STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375547	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ZARROW POINTE	2025 EAST 71ST STREET TULSA, OK 74136

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to: ~ ensure staffs' proper use of face masks; ~ screen staff for symptoms of COVID-19 before assuming resident care; ~ ensure new admissions were quarantined for 14 days for eight residents (#1, #2, #3, #4, #5, #6, #7, and #8) of eight new admissions whose records were reviewed; ~ ensure the completion of a facility self-assessment to ensure compliance with CMS and CDC guidelines for infection control; ~ ensure staff education and updates regarding COVID-19; ~ ensure an infection control preventionist on staff; ~ ensure proper use of disinfectants related to the manufacturer's documented contact time; and ~ ensure guidelines regarding staffs' return to work were followed. The facility identified one employee who returned to work after a positive COVID test result. This had the potential to affect all 52 residents who resided in the facility. Findings: The Centers for Disease Control guidance, regarding donning PPE, documented, .Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin . The Centers for Disease Control guidance titled, Preparation for Covid 19 in Nursing Homes, documented, ~ Evaluate and manage healthcare personnel, .Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19 .Actively take their temperature and document absence of symptoms consistent with COVID-19 . ~ Creating a plan for managing new admissions and readmissions .Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . ~ Educate Residents, Healthcare Personnel, and Visitors about Covid 19 .Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety. Regularly review CDC ' s Infection Control Guidance for Healthcare Professionals about COVID-19 for current information and ensure staff and residents are updated when this guidance changes . 1. On 06/12/20 at 11:50 a.m., assistant activity director #1 was observed assisting a resident in his wheelchair down 100 hall after leaving the activity room. As she spoke with the resident in his room she was observed with her face mask under her chin, not covering her nose or mouth. She was not observed to distance herself 6 feet from the resident. At 11:58 a.m., she exited the resident's room and adjusted her face mask to cover her nose and mouth. At 12:01 p.m., she was asked why her face mask was observed under her chin and not covering her nose and mouth. She stated the resident had trouble understanding her so she pulled the mask down to talk to him. On 06/12/20 at 12:52 p.m., dietary aide #1 was observed in the dining room with her face mask pulled down not covering her nose and mouth. She then walked across the hall to the laundry room. She was asked why her face mask had not been covering her nose and mouth. She stated, I pull it down when residents leave because I get hot. On 06/12/20 at 1:02 p.m., CMA #1 was observed at the medication cart by the nurses station with her face mask positioned below her chin. At 1:03 p.m., she entered the medication room behind the nurses' station then returned to the medication cart. She was asked why her face mask was not covering her nose and mouth. She stated, I just forgot about it. On 06/12/20 at 1:25 p.m., the DON was asked who was responsible to monitor staff for proper use of face masks. She stated she and the other supervisors monitored. She stated if she saw one that was not properly covering the employees nose and mouth she would reeducate them. 2. A Coronavirus COVID-19 Screening Tool, dated 03/13/20, documented, .1. Do you have any of the following symptoms? a. Feeling Feverish? b. Cough? c. Muscle Aches? d. Shortness of Breath .2. Have you recently traveled to a restricted foreign country within the last 14 days? (currently, China, Iran, Italy and South Korea) .3. Have you had contact with someone diagnosed with [REDACTED].? 4. Have you been in a health care facility where COVID-19 was documented? . On 06/02/20 at 9:00 a.m., an employee stationed at the front door of the facility obtained the surveyor's temperature and asked the surveyor to sign in. The employee was informed by another employee that a screening form was required since the surveyor had not visited the facility before. At 9:15 a.m., the administrator was asked how staff was screened prior entering the facility. He stated their temperature was taken at the front door. He was asked if they were screened for symptoms or if they were asked any questions regarding exposure. He stated other than obtaining staffs' temperatures, no other screening was completed for staff. He stated they knew the staff and knew if they did not feel well. 3. A list of new admissions were reviewed which revealed the following residents had been admitted in the past 14 days. The record documented the residents' assigned rooms were on all three halls: ~ Resident #1 was admitted for skilled services on 05/28/20 with [DIAGNOSES REDACTED].~ Resident #2 was admitted for skilled services on 05/29/20 with [DIAGNOSES REDACTED].~ Resident #3 was admitted for skilled services on 06/08/20 with [DIAGNOSES REDACTED]. Resident #8 was admitted on [DATE] and was in the same room as resident #3; ~ Resident #4 was admitted for skilled services on 06/08/20 with [DIAGNOSES REDACTED].~ Resident #5 was admitted for skilled services on 06/08/20 with [DIAGNOSES REDACTED].~ Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED].~ Resident #7 was admitted for skilled services on 06/11/20 with [DIAGNOSES REDACTED]. On 06/12/20 at 10:27 a.m., the DON was asked if any residents were quarantined or in isolation. She stated no. She was asked what the process was for quarantine with new admissions. She stated they took the same precautions with new admissions as they did with other residents. On 06/12/20 at 10:55 a.m., CNA #1 was asked if any of his assigned residents were quarantined. He stated no residents were quarantined. He stated the residents were only required to wear a face mask and gloves. At 11:00 a.m., CNA #2 was asked if any of her assigned residents were quarantined. She stated no. At 11:02 a.m., CNA #3 was asked if any of his assigned residents were quarantined. He stated no. At 11:03 a.m., LPN #1 was asked if any resident on the 200 hall were quarantined. She stated no. She was asked what precautions staff took when they provided resident care. She stated they were required to wear a face mask and gloves. At 11:10 a.m., CNA #4 was asked if any of his assigned residents were quarantined. He stated no. At 11:12 a.m., LPN #3 was asked if any residents on the 300 hall were quarantined. She stated no. At 11:58 a.m., LPN #2 was asked if any residents on the 100 hall were quarantined. She stated no. On 06/12/20 at 2:05 p.m., the administrator was asked why new admissions were not quarantined for 14 days. He stated the facility required a negative COVID-19 test from the hospital before admission. He stated the new admissions were skilled and required therapy and they did not have enough therapists to provide therapy in their rooms one at a time. 4. On 06/12/20 at 2:05 p.m., the administrator was asked if they had completed a self assessment to determine compliance with CDC and CMS guidelines for infection control. He stated no. He was asked why the facility had not completed a self survey. He stated he had completed a risk assessment. He was asked when he had completed a risk assessment. He stated he did not remember. He stated he thought he had updated the assessment recently but had not monitored or assessed for compliance with infection control guidelines. 5. On 06/12/20 at 12:59 p.m., CNA #4 was asked what type of education he had received regarding COVID-19. He stated the unit manager had discussed monitoring for cough, shortness of breath, and hand washing during shift change. He was asked when he had received education. He stated about a month and a half ago. He was asked if he had received any further education, training, or inservice. He stated no. On 06/12/20 at 1:05 p.m., CMA #1 was asked what type of education

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) or training she had received regarding COVID-19. She stated there had been a paper passed around one time. She was asked when the paper had been provided. She stated she did not remember. She was asked if she had received any other education or training regarding COVID-19. She stated no. On 06/12/20 at 1:31 p.m., the DON was asked how staff were educated and trained on COVID-19 such as transmission, screening criteria, and work exclusion. She stated she had inserviced the department heads and they were to inservice their staff. She was asked where the inservice was documented. She stated the administrator had the documentation. On 06/12/20 at 2:05 p.m., the administrator was asked how staff were educated and trained on COVID-19. He stated the supervisors educated them. He was asked where the education was documented. He stated the education consisted of a conversation between the supervisor and the employees and had not been documented. He referred to the inservice book and provided the surveyor a COVID-19 policy inservice. He was asked who attended the inservice. He stated there should have been a sign in sheet with the form. Review of the inservice book revealed an inservice was conducted by the administrator on 03/19/20. The topic was resident rights with coronavirus. By the end of survey, no further education and/or training documentation dated after 03/19/20 had been provided. 6. On 06/12/20 at 9:15 a.m., the administrator was asked who the infection control preventionist was for the facility. He stated the DON. At 11:45 a.m., the DON was asked what training she had completed regarding the role of infection control preventionist. She stated she had just begun employment at the facility on 04/06/20 and had not completed all of the modules of the training. She provided a certificate for Module one and Module two which were both dated 07/25/19. At 2:05 p.m., the administrator was asked why there was not an infection control preventionist for the facility. He stated the former DON had been the infection control preventionist prior to the current DON. He stated the current DON had recently began working for the facility and he could not find the documentation of the former DON's completion of the training. 7. On 06/12/20 at 3:13 p.m., the housekeeping supervisor was asked what disinfectant was utilized in the facility. She provided a bottle of HDQ Neutral. The EPA List N documented a ten minute contact time to kill COVID-19. She was asked what the contact time was for the disinfectant. She stated she trained the housekeepers to spray the surface, let it sit for one to three minutes, and then wipe off. She was informed of the ten minute contact time which was documented on the EPAs List N. She stated she was not aware there were specific contact times for disinfectants. At 3:33 p.m., the administrator was asked why the disinfectant, utilized in the facility, was not being used according to List N to kill COVID-19. He stated he was not aware there was a list of disinfectants which were effective against COVID-19. 8. Review of the administrator's list of employee testing documented LPN #2 was tested on [DATE] and received a positive COVID-19 result on 06/07/20. The administrator stated she was retested on [DATE] and received a negative result on 06/10/20 at which time she had returned to work. Review of the time detail revealed LPN #2 returned to work on 06/11/20. The administrator was asked why LPN #2 had been retested . He stated he wanted to confirm the results due to a high volume of false positive results he had heard about. He was asked what the facility's policy was regarding an employees' return to work He stated the facility utilized both symptom-based and test-based criteria for an employee to return to work. He was asked what criteria LPN #2 met to return to work. He stated the employee was asymptomatic, retested with a negative result, the facility monitored her for signs and symptoms of COVID-19, and she was allowed to return to work after the negative result was received on 06/10/20.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to notify residents and their families of staff members' positive COVID-19 test result for two (LPN #2 and CNA #5) of two positive staff test results reviewed. This had the potential to affect all 52 residents who resided in the facility. Findings: On 06/12/20 at 9:23 a.m., the administrator was asked who was responsible to notify residents and families of positive COVID-19 test results within the facility. He stated he was responsible. He was asked when LPN #2 had received a positive COVID-19 result. He stated LPN #2 was tested on [DATE] and received a positive result on 06/07/20. He stated she was then retested on [DATE] and received a negative result on 06/10/20. He was asked when CNA #5 had received a positive COVID-19 result. He stated CNA #5 was tested on [DATE] and received a positive result on 06/06/20. He stated the CNA was pending an antibody test. He was asked when the residents and families had been notified of the positive test results for LPN #2 and CNA #5. He stated he had not notified the residents or families yet. He was asked why residents and families had not been notified. He stated he was waiting on a final report from the county health department and for CNA #5's antibody test before he notified residents and families. He stated he wanted to be able to give all of the test information at one time.