STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375459	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENWOOD MANOR	**502 WEST PINE ENID, OK 73701**

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 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, it was determined the facility failed to have an effective administration who: ~ implemented infection prevention and control practices to prevent the potential development and transmission of COVID-19; ~ conducted respiratory surveillance tracking/monitoring of staff and residents who had signs/symptoms associated with COVID-19. The DON (director of nurses)/IP (Infection Preventionist) identified one staff and one resident who had experienced signs/symptoms of COVID-19 since 03/01/20; ~ provided appropriate PPE (personal protective equipment) for staff to care for a resident who required contact/droplet precautions for one (#1) of one resident observed on contact/droplet precautions. The DON/IP identified two residents on transmission based precautions; ~ initiated appropriate transmission based precautions and quarantine for a resident who received outpatient [MEDICAL TREATMENT] services three times a week for one (#8) of one resident who received [MEDICAL TREATMENT] services. The administrator identified one resident who received outpatient [MEDICAL TREATMENT] services; ~ ensured staff and residents (#1, 2, 3, 4, 5, and #6) were provided and wore face masks in an appropriate manner; and ~ ensured staff were knowledgeable and followed the approved contact time for a disinfectant. The DON/IP identified 32 residents who resided in the facility; Findings: A CDC (Centers for Disease Control and Prevention) website article, updated 05/19/20, titled, CDC Preparing for COVID-19 in Nursing Homes, documented: .HCP (health care personnel) should wear a facemask at all times while they are in the facility. When available, face masks are generally preferred over cloth face coverings for HCP as face masks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others .Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility . .Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas . Keep Your Distance to Slow the Spread .To practice social or physical distancing stay at least 6 feet (about 2 arms' length) from other people . Make necessary PPE available in areas where resident care is provided .Facilities should have supplies of face masks, respirators .gowns, gloves, and eye protection (i.e., face shield or goggles). .Environmental Cleaning and Disinfection .Ensure EPA (environmental protection agency)-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 Nexternal 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 . The EPA registration website for, Clorox .Clean-Up, documented the disinfectant required a dwell time of five minutes after it was sprayed on a surface before it was wiped away to be effective against COVID-19. On 06/18/20, the following observations were made: Upon entrance to the facility, the administrator was observed to answer the front door without a mask on. Two unidentified staff members were observed walking through the common area without masks on. Residents numbers #1, 2, 3, 4, 5, and #6 were observed to self ambulate or moved via assuasive devices by staff throughout the facility with a face mask in place. The administrator and DON/IP were observed throughout the survey with their masks off or below their nose. The DON was observed in the hallway, walking from the copy room to her office, she held a piece of paper in front of her face. She stated she forgot her mask. At 10:25 a.m., housekeeper #1 was asked what disinfectant was used in the facility against COVID-19. She stated she used Clorox Clean-Up. She stated she was unsure what the contact time was. She than stated she did not know what the word contact was referring to. She stated she sprayed the hard surface area and immediately wiped the product up. At 10:30 a.m., the housekeeping supervisor was observed spraying the disinfectant on the hand rails in the facility and immediately wiping the surfaces with a towel. She stated she did not understand what was meant by the words contact time. She said, I don't think there is a contact time. At 10:32 a.m., resident #3 and #5 stated the facility had not provided them with a mask to wear and they had not been told they needed to wear one. At 10:44 a.m., the administrator was asked what the contact time was for the disinfectant the facility used against COVID-19. She read the bottle of Clorox Clean-Up and stated 38 seconds to one minute. She was asked if she had verified this information with the EPA. She stated she would check. The administrator stated resident #1 was on quarantine for 14 days due to readmission to the facility two days prior to the survey. An isolation cart was observed outside of resident #1's room. There was no eye protection stocked on the cart. At 11:08 a.m., the following observations were made of resident #1, who was on transmission based precautions due to readmission to the facility. Staff members were observed while they provided incontinent care for resident #1. CNA #1, 2, and #3 donned a face mask, gloves, shoe covers, and a gown and entered the resident's room to provide her incontinent care. The CNAs did not don any eye protection. At 11:28 a.m., CNA #1 stated she was unsure what type of transmission based precautions the resident was on. She stated full PPE, including a eye protection, was required to care for the resident. She stated the facility administration staff had never provided the staff with eye protection. At 11:32 a.m., CNA #2 stated the resident was on a 14 day quarantine due to being a readmission from the hospital. She stated full PPE was required, including eye protection when providing care to the resident. She stated the facility had not provided the staff with eye protection. At 11:33 a.m., CNA #3 and #4 were asked if resident #8 left the facility three times weekly for [MEDICAL TREATMENT]. They stated she did. They were asked if she was on any type of transmission based precautions. They stated she was on contact precautions due to a wound on her leg. They stated full PPE was required to provide care to the resident. They stated the facility had not provided eye protection. They were asked if the resident was on quarantine related to her leaving the facility frequently for [MEDICAL TREATMENT]. They stated she was not. They stated she was allowed to go to the dining room and eat meals with the other residents as long as they practiced social distancing. At 11:40 a.m., a meeting was held with the administrator and the DON/IP. They were asked if staff were required to wear masks in the facility. The DON said, We haven't been enforcing this forcefully. They haven't been wearing consistently unless they are providing care. She further stated the residents were not wearing masks unless they had a cough or respiratory symptoms. They were notified of CDC guidance related to mask use. The DON/IP was asked what type of precautions resident #8 was on. She stated she was on contact precautions [MEDICAL CONDITION] (a multi-drug resistant organism). She stated she did not know the resident needed to be quarantined since she left frequently for [MEDICAL TREATMENT]. She stated the resident had been coming out to eat meals in the dining room often. They were asked about eye protection and full PPE for the residents on quarantine due to readmission/new admission. The DON/IP stated she did not know residents on quarantine required full PPE, including eye protection. She stated she had not provided the staff members with access to eye protection until she was notified it was necessary. The DON/IP was asked if she had completed respiratory surveillance tracking/monitoring of staff and residents with signs/symptoms associated with COVID-19. She stated she had not. She stated she was not aware this should have been done. They were asked what the dwell time was for the disinfectant the facility used. The administrator stated the facility

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.

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) utilized Clorox Clean-Up, but she was not sure if it was on the approved EPA list against COVID. She stated she was unsure what the dwell time was. The disinfectant was entered into the EPA registration site. It was determined the disinfectant was approved and required a five minute dwell time. She was notified of the observations and interview with the house keeping supervisor.
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 observations, record reviews, and interviews, it was determined the facility failed to: ~ implement infection prevention and control practices to prevent the potential development and transmission of COVID-19; ~ conduct respiratory surveillance tracking/monitoring of staff and residents who had signs/symptoms associated with COVID-19. The DON (director of nurses)/IP (Infection Preventionist) identified one staff and one resident who had experienced signs/symptoms of COVID-19 since 03/01/20; ~ provide and don appropriate PPE (personal protective equipment) for a resident who required contact/droplet precautions for one (#1) of one resident observed on contact/droplet precautions. The DON/IP identified two residents on transmission based precautions; ~ initiate appropriate transmission based precautions and quarantine for a resident who received outpatient [MEDICAL TREATMENT] services three times a week for one (#8) of one resident who received [MEDICAL TREATMENT] services. The administrator identified one resident who received outpatient [MEDICAL TREATMENT] services; ~ ensure staff and residents (#1, 2, 3, 4, 5, and #6) were provided and wore face masks in an appropriate manner; and ~ ensure staff were knowledgeable and followed the approved contact time for a disinfectant. The DON/IP identified 32 residents who resided in the facility; Findings: A CDC (Centers for Disease Control and Prevention) website article, updated 05/19/20, titled, CDC Preparing for COVID-19 in Nursing Homes, documented: .HCP (health care personnel) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as face masks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others .Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility . .Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas . Keep Your Distance to Slow the Spread .To practice social or physical distancing stay at least 6 feet (about 2 arms' length) from other people . Make necessary PPE available in areas where resident care is provided .Facilities should have supplies of face masks, respirators .gowns, gloves, and eye protection (i.e., face shield or goggles). .Environmental Cleaning and Disinfection .Ensure EPA (environmental protection agency)-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 Nexternal 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 . The EPA registration website for, Clorox .Clean-Up, documented the disinfectant required a dwell time of five minutes after it was sprayed on a surface before it was wiped away to be effective against COVID-19. On 06/18/20, the following observations were made: At 10:10 a.m., upon entry to the facility, the administrator was observed to answer the front door without a mask on. Two unidentified staff members were observed walking through the common area without masks on. The administrator stated resident #1 was on quarantine for 14 days due to readmission to the facility two days prior to the survey. From 10:16 a.m. through 10:21 a.m.,, the following observations were made. Resident #2 was observed seated in the common area without a mask on. Resident #3 was observed to walk to the nurse's station, through the common area, and than outside without a mask on. An isolation cart was observed outside of resident #1's room. There was no eye protection stocked on the cart. The administrator was observed walking through the common area towards the business office with her mask below her nose. At 10:25 a.m., housekeeper #1 was asked what disinfectant was used in the facility against COVID-19. She stated she used Clorox Clean-Up. She stated she was unsure what the contact time was. She than stated she did not know what the word contact was referring to. She stated she sprayed the hard surface area and immediately wiped the product up. At 10:30 a.m., the housekeeping supervisor was observed spraying the disinfectant on the hand rails in the facility and immediately wiping the surfaces with a towel. She stated she did not understand what was meant by the words contact time. She said, I don't think there is a contact time. At 10:32 a.m., resident #3 and #5 stated the facility had not provided them with a mask to wear and they had not been told they needed to wear one. At 10:44 a.m., the administrator was asked what the contact time was for the disinfectant the facility used against COVID-19. She read the bottle of Clorox Clean-Up and stated 38 seconds to one minute. She was asked if she had verified this information with the EPA. She stated she would check. From 10:44 a.m. to 11:07 a.m., the following observations were made. Residents #4, #5, and #6 were observed to ambulate about the facility without face masks on. One unidentified resident was observed to be moved to his room from the shower room by a staff member without a mask in place. The DON/IP and administrator were observed in the administrator's office without a mask on. The DON/IP was observed to screen a staff member who walked into the facility without a mask on. At 11:08 a.m., the following observations were made of resident #1, who was on transmission based precautions due to readmission to the facility. Staff members were observed while they provided care to resident #1. CNA #1, 2, and #3 donned a face mask, gloves, shoe covers, and a gown and entered the resident's room to provide her incontinent care. The CNAs did not don any eye protection. At 11:28 a.m., CNA #1 stated she was unsure what type of transmission based precautions the resident was on. She stated full PPE, including a eye protection, was required to care for the resident. She stated the facility administration staff had never provided the staff with eye protection. At 11:32 a.m., CNA #2 was asked if resident #1 was on any transmission based precautions. She said, No precautions that I know of. She than stated the resident was on a 14 day quarantine due to being a readmission from the hospital. She was asked what PPE was required to provide care for the resident when splashes or sprays were probably. She stated full PPE was required, including eye protection. She stated the facility had not provided the staff with eye protection. At 11:33 a.m., CNA #3 and #4 were asked if resident #8 left the facility three times weekly for [MEDICAL TREATMENT]. They stated she did. They were asked if she was on any type of transmission based precautions. They stated she was on contact precautions due to a wound on her leg. They stated full PPE was required to provide care to the resident. They stated the facility had not provided eye protection. They were asked if the resident was on quarantine related to her leaving the facility frequently for [MEDICAL TREATMENT]. They stated she was not. They stated she was allowed to go to the dining room and eat meals with the other residents as long as they practiced social distancing. At 11:40 a.m., a meeting was held with the administrator and the DON/IP. They were asked if staff were required to wear masks in the facility. The DON said, We haven't been enforcing this forcefully. They haven't been wearing consistently unless they are providing care. She further stated the residents were not wearing masks unless they had a cough or respiratory symptoms. They were notified of CDC guidance related to mask use. The DON/IP was asked what type of precautions resident #8 was on. She stated she was on contact precautions [MEDICAL CONDITION] (a multi-drug resistant organism). She stated she did not know the resident needed to be quarantined since she left frequently for [MEDICAL TREATMENT]. She stated the resident had been coming out to eat meals in the dining room often. They were asked about eye protection and full PPE for the residents on quarantine due to readmission/new admission. The DON/IP stated she did not know residents on quarantine required full PPE, including eye protection. She stated she had not provided the staff members with access to eye protection until she was notified it was necessary. The administrator and the DON/IP stated they had an abundabce of disposable face shields they had been storing for furture use if a resident was symptomatic or positive for COVID-19. The DON/IP was asked if she had completed respiratory surveillance tracking/monitoring of staff and residents with signs/symptoms associated with COVID-19. She stated she had not. She stated she was not aware this should have been done. They were asked what the dwell time was for the disinfectant the facility used. The administrator stated she had looked up the product on the EPA registration site. She stated it was recommended against COVID-19 and had a five minute dwell time. She was notified of the observations and interview with the house keeping supervisor.