STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375470	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHANDLER THERAPY & LIVING CENTER LLC	**601 WEST 1ST STREET CHANDLER, OK 74834**

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)
E 0024 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** Based on record review and interview, it was determined the facility failed to have an emergency staffing contingency policy and procedure for the 36 residents who resided at the facility. Findings: On 08/25/20 at 3:00 p.m., the facility's emergency staffing contingency policy and procedure was not located in the facility's policy and procedure manuals. At 3:13 p.m., the administrator was asked if they had an emergency staffing contingency plan. He stated the facility had contracts with three staffing agencies and had been using agency staff. He was asked if the facility had an emergency staffing contingency policy. He stated, no, but he would get something written up.
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 implement their infection control program to prevent the potential spread of infection for three (#1, #2, and #3) of five sampled residents. The facility failed to: a) Ensure staff changed gloves and completed hand hygiene as required. b) Ensure staff stored and used gloves from appropriate sources, not from their uniform pockets. c) Ensure residents were thoroughly screened/monitored daily for all possible symptoms of COVID-19. d) Ensure the biohazard bags were secured in storage. The facility identified 36 residents lived in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Reinforce adherence to standard IPC (infection prevention control) measures including hand hygiene and selection and correct use of personal protective equipment (PPE) . 1. On 08/25/20 at 11:15 a.m., certified nurses aide (CNA) #1 was walking in the hall way with full personal protective equipment (PPE) on including gloves. The CNA went in the room of resident #2, she was getting things out of resident's dresser. She then left the room with her gloves on and went to the medication cart and then proceeded to go to a back office. The CNA then went in the dining room and touched the charting screen with her gloved hands. She went to room of resident #1 with her gloves on and assisted the resident with a drink. The CNA left the resident's room, went down the hall, and then returned to assist the resident with positioning her right arm. The CNA removed her gloves, she did not wash her hands or use alcohol based hand rub after removing her gloves, she donned a new pair of gloves. The CNA used a stylet to document on the charting screen on the wall in the hallway and then went to assist resident #3 without changing her gloves or performing hand hygiene. CNA #1 stated she had gotten things out for resident #2 to get ready for a window visit with her family, had assisted resident #1 with a drink and positioning and assisted resident #3 with his urinal. She stated she should have performed hand hygiene and changed gloves when she left each residents' room. 2. At 12:30 p.m., CNA #2 pulled gloves out of her pocket under her isolation gown and donned them prior to entering room of resident #4. At 2:15 p.m., licensed practical nurse (LPN) #1/charge nurse on the COVID unit, stated the CNA should not have been using gloves from her pocket under her isolation gown. 3. The resident screening form did not contain runny nose, congestion, or sore throat as one of the symptoms of COVID-19 to be monitored. At 3:44 p.m., LPN #2 stated she documented the covid screening assessment on the resident evaluation and observation report. She stated she asked the resident about sore throat, congestion, and runny nose but did not document it on the form. At 3:47 p.m., the director of nursing (DON) stated she assessed the residents' lung sounds, temperature, shortness of breath, heart rate, [MEDICAL CONDITION] and any change of condition. She stated she did not document sore throat, runny nose, or congestion on the assessment form unless the resident complained of the symptoms. 4. On 08/25/20 at 2:35 p.m., out the back window there were multiple red biohazard bags on the ground between two buildings. There were two dogs on and around the biohazard bags. The dogs were biting at the bags and one of the dogs was dragging one of the bags. At 2:38 p.m., the administrator was shown the red biohazard bags and the dogs. He left the room and went outside. The administrator and another staff member chased the dogs away and began removing the biohazard bags. At 3:35 p.m., the administrator was asked what was in the red biohazard bags the dogs were biting and/or dragging. He stated it was left over food from the COVID positive hall. The administrator stated they had put the biohazard bags in the closed outside smoke room. He stated the biohazard removal company was supposed to come that day and pick up their biohazard. He stated he had no boxes left at that time to box up the biohazard bags. He stated they had left the biohazards bags outside of their biohazard storage building as the building was full. He stated they were waiting for the biohazard removal company to come pick up that day.

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.