STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375392	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST HILLS CARE AND REHABILITATION CENTER	4300 WEST HOUSTON BROKEN ARROW, OK 74012

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 implement their infection control program to prevent the potential spread of infection for eight (#1, #2, #3, #4, #5, #6, #7, and #8) of eight sampled residents. The facility failed to: a) Thoroughly implement transmission based precautions to prevent the potential spread of infection. b) Ensure staff disinfected shared resident equipment after use. c) Ensure EPA N list sanitizers were used to clean the facility floors and resident beds. The facility identified 98 residents lived in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP (health Care Provider) 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 . Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas .Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment .Use an EPA-registered disinfectant from List Nexternal icon on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use . 1. On 06/18/20 at 10:28 a.m., licensed practical nurse (LPN) #1 obtained the finger stick blood sugar (FSBS) of resident #1. The LPN carried a white plastic basket out of the resident's room and placed it on top of the treatment cart. A glucometer was in the plastic basket. The LPN removed her gloves and sanitized her hands. She then obtained a pair of gloves and picked up the white plastic basket and went into the room of resident #2. The LPN did not sanitize the glucometer or basket prior entering the room of resident #2. 2. On 06/18/20 at 10:30 a.m., after entering the room of resident #2 LPN #1 placed the white plastic basket onto the counter top. The LPN obtained the resident's FSBS. The LPN then removed her gloves and brought the plastic basket out of the resident's room. She sat the basket on top of the treatment cart. She sanitized her hands. She did not sanitize the glucometer or plastic basket prior to obtaining the next resident's FSBS. 3. The LPN then obtained a pair of gloves and picked up the white plastic basket and went into the room of resident #3. She sat the glucometer and the plastic basket onto the resident's overbed table. Then obtained the resident's FSBS. She placed the glucometer into the plastic basket. The LPN removed her gloves and carried the plastic basket out of the resident's room. She placed the basket on top of the treatment cart. The LPN sanitized her hands. Unlocked the treatment cart, obtained some cotton balls and a pair of gloves. She did not sanitize the glucometer or plastic basket prior to obtaining the next resident's FSBS. 4. At 10:35 a.m., the LPN then picked up a pair of gloves and the white plastic basket and entered the room of resident #4. The following observations were made on what the facility called the 'transition hall' (quarantine) halls. There was no isolation set up outside all but one of the residents' room doors on the 300 hall. There was no isolation red bags set up in the residents' rooms. 5. On 06/18/20 at 11:08 a.m., nurse aide (NA) #1 entered the room of resident #8. The NA did not put on a isolation gown, face shield, or gloves prior to entering the resident's room. She then exited and then re-entered the resident's room. The resident was laying on the floor. At 11:11 a.m., the assistant director of nursing entered the resident's room without putting on a isolation gown, face shield, or gloves prior to entering the resident's room. 6. At 11:17 a.m., NA #1 entered the room of resident #5 without putting on a isolation gown, face shield, or gloves prior to entering the resident's room. At 11:22 a.m., the NA exited the resident's room. The NA was asked what care that had been provided the resident. She stated, peri care. The NA was asked if she had put a gown on to provide the resident's peri care. She stated no. 8. At 11:22 a.m., housekeeper #1 was observed to exit the resident room of resident #6 with a wet mop and placed the mop into the mop bucket. 9. At 11:34 a.m., housekeeper #1 was sweeping the floor in the room of resident #7. At 11:36 a.m., the housekeeper obtained the dust pan from the housekeeping cart and used the dust pan in the resident's room. The housekeeper exited the room with the broom and dust pan. She clipped the broom and the dust pan onto the side of the housekeeping cart. At 11:37 a.m., the housekeeper took the mop out of the mop bucket, squeezed extra cleaner out of the mop, and then moped the floor of resident #7. At 11:40 a.m., the housekeeper came out of the resident's room and put the mop back into the mop bucket. The housekeeper was asked what was in her mop water. She stated, a sanitizer. She stated she did not know the name. She was asked if she changed the mop water. She stated yes, the mop water and mop head were changed after every fourth room. 10. At 11:45 a.m., on the 200 transition (quarantine) hall LPN #2 and certified medication aide #1 had cloth masks on instead of surgical masks. These were the direct care staff that took care of the eight residents on the 200 hall that day. When asked about their cloth masks. The LPN, stated she had a filter in her mask and the CMA stated, yeah. At 11:53 a.m., LPN #1 when told about the earlier FSBS' observations stated she had gotten nervous and had forgotten to clean the glucometer between the residents. She stated she usually had a cup of purple wipes and cleaned the glucometer and white plastic basket before she leaves each resident's room. At 1:56 p.m., the administrator and director of nursing (DON) stated the transition hall was for the residents that had recently been admitted to the facility, the residents who had gone to the ER and back to the facility, and the residents who received [MEDICAL TREATMENT]. The residents that had been admitted to the facility and the residents back from the ER were on the transition hall for 14 days. The residents who received [MEDICAL TREATMENT] remained on the hall as they left the facility multiple times each week. The administrator and DON were asked why full personal protective equipment (PPE) was not worn into the residents' room. They stated the staff members were previously wearing the full PPE into the residents' rooms. They stated that corporate had told them not to do that and to use droplet precautions when a resident had COVID symptoms or tested positive for COVID, as they were, burning through too much PPE. 11. At 2:37 p.m., the housekeeping supervisor stated she had recently gotten the position about two to three months before. She was asked what cleaners the facility used. The facility cleaners were observed in the maintenance room. The housekeeping supervisor stated the floors were cleaned with Stride Floral HC - Neutral Cleaner. There was no EPA number on the bottle. The housekeeping supervisor did not know about the EPA number. The housekeeping supervisor stated the residents' beds were cleaned with Clorox - urine remover for stains and odors. She stated in addition, the cleaner was used on the beds that were cleaned after residents discharged . The above cleaners were not located on the EPA N list disinfectants. The facility floors were not being sanitized. The residents' beds were not being sanitized when dirty or between residents. The housekeeping supervisor was shown how to check the EPA number on the EPA N list. She stated she had was not aware of the EPA N list or the contact time of the cleaners. When she was shown the contact time of two cleaners, she stated, that was good to know. The housekeeping supervisor was asked if she had had any training r/t sanitizers, types of cleaners, or contact times. She stated no, but there was a training that was coming out soon. She was asked if her housekeepers (who had only been working at the facility a few weeks) knew what the contact times of the facility cleaners were. She stated, no, probably not. At 3:12 p.m., the above was revealed to the administrator. She was asked if she would want the facility floors to be sanitized. She stated, of course. She was not aware a sanitizer was not being used to clean resident beds or the facility floors.

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.