STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375575	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW NURSING & REHAB	607 WOODLAND AVENUE EUFAULA, OK 74432

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 observation, interview, and record review, it was determined the facility failed to maintain an infection control program and implement measures to provide a safe environment to help prevent the development and transmission of COVID-19 for five (#1, 2, 3, 4, and #5) of five residents sampled for infection control. The facility failed to ensure: a) face shields or goggles were worn in the rooms of quarantined residents, b) staff did not wear masks below their chins and below their noses, c) residents wore face coverings while out of their rooms, d) residents who were on quarantine status had precaution signage on their doors and personal protective equipment (PPE) available near the entrance of their doors. The director of nursing (DON) reported there were no residents who were COVID-19 positive, three residents were quarantined on droplet precautions, and 49 residents resided 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 .HCP should wear a facemask at all times while they are in the facility . Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility . The Center for Disease Control guidance titled, How to Wear Cloth Face Coverings documented, .Wear your Face Covering Correctly .Put it over your nose and mouth and secure it under your chin. Try to fit it snugly against the sides of your face .Use the Face Covering to Protect Others. Wear a face covering to help protect others in case you're infected but don't have symptoms . The State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, F880, 483.80 Infection Control, Implementation of Transmission-Based Precautions documented, .When a resident is placed on transmission-based precautions, the staff should implement the following: Clearly identify the type of precautions and the appropriate PPE to be used; Place signage in a conspicuous place outside the resident's room such as the door or on the wall next to the doorway identifying the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering .Make PPE readily available near the entrance to the resident's room . On 06/25/20 at 8:45 AM, upon entrance to the facility, in the lobby area, one licensed practical nurse (LPN) was observed with her mask under her chin, a certified nurse aide (CNA) and a business office staff member were observed coming from the residents' hallway with masks under their noses. A housekeeper was also observed with her mask under her nose. During this initial observation, six residents were in the lobby area. Only one had a mask on and it was under her nose. This resident was on quarantine because of a stay outside the facility. The dining room area was observed with at least one resident at each table and a few tables held two. No mask were observed being put on after dining. The two dietary staff were observed to wear their masks under their noses. On 06/25/20 at 9:03 AM, on 200 Hall, resident #1 had a PPE station outside the door. The station did not contain eye protection. The resident's door did not have any signage related to the type of precaution or PPE required. On 06/25/20 at 9:10 AM, on 200 Hall, resident #5 was coming out of his room without a mask. He was asked if ever wore a mask. He stated he did not want to wear a mask. He stated most of the staff wore one so he felt safe. On 06/25/20 at 9:45 AM, at the 100 Hall nurse station, resident #4 was requesting some medication for an upset stomach. The resident was asked if she ever wore a mask at the facility. She stated she was given a mask way back when COVID began and wore it until it got dirty, but never received another one. She stated she would wear one if she had one. On 06/25/20 at 9:53 AM, ten residents were observed in the lobby. Most were well spaced but none wore masks. On 06/25/20 at 10:04 AM, a list of new admits for the last two weeks and a list of residents who were on quarantine status was received. Residents #1, 2, and #3 were on the quarantine list. On 06/25/20 at 10:06 AM, resident #2 was observed lying on her bed. A station for PPE was not anywhere near. Precaution signage was not present on the door. On 06/25/20 at 10:11 AM, resident #3 was not in his room. A PPE station was not near his door. There was no signage related to precautions on the door. The resident was observed in the hallway with a staff member. The resident's mask was below his nose. Other staff and residents were passing by in the hallway. On 06/25/20 at 10:31 AM, eleven residents were observed in the lobby area. Nine of the residents were wearing masks at this time. During interviews with the CNAs, they voiced they had not been wearing shields while caring for the quarantined residents. Two of the CNAs voiced they were not sure what residents were on quarantine status. On 06/25/20 at 11:30 AM, the DON toured 100 and 200 Halls with the surveyor. The DON stated residents #2 and #3 were admitted yesterday. She stated stations and signage should be near the residents' doors so the staff know what to do. She stated they had not been wearing face shields with their surgical masks. She stated later she had found some shields in their storage of PPE. On 06/25/20 at 12:02 PM, the administrator stated they had provided masks for the quarantined residents but had not pushed the use of a mask for the other residents. She stated the staff know to keep their masks up over their mouths and noses.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE