STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375107	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND AT BETHANY SKILLED NURSING AND THERAPY	**7000 NORTHWEST 32ND STREET BETHANY, OK 73008**

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 observations, interviews, and record reviews, it was determined the facility failed to ensure: ~ residents whose COVID-19 status were unknown were quarantined in a single room without another resident for six (#1, 2, 5, 6, 7, and #8) of 14 residents observed who were new admissions or readmissions and on a 14 day quarantine. The DON/IP (director of nurses/infection preventionist) identified 14 residents who were on quarantine due to being newly admitted or readmitted within the last 14 days; and ~ residents who left the facility frequently for [MEDICAL TREATMENT] services were quarantined in a single room without another resident for two (#3 and #4) of six residents observed who received [MEDICAL TREATMENT] services and were on quarantine. The DON/IP identified six residents who left the facility frequently for [MEDICAL TREATMENT] services. Findings: A CDC (Centers for Disease Control and Prevention) website article, last updated 06/22/20, titled, Preparing for COVID-19 in Nursing Homes, documented: .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .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 . On 06/25/20, the following observations were made: Resident #1 and #2 were observed to reside in the same room. Resident #3 and #4 were observed to reside in the same room. Resident #5 and #6 were observed to reside in the same room. Resident #7 and #8 were observed to reside in the same room. There were signs posted on the outside of each resident's door which documented the residents were on quarantine due to being a new admission, readmission, or they received outpatient [MEDICAL TREATMENT]. The signs did not indicate which of the three reasons the residents were on quarantine. The signs documented staff who entered the residents' rooms were required to don an N95 face mask, gown, gloves and face shields prior to entering. At 10:50 a.m., LPN (licensed practical nurse) #1 was asked why each set of residents were on quarantine. She stated resident #1 and #2 were newly admitted to the facility within the last 14 days. She stated resident #3 and #4 left the facility three times weekly for [MEDICAL TREATMENT] services. She stated residents #5 was a new admission and resident #6 was a readmission from the hospital within the last 14 days. She stated resident #7 and #8 were readmissions from the hospital within the last 14 days. At 10:55 a.m., it was observed there were six empty rooms on hall 300. The DON/IP identified hall 300 as a unit which only housed residents who required quarantine. At 11:04 a.m., a meeting was held with the administrator, DON/IP, and the regional nurse consultant. They were asked why newly admitted , readmission, and [MEDICAL TREATMENT] residents were not residing in private rooms. The DON/IP stated the facility believed it was appropriate for newly admitted and/or readmitted residents to reside in the same room as long as they were admitted within 48 hours of each other. The regional nurse consultant stated the facility believed it was appropriate to place newly admitted and/or readmitted residents in a room together as long as they both admitted on the same day from the same hospital. They stated they felt it was appropriate to place residents who left the facility for [MEDICAL TREATMENT] appointments together in the same room. They stated newly admitted /readmitted residents were required to have one negative COVID-19 test within 72 hours of admission the facility. They were notified residents who were newly admitted and readmitted were considered to be COVID-19 status unknown since they had only received one test up to three days prior to admission to the facility. They were notified residents who left the facility frequently for appointments were at an increased risk to contract COVID-19 and required quarantine in single rooms. They acknowledged the concerns. At 11:50 a.m., the administrator stated the entire hall 300 had been converted to a quarantine only unit two weeks prior to the survey. Before the hall was converted the quarantined residents resided on the east side of hall 300. He stated the west side of hall 300 had housed residents who had come of their 14 day quarantine and were asymptomatic. He stated the facility realized they need the additional rooms due to the number of new admissions to the facility. He acknowledged there were several empty rooms on hall 300. He was asked how long had the five empty rooms on the west side of hall 300 been empty. He said, Those rooms have been empty for a while. He further stated the facility had been doubling up quarantined residents in semi-private rooms for a while. He then stated he understood and agreed the newly admitted , readmitted and [MEDICAL TREATMENT] residents needed to be in private rooms to avoid possible contraction and spread of COVID-19.

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