STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375558	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HIGHLANDS AT OWASSO	10098 N 123 E AVE OWASSO, OK 74055

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 13 (#1 through #13) of 13 sampled residents reviewed for infection control. The facility failed to: a) Ensure staff members were thoroughly screened for all possible COVID-19 symptoms that are documented on the centers for disease control (CDC) website. b) Ensure the residents were thoroughly monitored for all possible COVID-19 symptoms that are documented on the CDC website. c) Ensure staff members wore the appropriate personal protective equipment (PPE) in the isolation/quarantine resident rooms. d) Ensure staff members wore their surgical masks to cover their nose and mouth. e) Ensure staff members did not wear cloth masks. f) Ensure staff disinfected shared resident equipment after use. g) Ensure residents were seated at tables at least six feet apart, to ensure social distancing. h) Ensure staff did not have their own drink cups on or in the medication cart. i) Ensure environmental protection agency (EPA) N list sanitizers were used to clean the facility floors. The facility identified 87 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 . 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. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace . The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . Immediately before touching a patient . Before performing an aseptic task . Before moving from work on a soiled body site to a clean body site . After touching a patient or the patient's immediate environment . After contact with blood, body fluids, or contaminated surfaces . Immediately after glove removal . Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices. Environmental Cleaning and Disinfection .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 06/26/20 at 10:05 a.m., the surveyor entered the facility. The staff member who met the surveyor, took the surveyor's temperature, and had the surveyor fill out the employee screening tool. The tool asked if had a fever in the last 14 days, 73 hours, or 24 hours. The tool asked if had cough or trouble breathing. The tool did not screen for all the possible symptoms of COVID-19 as documented on the CDC website. The visitor screening tool asked the same questions as the employee screening tool. At 1:07 p.m., RN #1 when asked stated the resident were monitored for COVID-19 symptoms by checking their temperatures and pulse oxygenation. She stated she checked for shortness of breath, coughing, and lung sounds. She was asked if there were any other symptoms to monitor the residents for. She stated gastric upset, nausea, vomiting, weakness, and tiredness. She stated she did not always ask if the residents had sore throats. The RN was asked how often the employees temperatures were checked. She stated every time the employee entered the building. When asked she stated they ask the staff the respiratory questions and have them fill out the form every time a staff member entered the building. 2. At 10:48 a.m., a tall metal cup was on top of a medication cart. After the surveyor walked by the medication cart certified medication aide (CMA) #1 put the metal cup into the medication cart. The CMA was asked whose cup was on top of the medication cart. She stated it was hers. She was asked where the cup was at that time. She stated in the medication cart. She was asked to open the medication cart to show where the metal cup was located. The CMA's metal cup was laying in the bottom right drawer of the medication cart, on top of and by two medication bottles and by one bubble pill card. The CMA was asked if she had previously been drinking from the cup. She stated, not in front of the residents. She stated she had not had time to take her cup to the desk. At 10:54 a.m., the above observation was discussed with registered nurse (RN) #1. The cup in the medication cart was observed with the RN. The metal cup remained in the same location as above, in the drawer. There was a medication card for tamsilosin medication for resident #6. On top of a resident's pill bottle and bottle of liquid milk of magnesia for resident #7. The CMA placed her metal cup in a holder on the side of the medication cart by an open box of gloves. At 10:56 a.m., RN #1 was asked if the CMA should have her own personal cup on top of or inside the medication cart. She stated, no. She stated she would talk to the CMA. 3. At 11:16 a.m., certified nurse aide (CNA) #1 had her surgical mask below her nose. The CNA propelled resident #1 down the hallway with the CNA's mask below her nose. 4. At 11:17 a.m., CNA #2 washed her hands in the nurses station, moved her mask, rubbed her nose, then pulled her mask up. She did not wash/sanitize her hands after removing and raising her mask, and touching her face. The CNA had her surgical mask below her nose. At 1:13 p.m., CNA #2 came out of the linen cart area on center hall with her mask below her nose. 5. At 11:25 a.m., CNA #3 was walking down center hall with her surgical mask down below her nose. At 1:21 p.m., CNA #3 was on the non-isolated north hall. She wore her surgical mask down below her nose. She was asked why her mask was below her nose. She stated, it must have slid down. 6. At 11:27 a.m., resident #1 was sitting at a table in a sitting area across from the center hall nurses station. Resident #11 was seated at the other end of the table. 7. At 11:28 a.m., CNA #2 was in the area between the center hall nurses station and the little sitting area (where resident #1 and #11 were seated) she pulled down her mask under her chin, touched her face, and then pulled the mask back up. The CNA did not wash/sanitize her hands after touching her mask or her face before she walked down the center hallway. At 11:48 a.m., CNA #2 was observed to have her mask below her nose in resident room [ROOM NUMBER]. At 11:50 a.m., CNA #2 went to the area and spoke to one of the residents that sat at the table that were seated less than six feet apart. 8. At 11:35 a.m., licensed practice nurse (LPN) #1 entered the room of resident #2. At 11:37 a.m., the LPN exited the room. She placed a glucometer on top of the nurse's cart, took out two alcohol prep pads and placed them by the glucometer. The LPN then pushed the nurse's cart down the hall, put gloves on, and cleaned the glucometer with the alcohol prep pads. She removed her gloves, pushed the cart a little further down the hall, took her keys out of her uniform pocket and unlocked the nurse's cart and put the glucometer into the cart. The nurse had not washed/sanitized her hands after exiting the resident's room and removing her gloves. 9. At 11:45 a.m., resident #8 was sitting at the table between resident #1 and resident #11. The residents were not six feet apart at that time and they were not wearing masks. A corporate staff member walked by the area where the three residents were sitting together. At 11:46 a.m., the corporate staff member again walked by the area where the three residents were sitting together. At 11:51 a.m., the director of nursing (DON) and CNA #4 walked to the nurse's station across from the area where the three residents were seated less than six feet apart. At 11:52 a.m., resident #9 propelled herself to the table and was on the other side of the table between resident #1 and #11. The four residents were seated less than six feet away from one another. The DON told CMA #2 to put

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) masks on the residents and that the residents could not be at the same table. 10. At 11:55 a.m., LPN #1 entered the room of resident #10 with the glucometer. At 11:56 a.m., the LPN exited the resident's room, removed her gloves, put the glucometer on top of the nurse's cart, opened up the laptop, touched the mouse, and then pushed the cart to the room of resident #12. The LPN did not wash/sanitize her hands after exiting the resident's room and removing her gloves. 11. At 11:59 a.m., the LPN asked resident #12 if she could obtain her finger stick blood sugar (FSBS). The LPN cleaned the glucometer with an alcohol prep pad, gathered her supplies, and entered the resident's room. At 12:03 p.m., the LPN exited the resident's room and put the glucometer on top of the nurse's cart. At 12:08 p.m., the LPN cleaned the glucometer with an alcohol prep pad. The LPN was asked what she was cleaning the glucometer with. She stated, an alcohol wipe. The LPN was asked if the glucometer was used for multiple residents. She stated, yes. The LPN did not wash/sanitize her hands after exiting the resident's room and removing her gloves. 12. At 12:06 p.m., dietary aide (DA) #1 was walking down the center hall with the dietary manager. DA #1 was wearing a cloth mask. 13. At 12:11 p.m., LPN #1 knocked and asked resident #13 if she could stick her finger. The LPN entered the resident's room at 12:12 p.m. She exited the resident's room at 12:13 p.m., took off her gloves, used the alcohol based hand rub (ABHR), and used an alcohol prep pad to clean the glucometer. 14. At 1:14 p.m., CNA #5 wore her mask down below her nose. She was walking down center hall. When asked stated she had just come out of the kitchen. At 1:16 p.m., CNA #6 was walking down center hall with her surgical mask down below her chin. She was asked why her mask was below her chin. She stated, she had just pulled it down, as she could not breath. 15. At 1:35 p.m., certified occupational therapist aide (COTA) #1 was in the room of resident #3, an isolation (quarantine) room. The COTA was holding the resident's hand and talking to the resident. The COTA did not have an isolation gown or goggles/face shield on and had her surgical mask was pulled down below her chin. In addition physical therapist aide (PTA) #1 was in the resident's room with an isolation gown on, gloves, and surgical mask. The PTA did not have goggles/face shield on. The PTA left the resident's room. The PTA was asked if anyone besides the COTA was in the resident's room. She stated speech therapist (ST) #1 was in the resident's room. The PTA was asked if the three therapists (aides) had goggles/face shields on. She stated, no. She stated she had asked the nurse and the nurse had told her they did not have any face shields. At 1:38 p.m., the COTA came out of the isolation (quarantine) room of resident #3 with her gloves on her hands. The COTA stated to the PTA that she was going back into the resident's room. The COTA walked down the hallway to doorway of the temporary nurse's station. At 1:44 p.m., ST #1 was asked if she had been fit tested for an N95 mask. She stated yes. She was asked why she did not have her N95 mask on the isolation (quarantine) room of resident #3. She stated, she was told to only wear the N95 mask if the resident was positive for COVID-19. She stated the resident had a negative test from the hospital. She was asked why she did not wear goggles/face shield into the isolation room of resident #3. She stated she only put on what was in the isolation set up outside the resident's room. 16. At 1:47 p.m., CNA #7 was asked what she PPE she had worn while in the isolation (quarantine) room of resident #4. She stated she had worn gloves, gown, and a surgical mask. She was asked if she had worn goggles/face shield. She stated, no. The CNA was asked why not. She stated, they were waiting for the face shields to come. 17. At 1:51 p.m., CNA #8 who worked on the isolation (quarantine) hall wore a cloth mask not a surgical mask. He was asked if his mask was a surgical mask. He stated, no and that he had gotten the cloth mask from another nursing home. 18. At 1:52 p.m., PTA #2 brought a box of face shields into the temporary nurse's station. She wore a cloth mask not a surgical mask. She was asked if her mask was cloth. She stated, yes, It has ventilation in it, no one has told me otherwise. She was asked what kind of ventilation. She stated, the ones you can buy on Amazon. 19. At 1:55 p.m., CNA #9 (who was working the isolation (quarantine) hall) asked CNA #7 (who had worked the isolation/quarantine hall on the day shift) about how to use the face shields. CNA #7 told the CNA #9 the face shields needed to be cleaned after coming out of the residents' rooms. CNA #9 asked what needed to be used to clean the shields. CNA #7 stated she did not know, then stated maybe alcohol wipes. CNA #9 asked maybe those wipes, then CNA #7 stated, she did not know. 20. CNA #7 and CNA #8 entered the isolation/quarantine room of resident #5 without their face shields on. 21. At 2:15 p.m., the facility's cleaners/disinfectants were observed with the housekeeping supervisor. The housekeeping supervisor stated, Revolution Multi-Surface Neutral Cleaner (2), was used to mop the facility floors. There was no EPA registered number on the bottle. At 2:21 p.m., the housekeeping supervisor was asked if she had looked up the cleaners that were used in the facility to ensure they were on the EPA N list. She stated, she did not know anything about the list that she had become the housekeeping supervisor in 12/2019. At 4:34 p.m., the DON was asked why multiple staff members walked pass the four residents that were seated at the table less than six feet apart. She stated that she had heard that the corporate staff member told the facility staff members it was ok for the residents to be sitting that close to each other. She stated they should have had masks on and sitting at least six feet away from each other. The DON was asked why the LPN had cleaned the glucometer with alcohol prep pads between residents. She stated, she should have used glucophinal wipes. She agreed the LPN should have washed/sanitized her hands after taking off her gloves. The DON was asked why multiple staff members in the isolation/quarantine hall did not use PPE appropriately. She stated the staff members, including the therapy staff members, had been trained multiple times r/t PPE use. She was asked why a staff member had left an isolation/quarantine room with gloves on. She stated, she had not heard that. The DON was asked when should the facility staff members to be wearing their surgical masks. She stated at all times, all staff. She was asked why multiple staff members, from various departments, wore their masks below their noses/chins. She stated, she had educated them, monitored them. She stated, she continued to remind staff members to pull up their masks on a daily basis. She was asked why some staff members wore cloth masks. She stated, all staff members, in all departments were to wear surgical masks. The DON was asked why are your residents and staff not screened for all possible COVID-19 symptoms. She stated, she did not make the forms. She stated, she thought the forms were made by the regional director and handed out to all the facilities.