STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375303	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEWOKA HEALTHCARE CENTER	1400 WEST FIRST STREET WEWOKA, OK 74884

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, interview, and record review, 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 for four (#1, 2, 3, and #4) of four residents sampled for infection control. The facility failed to ensure: a) face shields or goggles and gloves were worn in the rooms of quarantined residents #1, 2, and #3. b) staff did not wear face masks below their noses. c) station drawers for personal protective equipment (PPE) were clean and without dirt and debris for resident #1. d) trash in biohazard boxes was not overflowing onto resident's furniture for resident #2. e) resident equipment was disinfected with an environmental protection agency (EPA) registered disinfectant for use against [DIAGNOSES REDACTED]-CoV-2 for residents #1, 2, 3, and #4. The administrator (adm) reported there were no residents who were COVID-19 positive, three residents were quarantined on transmission based precautions, and 29 residents resided in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . The Center for Disease Control guidance titled, How to Wear Cloth Face Coverings documented, .Wear your Face Covering Correctly .Put it over your nose and mouth and secure it under your chin. Try to fit it snugly against the sides of your face .Use the Face Covering to Protect Others. Wear a face covering to help protect others in case you're infected but don't have symptoms . The Center for Disease Control guidance titled, Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes documented, .Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices .Environmental Cleaning and Disinfection: Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas; Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging [MEDICAL CONDITION] pathogens program for use against [DIAGNOSES REDACTED]-CoV-2 . On 07/09/20 at 9:00 AM, upon entrance to the facility certified nurse aide (CNA) #1 and certified medication aide (CMA) #1 were observed to wear their face mask below their noses. On 07/09/20 at 9:38 AM, a dietary staff member was observed in the kitchen wearing his mask below his nose. On 07/09/20 at 9:40 through 9:49 AM, during a tour of the quarantine unit, resident #3's PPE station outside his door was stacked with books, VHS movies, and a jacket. No PPE supplies were stocked in the three drawer cabinet. At that time CNA #2 said the items did not belong to the resident. Plastic gowns were observed on the floor next to a PPE station of a room which was unoccupied at that time. CNA #2 stated the gowns had originally been on top of the table and had slid off to the floor. Resident #1's PPE station outside of his door had a box of gloves and a box of face masks sitting on top. The inside of the drawers of the station were observed to have dirt, debris, and dried spills. The drawers did not contain any PPE. The PPE station of resident #2 held three face shields. One shield had CNA #2's name on it. The other two had the names of therapists on them per the CNA. The CNA was asked what she cleaned the shield with. She stated she had not been wearing shields. Resident #2's room had the door opened. The biohazard box in her room was located across the room from the door next to the west wall. The trash in the box had overflowed onto the bedside table, wall, and window covering. Outside the west hall glass door was a covered trash barrel on wheels approximately five feet from the door. A chair was touching the far side of the barrel. CNA #2 stated resident #3 goes out to smoke and sits in the chair. She stated she didn't know why the barrel was there. She then opened the door to the outside and a foul odor from the barrel entered the building. On 07/09/20 at 9:50 AM, CNA #2 retrieved a sit to stand lift from off the quarantine unit. CNA #1 and #2 then donned gowns and gloves. They were already wearing surgical masks. The CNAs did not don any eye protection. The CNAs were observed to enter resident #2's room to help the resident to the bedside toilet. On 07/09/20 at 9:55 AM, CNA #2 was observed to exited resident #2's room. She had discarded her gown and gloves. CNA #2 left the unit and came back with a supply of briefs. The CNA donned a gown then used hand hygiene, but did not don a pair of gloves. She then re-entered the resident's room. On 07/09/20 at 9:59 AM, CNA #1 was observed to exited resident #2's room. She had discarded her gown and gloves. Her mask was well below her nose when she exited the room. A minute later CNA #2 exited the room with the lift. CNA #2 was observed to push the lift off the quarantine unit and down the hall into resident #4's room and then exit the room. She was asked at that time why the lift was stored in resident #4's room. She stated because resident #4 used the lift. The lift was not observed to be disinfected at that time. On 07/09/20 at 10:33 AM, during an interview with the director of nursing (DON), adm, and the corporate manager, the DON stated the staff were supposed to wear face shields while caring for the quarantined residents. The corporate manager stated the staff had been in-serviced related to PPE usage and know to wear shields and keep their masks pulled up. The DON stated the lift should be cleaned after each use. The adm stated the disinfectant to clean the lift was in a locked cabinet on the quarantine unit. The group was asked what was used to clean the equipment used to obtain the vital signs of the residents in quarantine. The adm handed me an individually wrapped wipe with the name [MEDICATION NAME]. The wipe's packaging did not have an EPA number on it. On 07/09/20 at 10:45 AM, the adm and surveyor went to the quarantine unit to look in the chemical cabinet to get the name of the disinfectant used to clean the lift. The cabinet on the wall of the quarantine unit was observed to be empty. When showed the overflowing trash, she said the trash should be contained. She said the gowns should be kept inside the stations at each resident door. When she visualized the dirty PPE station drawers, she stated they needed to be cleaned. She stated the barrel should not be left outside the door and the trash should have been taken to the dumpster. She opened the door to the outside and the foul odor entered the hall. She stated, That is disgusting. On 07/09/20 at 11:35 AM, during an interview with licensed practical nurse (LPN) #1, she stated the residents in quarantine did not have dedicated equipment. She stated she cleaned the shared vital sign equipment and glucometer with [MEDICATION NAME] wipes.

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