STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375331	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST NURSING CENTER	2120 NORTH BROADWAY MOORE, OK 73160

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 0727 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on record review and interview, it was determined the facility failed to ensure the DON had not served as the charge nurse for 13 of the 14 days the staffing schedule was reviewed. The facility identified 85 residents who resided in the facility. Findings: The staffing schedule, dated 05/22/20, documented the DON worked as the charge nurse on the second shift from 3:00 p.m. to 11:00 p.m. The staffing schedules, dated 05/23/20 through 05/24/20, documented the DON worked as the charge nurse on the first shift from 7:00 a.m. to 7:00 p.m. The staffing schedules, dated 05/25/20 through 05/29/20, documented the DON worked as the charge nurse on the second shift from 3:00 p.m. to 11:00 p.m. The staffing schedules, dated 05/30/20 through 05/31/20, documented the DON worked as the charge nurse on the second shift from 7:00 p.m. to 11:00 p.m. The staffing schedule, dated 06/01/20, documented the DON worked as the charge nurse on the second shift from 3:00 p.m. to 11:00 p.m. The staffing schedules, dated 06/03/20 through 06/04/20, documented the DON worked as the charge nurse on the second shift from 3:00 p.m. to 11:00 p.m. At 9:45 a.m., the DON was asked if she had been working the floor everyday. The DON stated yes, on the evening shift. At 11:18 a.m., the administrator and DON were asked if they had been aware the DON could not work as the charge nurse. The DON stated, I know that. The administrator stated, What do you expect us to do?
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on record review and interview, it was determined administration failed to effectively manage resources: ~ to ensure there was sufficient staff to meet minimum staffing ratios for 22 of 42 shifts from 05/22/20 through 06/04/20; and ~ to ensure the Director of Nursing was not required to act as charge nurse for 13 of the 14 days from 05/22/20 through 05/31/20, 06/01/20, 06/03/20, and 06/04/20. The facility identified 85 residents who resided in the facility. Findings: Findings: 1. The resident census was 86 from 05/22/20 through 05/25/20, which indicated 14 direct care staff were needed to meet the minimum direct care staff to resident ratio on the day shift, 11 direct care staff were needed to meet the minimum direct care staff to resident ratio on the evening shift, and six direct care staff were needed to meet the minimum direct care staff to resident ratio on the night shift. The staffing schedule, dated 05/22/20, documented 12 direct care staff worked the day shift, ten direct care staff worked the evening shift and five direct care staff worked the night shift. The staffing schedule, dated 05/23/20, documented 11 direct care staff worked the day shift. The staffing schedule, dated 05/24/20, documented 12 direct care staff worked the day shift. The staffing schedule, dated 05/25/20, documented eight direct care staff worked the day shift and nine direct care staff worked the evening shift. The resident census was 85 on 05/26/20, which indicated 14 direct care staff were needed to meet the minimum direct care staff to resident ratio on the day shift and 11 direct care staff were needed to meet the minimum direct care staff to resident ratio on the evening shift. The staffing schedule, dated 05/26/20, documented 11 direct care staff worked the day shift and ten direct care staff worked the evening shift. The resident census was 84 from 05/27/20 through 06/04/20, which indicated 14 direct care staff were needed to meet the minimum direct care staff to resident ratio on the day shift, 11 direct care staff were needed to meet the minimum direct care staff to resident ratio on the evening shift, and six direct care staff were needed to meet the minimum direct care staff to resident ratio on the night shift. The staffing schedule, dated 05/27/20, documented 12 direct care staff worked the day shift. The staffing schedule, dated 05/28/20, documented 11 direct care staff worked the day shift. The staffing schedule, dated 05/29/20, documented 13 direct care staff worked the day shift. The staffing schedule, dated 05/30/20, documented 12 direct care staff worked the day shift and five direct care staff worked the night shift. The staffing schedule, dated 05/31/20, documented ten direct care staff worked the day shift and ten direct care staff worked the evening shift. The staffing schedule, dated 06/01/20, documented eight direct care staff worked the day shift and ten direct care staff worked the evening shift. The staffing schedule, dated 06/02/20, documented ten direct care staff worked the day shift and nine direct care staff worked the evening shift. The staffing schedule, dated 06/03/20, documented 11 direct care staff worked the day shift. The staffing schedule, dated 06/04/20, documented 12 direct care staff worked the day shift. The staffing schedules from 05/22/20 through 06/04/20 documented the DON covered at least one shift a day for 13 of the 14 days and the ADON covered at least one shift a day for 11 of the 14 days. On 06/06/20 at 8:48 a.m., observations were made of the quarantine unit of the facility. Double doors were shut on both ends of the unit to close it off from the rest of the facility. Ten different rooms were observed in the unit. Four residents were observed in four of the rooms. No staff was observed on the unit. At 9:11 a.m., the administrator and RN #1 were observed to entered the unit and re-stock the PPE. At 9:13 a.m., RN #1 was asked if she was working the unit. She stated no, LPN #1 was assigned to work the unit but she was passing medication on another hall. RN #1 stated the LPN was assigned to work the quarantine unit and another part of the facility. At 9:16 a.m., a CNA was observed to enter the quarantine unit and acknowledged to RN #1 that she was working the unit. At 9:18 a.m., LPN #2 stated staffing was an issue. The CNA assigned to work in the COVID unit was often left by herself to care for all the residents. The LPN stated RN #2 and herself were working double shifts constantly. She was asked if the quarantined unit was left unattended by staff. The LPN stated it was always left without staff. At 9:35 a.m., RN #2 was asked if staffing was an issue. He stated they were still working on it but he had been working doubles to help cover the shortage. The RN stated they had tried to assign one nurse to the COVID unit and leave him alone to cover the rest of the facility but he refused to allow it. He stated that would have been to much for one nurse. At 9:45 a.m., the DON was asked how the shift was assigned to ensure the quarantined unit was covered by staff. She stated the nurse working the west hall was also responsible for covering the quarantined unit and a CNA was also assigned to the unit. The DON was asked how the quarantined unit was indicated on the staffing schedule. She stated it was documented as SW. She was asked of the 42 shifts reviewed, who would have known to cover the 17 shifts with no indication of a SW assignment. The DON had no response. The DON was asked if the ADON works on the floor everyday. She stated the ADON has been here a lot. She was asked if she (the DON) had been working the floor everyday. The DON stated yes, on the evening shift. She stated she would come in early or stay late to ensure her work as the DON was also completed. At 11:08 a.m., the DON was asked how she ensured they were sufficiently staffed. She stated they had a number they tried to achieve according to the number of residents and special units. She stated the staffing coordinator would notify her when they were not meeting that number. The DON was asked how often the staffing coordinator had been notifying her. She said pretty much daily. 2. The staffing schedule, dated 05/22/20, documented the DON worked as the charge nurse on

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

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