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

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

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 -** Few	**Provide and implement an infection prevention and control program.** 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, 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 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.

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