STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375438	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACEWOOD HEALTH & REHAB	6201 EAST 36TH STREET TULSA, OK 74135

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 implement their infection control program to prevent the potential spread of infection for 5 (#1, #2,#3, #7, and #8) of 5 sampled residents reviewed for infection control. The facility failed to: a) ~ Ensure staff members were thoroughly screened for all possible COVID-19 symptoms documented on the centers for disease control website. b) ~ Ensure the residents were thoroughly monitored for all possible COVID-19 symptoms documented on the centers for disease control website. c) ~ Ensure staff members wore the appropriate personal protective equipment when caring for residents who were in isolation/quarantine. d) ~ Ensure residents receiving [MEDICAL TREATMENT] were kept in isolation/quarantine. e) ~ Ensure staff used gloves/changed gloves/sanitized between resident care. f) ~ Ensure signs were posted on the door when a resident was in isolation/quarantine. g) ~ Ensure a glucometer and testing strip bottle were sanitized between residents and before placing back into the treatment cart. The facility identified 61 residents lived in the facility. Findings: Evaluate and manage residents with symptoms of COVID 19. .Actively monitor all resident upon admission and at least daily for fever .and symptoms consistent with COVID 19. 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 . Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19 . Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace . The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . Immediately before touching a patient . Before performing an aseptic task . Before moving from work on a soiled body site to a clean body site . After touching a patient or the patient's immediate environment . After contact with blood, body fluids, or contaminated surfaces . Immediately after glove removal . 1. On 08/18/20 at 11:20 a.m., the surveyors entered the building. The administrator opened the door and asked if we had a cough. The surveyors stated no. She filled out a document, took our temperatures, and allowed us to enter the building. The administrator was asked for a copy of the employee/visitor screening form. At 1:15 p.m., the administrator provided the surveyors with a copy of the employee visitor screening form. The form did not contain a complete list of COVID symptoms. The form documented fever, sore throat, cough and new shortness of breath. At 3:00 p.m., the administrator was asked if she was aware the screening form did not contain a complete list of COVID symptoms. She stated she was not aware. She stated the form came from the corporate office. 2. On 08/18/20 at 11:45 a.m., the director of nursing was asked how often residents had their temperatures taken and were assessed for signs and symptoms of COVID. He stated the residents were assessed and had their temperatures taken during the day shift. He was asked where the documentation would be located. He stated on the medication administration record. The residents' records were reviewed. There was documentation the residents' temperature had been taken daily. There was no documentation of any assessment for symptoms of COVID. On 08/19/20 at 11:38 a.m., the director of nursing was asked if the residents were assessed for signs and symptoms of COVID. He stated the residents' were assessed for pain. He stated residents' temperatures were taken daily but there was no assessment or documentation of COVID symptoms. 3. On 08/18/20 at 12:27 p.m., certified nurse aid #1 was observed to enter resident #2's room wearing only a surgical mask. She was observed to walk up to the resident, who was in bed. She then came back out of the room. She did not sanitize or wash her hands. The resident had a sign on the door stating the resident was in isolation and no one should enter without donning full personal protective equipment. At 12:29 p.m., certified nurse aid #1 entered the resident's room wearing a surgical mask and no other protective equipment. She walked up to the resident #2,'S bed which was next to the resident's over bed table. She put her hands on the over bed table and moved it. She put one glove on and gathered the resident's trash and came out of the resident's room. She removed the glove and took the trash down the hall and opened a door and went into a room. At 12:31 p.m., two staff members, certified nurse aid #1 and hospitality aid/certified nurse aid in training #1, who were both wearing gowns and surgical masks, entered the resident #2's room and shut the door. Certified nurse aid #1 was carrying a brief and a package of resident cleansing wipes. She closed the resident's room door. At 12:40 p.m., hospitality aid/certified nurse aid in training #1 came out of the resident's room with gloves on carrying the package of resident cleansing wipes. He was observed to carry the package of wipes and place them on a shelf in the clean linen cart. At 12:51 p.m., certified nurse aid #1 was asked what kind of personal protective equipment should be worn when caring for a resident in isolation/quarantine. She stated a gown, mask, gloves, and face shield. She was asked why she had not worn the appropriate personal protective equipment. She stated she had just forgotten and was in a rush. She was asked when she should sanitize her hands between residents. She stated everyone should sanitize their hands between residents. She was asked when providing resident care, where does she obtain supplies for incontinent care. She stated she would go get a resident brief and a container of wipes and provide inconvenient care and then bring the wipes back out and put them on the clean linen cart because they were not supposed to keep them in the resident rooms. At 1:39 p.m., Hospitality aid/certified nurse aid in training #1 was asked about bringing the contaminated wipes out of the resident's room. He stated the process was not to leave them in a resident's room. He stated he put the wipes back on the clean linen cart because he did not know where else to put them. He stated that was where the wipes were kept. On 08/19/20 at 11:38 a.m., the director of nursing was asked what personal protective equipment should be worn when entering a resident's room who was in isolation. He stated staff should wear a gown, mask, face shield, and gloves. He was asked when gloves should be changed and hands sanitized. He stated staff should be changing their gloves and sanitizing their hands between each resident. The DON was asked about storage of resident cleansing wipes. He stated wipes should be taken into a resident room and should be left in the resident's room. He stated if they were put back on the clean linen cart after having been in a resident room the whole cart would be contaminated. 4. On 08/18/20 at 12:35 p.m., certified nurse aid #3 was observed, with a face mask on, to go into resident #1's room, and assist him with the removal of his pants with her ungloved hands. She helped the resident to cover up and left the room. Without washing or sanitizing her hands she went into the next resident room and answered a call light. At 12:55 p.m., certified nurse aid #3 was observed with a face mask and gloves on. She entered resident #1's room and delivered his lunch tray. The door was open and she was observed to help the resident adjust his call light. She was observed to remove her gloves, reach in her pockets for new gloves, and put on the gloves. She did not wash or sanitize her hands in between the removal of the contaminated gloves and donning of new gloves. She retrieved the resident's roommate's tray from the kitchen cart and served him. At 1:40 p.m., certified nurse aid #3 was asked how she

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) sanitized her hands and obtained gloves between residents. She stated she usually carried gloves and hand sanitizer in her uniform pockets. She stated she forgot her hand sanitizer today. She was asked why she had not sanitized her hands after resident care. She stated she had forgotten to sanitize her hands because she had not brought her personal hand sanitizer today. She stated she should have washed her hands or used the hand sanitizer on the wall in the hallway between residents. On 08/19/20 at 11:50 a.m., the director of nursing was asked how the staff were to sanitize their hands and use gloves to provide resident care. He stated they should perform handwashing or use hand sanitizer between residents and take gloves in with them to do care. He was asked if they should carry gloves in their pockets. He stated no, the gloves would be contaminated if they were placed in the staff member's pockets. 5. Resident #1 was identified by the facility as receiving [MEDICAL TREATMENT]. On 08/18/20 at 12:20 p.m., resident #1, who resided on the 400 hall, stated he left the facility three times per week for [MEDICAL TREATMENT]. There was no sign on the resident's door to indicate he was quarantined. There was no personal protective equipment near the resident's room. The resident had a roommate. There was no barrier seen between the residents. At 12:30 p.m., certified nurse aid #3 was asked if any residents on the 400 hall were quarantined or in transmission based precautions/isolation. She stated no. At 1:40 p.m., certified nurse aid #3 was asked if a resident was quarantined/isolated what personal protective equipment would be required. She stated a gown, gloves, face mask, and face shield. She was asked how she was made aware if a resident required isolation precautions. She stated she would be told in report at shift change by staff. On 08/19/20 at 11:50 a.m., the director of nursing was asked why the resident who left the facility for [MEDICAL TREATMENT] three times per week was not quarantined. He stated it was missed. He stated the resident should be quarantined and not have a roommate. 6. On 08/18/20 at 12:25 p.m., resident #3 did not have a sign on her door stating she was in isolation/quarantine. The resident had been identified by staff as a resident who was in isolation/quarantine due to having come back from the hospital recently. On 08/19/20 at 11:38 a.m., the director of nursing was asked when signaled on a resident door was required. He stated residents' in isolation/quarantine should have a sign on the door. 7. On 08/19/20 at 9:58 a.m., licensed practical nurse #1 was observed to take out a glucometer, testing strips, insulin, an insulin syringe, a lancing device, and alcohol wipes for resident #7. She laid the supplies on the top of the treatment cart without a barrier. She did not sanitize the glucometer. She drew up the resident's ordered amount of routine insulin and carried the supplies, including gloves, into the resident's room in her left hand. Upon entering the room she obtained some hand sanitizer in her other hand. She placed the supplies on the resident's over bed table without a barrier. She used the sanitizer and put gloves on. She obtained the resident's finger stick result and placed the glucometer and strips container back onto the over bed table. She gave the resident the prescribed insulin and removed her gloves and gathered up the supplies in her hand and brought them back to the treatment cart. She unlocked the cart and placed the glucometer and test strips back into the cart. She did not sanitize the glucometer or the test strip container prior to placing them back into the cart. She did not sanitize her hands. Licensed practical nurse #1 turned the page on the treatment cart book and took out the same glucometer, the same testing strip bottle, insulin, an insulin syringe, a lancing device, and alcohol wipes for resident #8. She laid the supplies on the top of the treatment cart without a barrier. She did not sanitize the glucometer. She drew up the resident's ordered amount of routine insulin and carried the supplies, including gloves, into the resident's room in her left hand. Upon entering the room she obtained some hand sanitizer in her other hand. She placed the supplies on the resident's over bed table without a barrier. She used the sanitizer and put gloves on. She obtained the resident's finger stick result and placed the glucometer and strips container back onto the over bed table. She gave the resident the prescribed insulin and removed her gloves and gathered up the supplies in her hand and brought them back to the treatment cart. She unlocked the cart and placed the glucometer and test strips back into the cart. She did not sanitize the glucometer or the test strip container prior to placing them back into the cart. She did not sanitize her hands. At 10:16 a.m., licensed practical nurse #1 was asked when the glucometer/strip container should be sanitized. She stated they should be sanitized between residents. She was asked about placing supplies on the resident's over bed table. She stated she usually placed a barrier down on the over bed table to put supplies on but she had just forgotten today.