STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375326	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEEKER NURSING CENTER	**500 NORTH DAWSON STREET MEEKER, OK 74855**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation and interview it was determined the facility failed to maintain an infection control program and implement measures to provide a safe environment to help prevent the development and transmission of COVID-19. The facility failed to ensure disposable isolation gowns were worn properly and not re-used on two (North and South hall) of two halls with COVID-19 positive residents. This had the widespread potential to affect all 33 residents. Findings: The facility identified 33 residents resided in the facility. The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Reinforce adherence to standard IPC (infection prevention control) measures including .correct use of personal protective equipment (PPE) . On 10/21/20 at 9:44 a.m., the director of nursing (DON) stated all of the residents had tested positive and the staff were wearing full PPE to care for the residents. She stated the employees were reusing their isolation gowns. When asked what she meant by reusing the gown, she stated if an employee left the hall they would take off the isolation gown and hang it on the hooks on the wall and put it back on when they came back to the hall. At 9:50 a.m., upon entrance to the COVID-19 hall, hooks were observed on the wall. At 9:55 a.m., certified nurse aide (CNA) #1 removed her yellow isolation gown and hung it on a hook on the wall, she went outside with resident #1 to smoke. When the CNA came back in from outside she put the yellow isolation gown back on. The CNA stated she reused her gown unless it was soiled or wet. She stated if she went outside she hung her isolation gown on the hooks on the wall and put it back on when she came back. At 10:19 a.m., licensed practical nurse (LPN) #1 was wearing a blue isolation gown; the gown was ripped on the back of the sleeves. The LPN stated it was ripped because they reused the isolation gowns. She stated they hung them on the hooks when they went outside and put them back on when they came back into the building. At 10:29 a.m., a yellow isolation gown was hanging from the top door hinge on the biohazard closet and a blue isolation gown an employee had removed prior to leaving the hall was hanging off of a hand-rail in the hall. At 10:56 a.m. CNA #2 had a blue isolation gown on with the sleeves rolled up past her elbows. The CNA stated she had the sleeves rolled up because they were so long. The CNA went into resident #4's room to provide care; when she came out of the room her sleeves remained rolled up. At 3:15 p.m., the DON was made aware of an employee wearing an isolation gown with the sleeves rolled up. She stated the employee should not have the sleeves rolled up on the isolation gown.
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	Based on interview and record review, it was determined the facility failed to ensure residents and resident representatives had been notified of positive COVID cases in the facility for three (#1, 2 and #3) of three sampled residents. This had the potential to affect all 33 residents who resided in the facility. Findings: The facility identified 33 residents resided in the facility. Review of the testing logs for residents and staff documented the facility had positive cases of COVID for staff and/or residents from 09/22/20 to current and were doing weekly testing. Review of the clinical records for resident #1, #2, and #3 did not reveal documentation the residents/resident representatives were updated at least weekly of the COVID-19 status and mitigating actions the facility had taken to prevent the spread of COVID-19 in the building. On 10/21/20 at 1:05 p.m., the director of nursing (DON) stated the nurses, social worker or administrator would notify the families with updates. She stated they made phone calls and it should be documented in the progress notes. The DON stated the facility may not have contacted all of the residents and/or representatives each time. She was not able to provide documentation the residents and/or representatives were given updates at least weekly after the initial notification on 09/22/20.

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.