STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375501	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORREST MANOR NURSING CENTER	**1410 NORTH CHOCTAW DEWEY, OK 74029**

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 who required [MEDICAL TREATMENT] outside of the facility were placed in quarantine for two (#1 and #2) of two residents who required [MEDICAL TREATMENT] outside of the facility and required quarantine. The director of nursing documented there were 56 residents in the facility. 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 . A list of residents who required [MEDICAL TREATMENT], documented there were two residents who left the facility three times a week to go to a [MEDICAL TREATMENT] center. ~ Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. ~ Resident #2 was admitted for skilled services on 12/22/14 and had [DIAGNOSES REDACTED]. On 06/29/20 at 9:30 a.m., the director of nursing was asked if there were any residents in the facility who received [MEDICAL TREATMENT]. She stated yes. She stated there were two residents who left the facility for [MEDICAL TREATMENT]. The DON was asked if there were any residents in the facility who were in quarantine. She stated no. At 10:00 a.m., resident #two was out of the building for [MEDICAL TREATMENT]. There were no signs on the door documenting the resident was in quarantine. There was no personal equipment outside of the resident's room. At 10:15 a.m., resident #1 was out of the building for [MEDICAL TREATMENT]. There were no signs on the door documenting the resident was in quarantine. There was no personal equipment outside of the resident's room. At 11:12 a.m., certified nurse aid #one was asked if there were any residents who were in quarantine in the facility. She stated no. She was asked why type of personal protective equipment she used when caring for resident #two. She stated she wore a surgical mask and gloves. At 12:00 p.m., the director of nursing was asked if the residents on [MEDICAL TREATMENT] had ever been on quarantine. She stated yes. She stated they had both had been tested and were negative for [MEDICAL CONDITION]. She stated she just felt it was mean for the [MEDICAL TREATMENT] residents to be in quarantine all of the time. At 12:10 p.m., licensed practical nurse #one was asked if there were any residents in the building who were on quarantine. She stated no. She stated she wore a mask and gloves when caring for the 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.