STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEISURE VILLAGE HEALTH CARE CENTER	2154 SOUTH 85TH EAST AVENUE TULSA, OK 74129

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** - Many	**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 ten (#1 through #6, #8, #9, #10, and #11) of 11 sampled residents reviewed for infection control. The facility failed to: a) Ensure staff completed hand hygiene as required. b) Ensure staff disinfected share equipment after use. c) Ensure staff used disposable gowns per CDC guidance in resident quarantine rooms. d) Ensure staff used an EPA N list disinfectant for cleaning. e) Ensure that mulitple residents are not in the same room on the quarantine hall. There were 96 residents in the facility. Findings: CDC guidance: CDC Preparing for COVID-19 in Nursing Homes - Personal Protective Equipment: - 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 . Environmental Cleaning and Disinfection: - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas; - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. - Use an EPA-registered disinfectant from List N external icon on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use. 1. On 06/19/20 at 11:00 a.m., licensed practical nurse (LPN) #1 took a tray of supplies and the blood sugar notebook into the room of resident #1. The LPN put the tray and notebook onto the resident's overbed table. The LPN obtained the resident's finger stick blood sugar (FSBS). After leaving the resident's room layed the tray and notebook on top of the treatment cart. The LPN did not sanitize the tray or the notebook. 2. At 11:12 a.m., LPN #1 then took the tray and notebook into the room of resident #2. The LPN placed the tray on the foot of the resident's bed. The LPN obtained the resident's FSBS. The LPN after leaving the resident's room put the tray and the notebook on top of the treatment cart. The LPN did not sanitize the tray or the notebook. The LPN removed the supplies from the tray and then placed the tray into the treatment cart. At 2:56 p.m., LPN #1 was asked why she had not sanitized the tray or notebook that had been carried room to room, placed in different locations in resident rooms, placed on top and inside the treatment cart. She stated because of nerves. She stated she was not normally on the hall. 3. At 11:26 a.m., the housekeeping supervisor when asked stated Tribose multi-purpose cleaner was used on all surfaces and floors. The bottle did not have an EPA registered number. The cleaner was not found on the EPA N list. At 12:20 p.m., the housekeeping supervisor stated the high touch areas were cleaned with Simple Green All-Purpose Cleaner. There was no EPA registered number on the bottle. The cleaner was not found on the EPA N list. The housekeeping supervisor was not aware of the need for disinfectant cleaners to be on the EPA N list. 4. At 11:37 a.m., certified nurse aide (CNA) #1 took two drinks in the room of resident #5. The CNA picked up the resident's water pitcher and moved the overbed table by the resident. The CNA left the room and then reached into his uniform pant pocket and pulled out alcohol based hand rub (ABHR) and sanitized his hands. He put the ABHR back into his pants pocket. He re-entered the resident's room and took the resident some tea. He then pushed the overbed table up and positioned it for resident #6. He left the room and then reached into his uniform pant pocket and pulled out the ABHR and sanitized his hands. He returned the ABHR back to his pant pocket. 5. At 11:43 a.m., CNA #2 delivered the meal plate into the room of resident #8. The CNA then left the room and reached into his uniform pant pocket and pulled out the ABHR and sanitized his hands. He returned the ABHR back to his pant pocket. 6. At 11:45 a.m., CNA #2 took the meal plate into the room of resident #9. He raised the resident's overbed table. He left the resident's room and then without washing/sanitizing his hands he delivered the meal plate to resident #10. At 11:51 a.m., CNA #1 was asked when he was using the ABHR. He stated every time he came out of the resident's room. He was asked if he should be reaching into his uniform pant pocket to use the ABHR. He stated, no he did not think he should. At 11:56 a.m., CNA #2 was asked if he should be reaching into his pants pocket to get the ABHR out to use. He stated the facility got the ABHR for them and told the staff to use them. He was asked why he did not use the ABHR from the dispensers on the hallway walls. He stated, the facility had gotten the bottles for them to use. 7. At 12:13 p.m., on the quarantine hall yellow isolation gowns were observed hanging in the resident rooms. At 12:20 p.m., speech therapist (ST) #1 was standing in the hallway outside of the room of resident #4. She had gloves on and had a yellow disposable isolation gown that had been tied at the neck over her head. She then felt down the front of the gown with both hands, located the ties of the gown, and tied the gown in the back. She was asked where she had gotten the gown. She stated in had been hanging inside the resident's room. She stated she had seen the resident earlier that day. When asked she stated she had used the same gown she had used earlier that day then she entered the resident's room. 8. At 12:26 p.m., CNA #3 was observed to enter the room of resident #3. She then put a yellow disposable gown on. She pulled the gown onto her shoulder by grabbing the front of the gown with her ungloved hand. She then tied the neck and did not tie the waist ties. 9. At 12:28 p.m., certified medication aide (CMA) #1 entered the room of resident #4. The CMA put the medication cup and the cup of water onto the bedside table. The CMA took a yellow disposable gown off the glove box holder rack and put on the gown. He used his left ungloved hand on the outside of the gown to pull the gown onto his shoulder. He did not tie the gown at the neck or waist. The CMA gave the resident medication by mouth. At 12:33 p.m., the CMA removed his gown. He pulled on the outside of one sleeve and held the gown by the neckline and hung it up over another gown on the glove box holder rack. At 12:36 p.m., CNA #3 was asked what she had done with the gown she had been wearing in the room of resident #3. She stated she had hung it back up in the room as she had to re-enter the resident's room before the end of her shift. She was asked if she considered the gown clean after it had been worn. She stated yes, unless it was soiled. She was asked why the two residents (#3 and #11) were together in the same room. She stated because they were both residents received [MEDICAL TREATMENT]. Then CNA #3 and CMA #1 went with the surveyor to look in the room of resident #4. CNA #3 was asked how many yellow gowns were hanging on the glove box holder rack. She stated it looked like two. CMA #1 was asked why he had hung his yellow gown over another gown. He stated, we need more hooks. At 4:27 p.m., the director of nursing (DON) was asked if resident #3 and #11 went to the same [MEDICAL TREATMENT] center. She stated, no. She was asked why they were in the same room. She stated, because at one time the quarantine hall was full and they had to double up, so they doubled up the two [MEDICAL TREATMENT] residents. The DON was asked why disposable gown were hung on the quarantine hall in the residents' rooms. She stated they were told by their corporation to do that as they were burning through their supplies. She was asked if she would want one gown hung over another gown. She stated no, they should be hung separately. At 4:40 p.m., the administrator was asked if she was aware that the facility's floor and surface cleaner was not on the EPA N list of disinfectants. She stated she did not know until then. She was asked whose responsibility it was to ensure the appropriate cleaners were being used. She stated the housekeeping supervisor.

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.