STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255185	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INDIANOLA REHABILITATION AND HEALTHCARE CENTER	**401 HIGHWAY 82 WEST INDIANOLA, MS 38751**

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.** Based on observations, staff interviews, record reviews, and facility policy reviews, the facility failed to ensure staff properly cleaned and sanitized their hands and disinfected reusable equipment for monitoring resident's vital signs and removing clothes hangers from a resident's room and placing in a clean laundry cart to prevent the possible spread of infection for seven (7) of seven (7) residents not located in the COVID-19 designated area. (Residents # 1, 2, 3, 4, 5, 6, and 7). Findings include: Review of the facility's policy titled, Infection Control Policy-Coronavirus Disease 2019 (COVID-19), revealed employees are educated and reminded to clean their hands according to Centers for Disease Control (CDC) guidelines , including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing Personal Protective Equipment. Staff to perform hand hygiene upon exiting patient rooms. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. An observation, on 8/11/20 at 9:45 AM, revealed Laundry Staff #1 pushed a covered laundry cart down the A wing hall. The laundry staff removed clothes on hangers from the cart and entered Room A-20. She did not have gloves on. She touched the door to the room and the closet door before hanging the clothes in the closet. She then removed several clothes hangers from the closet and exited the room. She placed these hangers inside the cart. She did not use hand sanitizer or wash her hands at any time. She returned to the laundry where she left the cart and exited the laundry area. An interview, on 8/11/20 at 9:50 AM, with the Director of Nursing (DON) and the Housekeeping Director, revealed Laundry Staff #1 should have washed her hands or used hand sanitizer when she came out of the room and she should not have put the hangers in the clean laundry cart because they were considered dirty. The DON stated she should have cleaned them first. An interview, on 8/11/20 at 10:00 AM, with Laundry Staff #1, confirmed she did not wash her hands or use hand sanitizer before or after entering the resident's room and that she placed the hangers in the clean laundry cart with out cleaning them. She stated that not using hand sanitizer and putting the hangers in the cart spreads germs. She confirmed she has had in-services on infection control and COVID. An observation, on 8/11/20 at 10:30 AM, revealed Certified Nursing Assistant (CNA) #1 inside Room B-2. CNA #1 left the room and walked to the nurse's station, picked up a roll of clear trash bags and tore one (1) off and left the floor. She returned still holding the bag and also had a pillowcase in her hands and entered Room B-2. She exited the room and went to the nurse's station and charted vital signs. An interview, on 8/11/20 at 10:45 AM, with CNA #1, confirmed she had hand sanitizer in her pocket but, did not use hand sanitizer or wash her hands when she exited the resident's room. She stated that this spreads germs. She stated she has attended in-services on infection control and COVID. An observation, on 8/11/20 at 10:57 AM, revealed CNA #2 exited Room A-14 with an infrared thermometer, pulse oximeter, and a blood pressure cuff. She did not clean or sanitize the equipment when she exited the room. She entered Room A-17 and checked vital signs on the residents in the room. CNA #2 did not sanitize the equipment between rooms or between use on each resident. While in Room A-17, she placed the infrared thermometer on a dresser in the room without using a barrier. When she exited Room A-17 she took the equipment to the nurse's desk without cleaning or disinfecting it. An interview, on 8/11/20 at 11:05 AM, with CNA #2 confirmed she did not sanitize the vital sign equipment between rooms or residents or when she put it up. She stated that this was cross-contamination. An interview, on 8/11/20 at 11:07 AM, with Registered Nurse (RN) #1, the A-wing Supervisor confirmed the blood pressure cuff, thermometer, and pulse oximeter should have been cleaned between patient contact and after use. He stated this was an infection control problem and if a resident had any infection, COVID or not, it could be easily transmitted. An interview, on 8/11/20 at 12:05 PM, with RN #2 confirmed that she provided staff in-service education on COVID-19 and infection control. An interview, on 8/11/20 at 12:37 PM, with the Director of Nursing (DON), revealed that these are infection control issues but stated that she felt like they had done something right because they had kept it out of the facility for five (5) months. An interview, on 8/11/20 at 12:45 PM, with the Administrator, revealed they need to step up and monitor the staff better. She stated they need to work on some areas and educate staff on points of contact. Record review of facility's in-service attendance forms revealed CNA #1 and #2 had attended in-service education on COVID-19, handwashing/hand sanitizing, and cleaning of medical equipment on 3/16/20, 6/26/20, and 7/30/20.

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.