DCT #1 should have put a glove on to get the glove off the hand rail because it could have been dirty, and it should have been put in a red bag container and not in a resident's trash can. An observation, on 8/17/20 at 12:37 PM, with the Director of Nursing, during the lunch meal tray delivery revealed Certified Nursing Assistant (CNA) #2 dressed in full Personal Protective Equipment (PPE) came out of a resident's room with a meal tray in her hand. She set the tray on top of metal table, opened the draw and picked up a roll of plastic trash bags and then placed them back in the drawer and then removed her PPE. She stated she was going to put the tray on the bottom of the meal cart. An interview, on 8/17/20 at 12:39 PM, with CNA #1, confirmed the meal tray was contaminated after being brought out of an isolation room. An observation, at 12:41 PM on 8/17/20, with the DON, revealed the remaining lunch trays on the cart. The food and beverages were in disposable ware and the eating utensils were disposable, but were being taken into all the resident rooms on a metal tray. An interview, on 8/17/20 at 12:42 PM, with the DON, revealed the staff pick up the metal trays at the end of the meal and put them on the cart and take them back to the pantry. She stated that when the trays come out of the rooms, they are contaminated and are going through the building back to the pantry. The DON stated that they had not thought about that. An observation, on 8/17/20 at 2:15 PM, revealed Dietary Staff #1 was sitting in the pantry in the food prep area without a mask on. When questioned, he donned a surgical grade mask. On the cabinet beside him was an open box of plastic wrap that he confirmed he would be using to wrap resident food in. Beside the box of plastic wrap was a cell phone and charger and a dirty cloth mask. An interview, on 8/17/20 at 2:17 PM, with Dietary Staff #1, revealed the cell phone, charger, and mask were his personal items. He confirmed the personal items should not be in the pantry because of contamination. He stated that they should be in his personal drawer. Dietary staff #1 confirmed that facility policy was for staff to wear masks at all times and that he should have his mask on. An interview, on 8/17/20 at 2:25 PM, with Dietary Staff #2, revealed she had not noticed that dietary Staff #1 did not have on his mask. Dietary staff #2 stated that Dietary Staff #1's personal things should not have been on the counter with kitchen supplies and he should have had his mask on. She stated that he was not being sanitary. An interview on 8/17/20, with the Administrator, at 2:30 PM, revealed Dietary Staff #1 should have known not to put his personal things on the counter and he should not have been sitting over supplies used for the residents. The Administrator stated that he had contaminated the plastic wrap. The Administrator stated that Dietary Staff #1 knew it was the facility policy for staff to wear a mask at all times and he should have had one on. Review of Staff Education/Continuing Education sign-in sheets revealed DCT #1 received training to prevent the spread of infection on 5/22/20. Review of Staff Education/Continuing Education sign-in sheets revealed CNA #2 received training on safety measures/training for COVID-19 on 3/25/20. Review of Staff Education/Continuing Education sign-in sheets revealed Dietary Staff #1 received training to educate on the requirement and importance of wearing a mask to prevent the spread of COVID-19 on 7/23/20. Review of Staff Education/Continuing Education sign-in sheets revealed Dietary Staff #1 received training to educate on the requirement and importance of wearing a mask to prevent the spread of COVID-19 on 7/23/20.

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