STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375570	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCEL AT CRYSTAL PARK	**315 SW 80TH STREET OKLAHOMA CITY, OK 73139**

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.** Based on observation and interview, it was determined the facility failed to implement their infection control program to prevent the potential spread of infection for one (#1) of ten sampled residents. The facility failed to ensure a staff member removed the personal protective equipment (PPE) prior to leaving a resident's isolation/quarantine room. Total residents: 45 Findings: At 11:58 p.m., therapy aide (TA) #1 was observed to walk away from a cart in the hall on 200 hall (quarantine). The TA had on a mask, face shield, and blue disposable isolation gown. At 11:59 a.m., the TA exited the room of resident #1. The TA was wearing a mask, face shield, and a blue disposable isolation gown. The TA carried a plastic bag into the soiled holding room. The TA then went back into the room of resident #1 with her mask, face shield, and isolation gown on. The TA then came out of the resident's room with the mask, face shield, and isolation gown on and carrying a cup. She entered the clean linen room. She exited the clean linen room and went back into the resident's room. At 12:02 p.m., the TA exited the resident's room. At 12:02 p.m., the TA verified the above observations of going in and out of the resident's room with the isolation gown on. She stated, she had taken the resident's dirty stuff to the soiled holding room as she had assisted the resident with a shower. She stated she had taken the resident's cup to the clean linen room to fill it up with ice. She verified she had worn her isolation gown out and back into the resident's room multiple times. The TA was asked if she was supposed to wear the isolation gown out in and out of an isolation resident room. She stated they had told them to change the gown between the residents. She stated she was going right back into the resident's room. At 4:46 p.m., the director of nursing stated it was not a good practice to take a resident's cup out of a quarantine room into the clean linen room to get ice. She was asked why a staff member was observed wearing an isolation gown out and back into a resident's quarantine room. She stated that should not have happened. She stated if a staff member was leaving a resident's room the isolation gown should have been removed. The observation of the TA was discussed.

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