STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375381	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAPTIST VILLAGE OF OKLAHOMA CITY	**9700 MASHBURN BLVD OKLAHOMA CITY, OK 73162**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined the facility failed to ensure the appropriate personal protective equipment was worn by staff during the provision of care to residents residing in two of two quarantine units whose COVID-19 status was unknown. The facility identified 21 residents who resided in the two quarantine units of the facility. Findings: On 06/10/20 at 9:20 a.m., the administrator and DON were asked who resided in the quarantine units. The administrator stated residents who were new admissions or re-admissions to the facility. They were asked what PPE was worn by the staff who provided care to the residents in the quarantine units. The administrator stated no PPE was used in the quarantine units. The staff only wore masks and gloves. The DON stated full PPE was only used by the staff in the isolation unit and the COVID-19 unit. At 9:30 a.m., observations were made of the quarantine units in the facility. Staff and residents were observed in the hallways of both units. Staff were observed to enter and exit resident rooms with surgical masks and gloves. No other PPE was observed to be worn by the staff. Staff was observed assisting residents in the hallways with transfers, ambulation and direct care needs. Staff was observed to wear surgical masks and gloves when in direct contact with the residents. No other PPE was observed to be worn by the staff. At 10:10 a.m., the DON and ADON were asked how they prevented the development and transmission of COVID-19 without implementing proper infection control practices with residents of unknown COVID-19 status. The DON stated their status was known when they tested negative for [MEDICAL CONDITION] and were discharged from the hospital. They were asked what the incubation period was for the [MEDICAL CONDITION]. The ADON stated seven to ten days. She was then asked why the residents were quarantined. She stated to monitor for signs and symptoms. The administrator, DON and ADON were asked if the residents COVID-19 status was known then why were the residents quarantined and monitored for signs and symptoms during the incubation period. No response was provided.

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.