STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375534	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIENNA EXTENDED CARE & REHAB	9221 HARMONY DRIVE MIDWEST CITY, OK 73130

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, record review and staff interviews, it was determined the facility failed to maintain CDC guidelines to aid in the prevention and spread of COVID-19 by failing to ensure: ~ residents who were in quarantine did not share a room and toilet with other residents who were in quarantine, for 6 of 12 residents who were in quarantine; ~ appropriate signage was posted on quarantine room doors to alert staff of necessary isolation precautions and PPE to be used, for 12 of 12 residents in the facility who were in quarantine; ~ residents were monitored for temperature, for three of three residents sampled for COVID-19 monitoring; and ~ facility staff were thoroughly screened for all possible symptoms of COVID-19, for three of three staff members sampled for COVID-19 entrance screening. The facility reported 55 residents residing in facility. Findings: The Center for Disease Control guidance titled, Coronavirus Disease 2019 (COVID-19), documented, .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 .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. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a 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 febrile and without symptoms for 14 days .Actively monitor all residents upon admission and at least daily for fever (T.100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0 F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 . 1. On 09/15/20 at 9:45 a.m., the administrator was asked how many residents the facility had in quarantine. He stated eight new admissions and four who received [MEDICAL TREATMENT]. He was asked if the residents who were in quarantine were in private rooms. He stated some of the residents in quarantine shared a room with other residents which included a shared bathroom. The administrator was asked why residents who were in quarantine were sharing a room. He stated he did not have enough staff for the residents to have private rooms. At 2:20 p.m., three room suites on hall 100, designated as quarantine rooms, were observed to have two residents in each suite. A hard wall was observed between the resident's beds. The suites had a common entry area and a common bathroom. On 09/16/20 at 11:35 a.m., the administrator was asked if residents of unknown COVID status should be quarantined together. He stated that from what had been explained to him they could. He stated that the previous DONs had clarified with the health department. 2. On 09/15/20 at 2:20 p.m., observations were made, with the DON, of the rooms of residents who were in quarantine. Supply containers were observed outside the rooms, each door stocked with PPE. There were no signs on the quarantine room doors indicating what type of isolation precautions and PPE should be used for the residents in the rooms. The DON was asked if there should be signs on the door indicating what type of PPE should be used for the residents in quarantine. She stated, Yes. She was asked how staff would know what PPE to wear. She stated they would not unless they had been trained or verbally instructed. 3. On 09/15/20 at 12:20 p.m., the DON was asked how often residents were monitored for signs and symptoms of COVID. She stated residents in the skilled unit were monitored for vital signs every shift including O2 sat and temperature. She stated residents in quarantine were checked every six hours for vital signs including O2 sat and temperature. The DON stated the long term care general population had vital signs monthly and PRN. She stated there was no routine monitoring of temperature or O2 sat. She stated if a resident had signs or symptoms of illness or a change in condition they would get vital signs and test for COVID. At 2:00 p.m. the DON was asked why the facility was not monitoring long term care residents at least every shift for vital signs, including temperature and O2 sat. She stated if the resident had any change in condition or signs or symptoms of illness they would do more and notify the physician. She stated if a resident was asymptomatic, it would not show up with a vital signs check. The DON was asked how you would know if a resident had a fever if a temperature had not been taken. She stated she guessed that was a possibility, unless they showed other indications. On 09/16/20 resident records were reviewed for three randomly selected residents: a. Resident # 1 was admitted with [DIAGNOSES REDACTED]. The resident's record was reviewed for temperature monitoring. The record had no documentation that been taken between 05/20/20 and 08/28/20. There was no documentation the resident the been assessed for signs and symptoms of illness. b. Resident #2 was admitted with [DIAGNOSES REDACTED]. The resident's record was reviewed for temperature monitoring. The record had no documentation that temperatures had been taken between 05/25/20 and 08/28/20. There was no documentation the resident the been assessed for signs and symptoms of illness. c. Resident #3 was admitted with [DIAGNOSES REDACTED]. The resident's record was reviewed for temperature monitoring. The record had no documentation that temperatures had been taken between 08/17/20 and 09/14/20. There was no documentation the resident the been assessed for signs and symptoms of illness. On 09/16/20 at 8:30 a.m., the DON was asked if resident #1 had temperature checks between 05/20/20 and 08/28/20. She stated, No. She was asked if there were any nurses notes regarding an assessment of the resident. She stated no, the facility does charting by exception. She was asked what charting by exception meant. She stated they only charted if there was something unusual or if there was a concern. The DON was asked if there should have been more frequent temperature assessments and notes. She stated she had not seen it that way before. At 08:40 a.m., the DON was asked if resident #2 had temperature checks between 05/25/20 and 08/28/20. She stated, No. She was asked if you would know a resident had a fever unless a temperature had been taken. She stated, No. At 08:56 a.m., the DON was asked if resident #3 had temperature checks between 08/17/20 and 09/14/20. She stated, No. She was asked if you would know a resident had a fever unless a temperature had been taken. She stated, No. The DON was asked with current CDC COVID guidance, should the residents have had more frequent monitoring of temperatures. She stated, Yes, I see it that way now. 4. On 09/16/20 at 10:32 a.m., the DON was asked how staff entered the building. She stated through the front entrance only. She stated the other entrances were locked. At 10:41 a.m., the DON was asked how they ensured staff were screened at entry. She stated there was a receptionist during the day shift and evening shift to screen staff upon entrance to the building and a nurse was assigned oversight during the night shift for staff screening. The DON and administrator were asked to review the daily symptom screening forms for COVID-19 for three randomly selected staff members. In reviewing the screening forms, they identified missing screening procedures for RN #1 for the dates of 08/20/20, 08/28/20 and 09/15/20 and CNA #1 for the dates of 08/20/20 and 08/28/20.

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.