STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375462	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN VIEW MANOR, INC	**107 EAST BARCLAY HENRYETTA, OK 74437**

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 and interview, it was determined the facility failed to maintain an infection control program and implement measures to provide a safe environment to help prevent the transmission of COVID-19. The facility failed to ensure staff's proper use, disinfection, and/or disposal of personal protective equipment. The administrator reported all 79 residents were either isolated or quarantined and on transmission based precautions. Findings: The Centers for Disease Control and Prevention guidance titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), documented, .Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment . The Centers for Disease Control and Prevention guidance titled, Strategies for Optimizing the Supply of Eye Protection, documented, .If a disposable face shield is reprocessed, it should be .reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on . The Centers for Disease Control and Prevention guidance titled, Using Personal Protective Equipment (PPE), documented, .Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles . On 10/20/20 at 12:25 p.m., CNA #2 was observed in a resident's room that was identified as isolation with precaution signage. She was observed in full PPE, delivering a meal tray. While in the room, she was observed to lean across a walker with clothes draped on it, touching her gown to the objects. She did not change her gown prior to entering the next resident room. On 10/20/20 at 12:35 p.m., CMA #1 was observed to exit a resident's room, enter the hallway, remove her face shield and place it on top of a pile of folded disposable PPE (gowns) lying on a overbed table located in the hallway pushed up against the wall. On 10/20/20 at 12:45 p.m., CMA #1 was asked why she placed her face shield on top of what appeared to be clean PPE, immediately after exiting a resident's room. She stated she thought she placed the face shield on the handrail, not on top of the PPE. She was asked what she should have done with her face shield after exiting the resident's room. She stated she should have either kept it on because it was not soiled, or after removing, should have wiped it off with a disinfectant wipe. On 10/20/20 at 12:50 p.m., an overbed table was observed pushed up against the wall in the northeast hallway. Observed on the table was a pile of folded disposable gowns, a bottle of hand sanitizer, a box of gloves, and a computer mouse. On 10/20/20 at 12:50 p.m., CNA #2 was asked why there were disposable gowns (PPE) on the overbed table in the hallway. She stated the table did not move but that was not where clean PPE was usually kept, they have a supply closet. She was asked if the resident's rooms had PPE supply carts outside the rooms. She stated no, never. She was asked why she did not change her gown after leaning over the resident's walker, touching it. She stated she did not realize she touched the walker and should have changed her gown. On 10/20/20 at 1:25 p.m., the administrator was asked what PPE the staff was utilizing. She stated staff was to wear full PPE when entering resident's rooms and if there are two residents in the room, change PPE between residents. She was asked where the PPE was located. She stated initially, they used hanging containers on each resident's door but now have PPE located centrally on each hallway, either on overbed tables or in boxes, depending on use. She was asked what was expected of staff, regarding PPE, when serving meal trays. She stated they have been instructed to change PPE between residents and when exiting the resident's room. On 10/21/20 at 2:50 p.m., LPN #1 was asked how she monitored staff on their infection control practices. She stated she monitored staff during resident care. She was asked what PPE staff was expected to wear when entering a resident's room with signage designating transmission based precautions. She stated when entering the room they they were expected to wear full PPE; gown, gloves, mask, face shield/eye protection, when exiting the room they were expected to change their PPE and wash / sanitize their hands. She was asked what staff was expected to do with their face shield. She stated face shields were to be sanitized if soiled or removed, prior to reuse. She was asked if a face shield should be removed and placed on a clean surface, prior to sanitization. She stated no, but they have. She was asked what actions are taken when staff was observed not following infection control practices. She stated would educate and redirect staff. She was asked if they had an adequate supply of PPE. She stated yes. She was asked where PPE was located. She stated PPE was located in a supply closet and each hallway had roll carts and trays located in a central location that contained gowns, gloves, and hand sanitizer. She was asked what was expected to be on the clean PPE cart, other than PPE. She stated nothing.

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