| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375448 | A. BUILDING _____ B. WING _____ | 06/19/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| EL RENO POST-ACUTE REHABILITATION CENTER | 2100 TOWNSEND DRIVE EL RENO, OK 73036 |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and staff interview, it was determined the facility failed to ensure the appropriate personal protective equipment was worn by staff during the provision of care to residents in a quarantine whose COVID-19 status was unknown, ensure residents who received services outside the facility were quarantined and ensure precautions were posted to alert staff of the need for appropriate personal protective equipment (PPE). The facility identified 40 residents resided in the facility, one resident was in quarantine and one resident received outside [MEDICAL TREATMENT] services. Findings:<br>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 . On 06/19/20 at 9:35 a.m., the director of nursing (DON) was asked if the facility had any residents in quarantiine. She stated they currently had one resident in quarantine due to being readmitted to the facility. She was asked if they had any resident who received outside [MEDICAL TREATMENT] services. She stated they had one. The DON was asked if the [MEDICAL TREATMENT] resident was in quarantine. She stated, No. She stated, He has a roommate. She stated, Honestly, I never really thought about it. The DON<br>stated the [MEDICAL TREATMENT] resident was bed bound and required a lift for transfers. At 10:00 a.m., a tour of the facility was conducted. There was no PPE outside the [MEDICAL TREATMENT] resident's room or signage to indicate quarantine/isolation precautions. At 10:20 a.m., the administrator was made aware of the above. He acknowledged the findings. |

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