STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375331	A. BUILDING _____ B. WING _____	05/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST NURSING CENTER	2120 NORTH BROADWAY MOORE, OK 73160

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 -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/06/20, an Immediate Jeopardy situation was determined to exist related to the facility's failure to implement infection prevention and control practices to prevent the development and transmission of COVID-19. The facility failed to perform appropriate screening of visitors and staff, failed to implement transmission based precautions and the use of PPE, failed to isolate known residents with COVID-19, failed to quarantine residents exposed to COVID-19, failed to quarantine residents with unknown status due to return admissions from the hospital and offsite [MEDICAL TREATMENT], and failed to provide thorough education to staff to ensure appropriate and safe care was provided to residents. The facility identified one resident who had passed in the hospital, six residents residing in the facility and seven staff who had all tested positive for COVID-19. One resident and 29 staff had test results still pending. OSDH verified the existence of the Immediate Jeopardy Situation. At 5:25 p.m., the DON was informed of the IJ related to the failure to implement infection prevention and control practices. A plan of removal for the IJ situation was requested. The DON was working as nursing staff for residents on the floor on the evening shift. No other administrative personnel were present in the facility at the time. At 8:36 p.m., an acceptable plan of removal was provided by the DON. The plan of removal documented, May 6, 2020 Hillcrest Nursing Center 2120 N. Broadway(NAME) OK Plan of Removal 1. Staff member is placed at front door monitoring station to ensure staff, and essential visitors are properly monitored upon entrance into the community. Front lobby and monitoring station are disinfected with approved product. 2. Evaluation is completed to include temperatures and sign/symptom are checked on all residents, staff, and persons in community at present. 3. Residents identified with positive test received this date are moved to an area of the community designated for contained isolation unit. This unit is contained by door closure at each end of the specified unit. The closed doors are identified by signage to indicate Isolation Precautions Required Past this Point, with instruction for application of PPE before entering. PPE is located at the entrance points of the contained unit. 4. Residents with exposure, return admits from hospital, and [MEDICAL TREATMENT] are placed in private rooms on quarantine unit with PPE placed outside of rooms. 5. Areas designated as contained isolation unit and quarantine unit are cleansed and disinfected with approved product; cleaning will be completed with increased frequency during each shift. Common areas within the community are cleansed and disinfected with increased frequency of high touch areas. 6. Staff are educated regarding manned front entrance monitoring and appropriate monitoring required every entry into facility, Proper use, location and application of PPE to include instruction of PPE use while assisting residents on contained isolation unit and quarantine unit, residents with potential exposure, and all other units within community, and cleaning and disinfecting requirements. Staff are educated regarding personal protection outside of facility to limit exposure and signs/symptoms to report to supervising staff for determination of absence from work necessary. This plan of removal will be in compliance May 6, 2020 by 11:59 pm. On 05/07/20 at 4:05 p.m., the documentation of the education provided to the staff was reviewed. No dates or times of when the education was provided were documented. No signatures were provided confirming the education was received by the staff. There were 61 staff members on the list, 21 were documented as having received a phone call, seven no answer, one busy, one quit, 12 left messages, six were blank and 13 were documented as having received the education in person. No written documentation was provided to the staff regarding the education. On 05/07/20 from 4:20 p.m. to 5:40 p.m., staff were observed working in the COVID unit without appropriate masks to protect against contracting COVID-19. Staff was observed to carry soiled trash, without the removal of gloves or shoe covers, from the COVID unit through the hallways and out the front entry of the facility to dispose of the trash. Staff reported they had not been provided any biohazard bags for soiled waste or cleaning and disinfectant supplies. Staff were unaware of the COVID negative status and infection control measures required to provide safe care for resident #3, who had refused to change rooms and remained on the COVID positive unit. Staff was unable to verify they had been educated and understood the components documented in the plan of removal. At 5:53 p.m., the DON was informed the IJ would not be removed due to the facility's failure to provide appropriate PPE to staff working the COVID unit, failure to implement appropriate transmission based precautions, failure to ensure appropriate environmental cleaning, failure to identify the status and care of resident #3 and failure to thoroughly educate staff. A plan of removal for the IJ situation was requested. The DON was working on the floor. No other administrative personnel were present in the facility at the time. At 7:59 p.m., an acceptable plan of removal was provided by the DON. The plan of removal documented, May 7, 2020 Hillcrest Nursing Center 2120 N. Broadway(NAME) OK Plan of Removal 1. All staff working the (sic) in the Contained Isolation Unit (COVID unit) will be provided and wear N95 mask and be fit tested prior to working. 2. Staff members currently working on the COVID unit have been verbally educated regarding infection control procedures when leaving the COVID unit; staff have been instructed on proper removal of PPE waste products from the COVID unit to utilize the exterior key pad exit door located on the unit for removal of trash; PPE soiled disposal will be placed in biohazard bags and properly sealed before removal from the COVID unit. 3. Facility will provide a housekeeping cart on the unit during this time of quarantine for housekeeping cleansing and disinfecting with instruction to staff for proper use of equipment, disinfectant supplies, and biohazard. 4. COVID negative resident choosing to remain in his room has been identified by placement of signage and staff educated. 5. Education will be provided to staff to include: - PPE application, removal, disposal - Laundry services - Dining services - Infection Control based precautions within and outside the unit - Cleansing and disinfecting This plan of removal will be in compliance May 8, 2020 by 5:00 pm. On 05/08/20 at 5:20 p.m., the DON stated she was typing the written part of the education to have been provided to the staff. She stated she was working the floor as the charge nurse at the same time. She was asked if all the staff had been educated. The DON stated no. She was asked if anything had been signed by those who had been educated. She stated no. At 6:30 p.m., the DON was unable to provide documentation of the education provided to staff. Staff was unable to verify they had been educated or understood the components documented in the plan of removal. At 6:40 p.m., the DON was informed the IJ would not be removed due to the facility's failure to thoroughly educate staff. A plan of removal for the IJ situation was requested. No other administrative personnel was present in the facility at the time. At 6:53 p.m., an acceptable plan of removal was provided by the DON. The plan of removal documented, May 8, 2020 Hillcrest Nursing Center 2120 N. Broadway(NAME) OK Plan of Removal 1. Education will be provided to staff to include: - PPE application, removal, disposal - Laundry services - Dining services - Infection Control based precautions within and outside the unit - Cleansing and disinfecting This plan of removal will be in compliance May 8, 2020 by 11:59 pm. On 05/09/20, interviews were conducted with a total of six employees who worked different shifts and in different departments. The employees verified they had been in-serviced regarding the components documented in the plan of removal and they understood the information provided. The IJ was removed as of 05/08/20 at 11:59 p.m., when all components of the plan of removal had been completed. Based on observation, record review and interview, it was determined the facility failed to: ~ ensure proper infection prevention and control practices were implemented to prevent the development and transmission of COVID-19; ~ ensure residents wore face masks when out of their rooms; ~ perform appropriate screening of visitors and staff; ~ implement transmission based precautions and the use of PPE; ~ isolate known residents with COVID-19; ~ quarantine

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) residents exposed to COVID-19 and residents with unknown status due to return admissions from the hospital and offsite [MEDICAL TREATMENT]; ~ provide appropriate environmental cleaning; ~ sanitize the dietary cart after being inside of the COVID positive unit, and dispose of trays and plates from the COVID positive unit appropriately; and ~ failed to provide thorough education to staff to ensure appropriate and safe care to residents. Seven residents and seven staff members were known to have contracted COVID-19. The facility identified 81 residents who resided in the facility. Findings: On 05/06/20 at 2:30 p.m., observations were made at the entrance to the facility. A screening desk was set up at the door with a thermometer and binder. No one was stationed at the screening desk to instruct or monitor visitors who had entered into the facility. Staff, with knowledge of the front door code, would open the door for others. At 2:35 p.m., the housekeeping supervisor stated there were residents positive for COVID-19 who had just been wandering around the facility without masks. As resident #1 approached, he stated she was positive for COVID-19. Resident #1 was observed to wander around the front entrance without wearing a mask. At 2:36 p.m., the staff was asked who was in charge. The housekeeping supervisor stated no one was in charge. The DON was out but would be back. From 2:36 p.m. to 2:50 p.m., resident #1 was observed to wander away and come back up to the front entrance. She had a surgical mask and was observed to cover and uncover her mouth with the mask. The resident was then observed to rub the mask all over the sign-in binder used for staff and visitors. Multiple staff would frequently attempt to redirect her and ask her to wear the mask. She was not observed to keep the mask on. At 2:50 p.m., the DON was observed to enter the facility. As she and another staff attempted to take their temperatures, an outside provider entered the facility. The provider asked them to allow her to sign in, then went on into the facility without taking her temperature or completing the screening process. At 2:55 p.m., resident #2 was observed self propelling his wheelchair in the hallway and to the lobby by the front entrance. He was observed wearing a surgical mask below his nose. The mask was observed to have been soiled. At 3:00 p.m., the DON stated they had received results of the COVID-19 testing on the residents and some of the staff. She stated the administrator, assistant administrator and ADON had all tested positive which left just her. The DON also stated she had to cover the shift and work the floor. The DON stated they currently had six residents in the facility who were positive for [MEDICAL CONDITION]. She stated two of them were wanderers. She continued to explain they had not made a plan for what they would do if residents who wandered were positive. The DON stated she was not sure she could have contained them because it would have gone against their rights. She was asked if she allowed residents, who were positive for [MEDICAL CONDITION], to wander around the facility putting others at risk, would that not have been against all the other residents rights to a safe environment. The DON stated she had not thought of it that way but yes. The DON was asked if the staff had been using PPE when caring for the residents who had COVID-19. She stated no, but they had it in the administrators office. At 4:42 p.m., a staff member was observed to have used the door code then walk into the facility without the screening process having been conducted. At 5:00 p.m., a staff member was observed as she assisted a resident in his wheelchair back into the facility after being transported. The screening process was not observed to have been conducted. At 5:15 p.m., PPE was observed to have been brought out to the hall. Staff had been working to designate a COVID unit for the six residents who were positive for COVID-19. Resident #3, who was negative for [MEDICAL CONDITION], refused to move from his room and would also remain on the unit. At 5:24 p.m., a staff member was observed to use the code to the front entrance and open the door for another staff member. The screening process was not observed to have been conducted. At 5:25 p.m., the DON was asked if the residents who returned from the hospital and residents who were new admissions had been quarantined to one area and monitored for 14 days due to their risk from outside exposure. She stated no. The DON was asked if the residents who received treatments outside of the facility, such as [MEDICAL TREATMENT], were on isolation precautions due to their risk from outside exposure. She stated they had two residents on [MEDICAL TREATMENT] but no, they had not been put on isolation precautions. The DON was asked if they had a plan for where they would provide a quarantined area in the facility. She stated no. Multiple residents were observed out of their rooms without masks on during observations on 05/06/20. At 6:33 p.m., after an enclosed unit was designated for the positive COVID-19 residents, staff was heard yelling in the hallway. They were attempting to redirect resident #1 back to the COVID unit. Staff was heard yelling in the hall to get the resident back to the unit. On 05/07/20 at 3:05 p.m., the DON arrived to the facility. The COO, who had been there for part of the day left the facility. The DON stated she had worked the night shift after she had covered the evening shift the day before and had just arrived for the day. At 4:05 p.m., the documentation of the education provided to the staff was reviewed. No dates or times of when the education was provided were documented. No signatures were provided confirming the education was received by the staff. There were 61 staff members on the list, 21 were documented as having received a phone call, seven no answer, one busy, one quit, 12 left messages, six were blank and 13 were documented as having received the education in person. No written documentation was provided to the staff regarding the education. At 4:12 p.m., the maintenance director was asked if he had received recent education. He stated last night, about all that. At 4:16 p.m., LPN #1 stated she had received education the night before regarding the isolation lock down and PPE. At 4:20 p.m., CNA #1 was observed to exit the COVID unit wearing a surgical mask, gloves, shoe covers and holding a bag of trash. She was asked if she had an N95 or higher-level respirator she wore when providing care to the residents who had COVID-19. She stated she had no idea about that, this mask was all they provided to her. CNA #1 proceeded to carry the trash, with the gloves and shoe covers still on, throughout the hallways and out the front door of the facility to dispose of the trash. At 4:25 p.m., the DON was asked if staff had been provided N95 masks and the PPE needed to protect themselves and the residents when providing care. The DON stated when the administrator had stated over the phone that he had the PPE ready to go she had assumed it was all there and had not checked it. She was asked if staff had been educated on PPE and the difference in the types of masks. The DON stated no, it was on her. At 4:30 p.m., CNA #2 stated, when the in-service was provided they said nothing about the masks. At 4:31 p.m., RN #1 stated he had little kids at home, he was very worried. At 4:32 p.m., LPN #1 stated, they were saying we would have to share the masks. She then stated, should they not have provided us with everything we needed to know. At 5:04 p.m., outside the unit, signs had been posted on the doors to indicate it was the COVID unit. Two CNAs were observed to have been working the unit. No signs were observed outside the room of resident #3 to indicate he was negative for COVID-19. At 5:06 p.m., CNA #1 stated they had not been provided any biohazard bags for soiled waste or cleaning and disinfectant supplies. At 5:17 p.m., CNA #1 was unsure about the care to have been provided to resident #3, who was negative for COVID-19 but had refused to move rooms and chose to remain on the unit. As she questioned how his care differed, CNA #3 stated she had not been made aware that resident #3 was negative or there was any difference in the care to have been provided to him. The staff had not been educated on the precautions to have been implemented when providing care, including the use of new PPE each time. At 5:30 p.m., the DON was asked if the same nurse was assigned to cover the regular hall and the COVID unit. She stated no, she (the DON) was to work the floor again. Multiple residents were observed out of their rooms without masks on during observations on 05/07/20. At 6:03 p.m., the DON stated, they did have a discussed plan for what they would have done. On 05/08/20 at 5:20 p.m., the DON was observed typing at her computer. She was asked if all the staff had been educated regarding the components documented in the plan of removal. She stated no, she was still typing it. She had worked until 1:30 a.m. and was back early this morning but had not been able to finish. The DON stated she was currently working the floor as the charge nurse. She was asked if anything had been signed by those who had been educated. She stated no. There were no other administrative staff in the building. At 6:02 p.m., the dietary cart was observed outside the doors of the COVID unit. The cart had multiple trays and Styrofoam dishware with partially eaten food on it. A resident was observed to approach the cart. As he went to touch the plates on the top of the cart the DON stopped him and he was redirected. At 6:06 p.m., in the COVID unit CMA #1 was observed wearing an N95 mask over his beard. The CMA was not wearing any eye protection. He was asked if he had been fit tested for the N95 mask. He stated no. He was asked if he had been educated to wear a face shield when providing care to a resident who was positive for COVID-19 until he was able to be tested . He stated no. CMA #1 was asked if he received any education on what to do with the dietary cart and trays following a meal, including discarding of the food and sanitizing the cart and trays before it left the unit. He stated the kitchen had told him to just push the cart outside the doors and leave it but he questioned it because of the possible contamination. At 6:10 p.m., RN #1 was asked if he was the only nurse on the schedule. He stated the DON would work the floor. The RN stated corporate could have sent the DON help but they do not. At 6:40 p.m., the DON stated she understood the importance of the education and how it was needed to provide appropriate and safe care to the residents. Multiple residents were observed out of their rooms without masks on during observations on 05/08/20.