STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375389	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TULSA NURSING CENTER	10912 EAST 14TH STREET TULSA, OK 74128

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.** **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 residents, whose health was compromised due to receiving [MEDICAL TREATMENT], were quarantined due to the COVID-19 pandemic for eight (#1, #2, #3, #4, #5, #6, #7, and #8) of eight residents whose records were reviewed for infection control. The facility identified eight residents who left the facility to receive [MEDICAL TREATMENT]. Findings: The Centers for Disease Control guidance titled, Preparation for Covid 19 in Nursing Homes, documented, 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 . 1. Resident #1 had [DIAGNOSES REDACTED]. Resident #10 was the resident's roommate. They resided on C hall. A physician order, dated 01/20/20, documented the resident received [MEDICAL TREATMENT] on Tuesday, Thursday, and Saturday. 2. Resident #2 had [DIAGNOSES REDACTED]. The resident resided on F hall. A physician order, dated 05/28/20, documented the resident received [MEDICAL TREATMENT] Monday, Wednesday, and Friday. 3. Resident #3 had [DIAGNOSES REDACTED]. Resident #11 was the resident's roommate. They resided on E hall. A physician order, dated 11/18/20, documented the resident received [MEDICAL TREATMENT] Monday, Wednesday, and Friday. 4. Resident #4 had [DIAGNOSES REDACTED]. Resident #13 was the resident's roommate. They resided on the E hall. A physician order, dated 11/08/19, documented the resident received [MEDICAL TREATMENT] Tuesday, Thursday, and Saturday. 5. Resident #5 had [DIAGNOSES REDACTED]. Resident #12 was the resident's roommate. They resided on E hall. A physician order, dated 05/19/20, documented the resident received [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. 6. Resident #6 had [DIAGNOSES REDACTED]. The resident resided on F hall. A physician order, dated 01/13/20, documented the resident received [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. 7. Resident #7 had [DIAGNOSES REDACTED]. Resident #9 was the resident's roommate. They resided on C hall. A physician order, dated 04/30/20, documented the resident received [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. 8. Resident #8 had [DIAGNOSES REDACTED]. The resident resided on C hall. A physician order, dated 05/07/20, documented the resident received [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. On 06/23/20 at 9:45 a.m., a tour of halls C, E, and F were conducted. Signage was not observed on any resident doors which indicated the residents were on any precautions, isolation, or quarantine. On 06/23/20 at 1:30 p.m., the DON/Infection Control Preventionist provided a list of residents who left the facility to receive [MEDICAL TREATMENT]. She was asked what type of precautions the residents who received [MEDICAL TREATMENT] were on. She stated the residents wore masks to and from the [MEDICAL TREATMENT] facility and the facility communicated weekly with the [MEDICAL TREATMENT] staff. At 1:40 p.m., CNA #1 was asked what hall she was assigned. She stated F hall. She was asked what precautions the residents who received [MEDICAL TREATMENT] were on. She stated none of the residents on F hall were on isolation or quarantine. She stated they utilized masks and gloves. At 1:43 p.m., CNA #2 was asked what hall she was assigned. She stated E hall. She was asked what precautions the residents who received [MEDICAL TREATMENT] were on. She stated none of the residents on E hall were on isolation or quarantine. At 1:47 p.m., LPN #1 was asked what hall she was assigned. She stated F hall. She was asked if any residents were in quarantine or isolation. She stated no. At 1:50 p.m., LPN #2 was asked what hall she was assigned. She stated E hall and she was also covering C hall until the assigned nurse returned. She was asked if any residents on E or C hall were in quarantine or isolation. She stated no. She stated if a resident was on isolation or quarantine they would have a sign on their door indicating the precaution and a bin outside the door with PPE. At 1:53 p.m. CNA #3 was asked what hall she was assigned. She stated C hall. She was asked what precaution the residents who received [MEDICAL TREATMENT] were on. She stated none of the residents on C hall were in isolation or quarantine and staff utilized masks and gloves when they provided care. At 1:57 p.m., the DON/Infection Control Preventionist was asked why residents who left the facility to receive [MEDICAL TREATMENT] were not quarantined. She stated they did not have a quarantine plan in place for [MEDICAL TREATMENT] residents.

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.