STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375483	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDMOND HEALTH CARE CENTER	39 EAST 33RD STREET EDMOND, OK 73013

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** (NAME)Health Care Center - 7/29/20 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 nine of 16 sampled residents who were reviewed for infection control. The facility failed to ensure: ~hand hygiene was completed between COVID-19 positive resident encounters, PPE was removed and discarded appropriately for confirmed positive COVID-19 residents, and signage was posted indicating the type of precaution the COVID-19 positive residents were on. The facility identified 18 residents who were confirmed COVID-19 positive; ~ residents on quarantine status had personal protective equipment (PPE) with biohazard receptacles readily available, appropriate PPE be worn by staff during the provision of care for quarantined residents, and signage posted specifying what precautions quarantined residents were on. The facility identified 19 residents who were quarantined; ~ rooms were single occupancy for residents who were quarantined. The facility identified six resident rooms, utilized for quarantine, with double occupancy; ~ staff utilized all precautionary measures in order to maintain infection control while administering breathing treatments via nebulizer for two (#8 and #16) of two residents who were observed with nebulizer breathing treatments whose COVID status was unknown. The facility identified three residents in quarantine, who resided on hall 100, received nebulizer breathing treatments; and ~staff and/or vendors were screened for all symptoms of COVID-19 with temperatures obtained prior entering the facility per guidance of the CDC. This had the potential to affect all 64 residents who resided in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes, dated 06/25/20, documented, .Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .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 disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . 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 . The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings, .Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal The State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, F880, 483.80 Infection Control, Implementation of Transmission-Based Precautions documented, .When a resident is placed on transmission-based precautions, the staff should implement the following: Clearly identify the type of precautions and the appropriate PPE to be used; Place signage in a conspicuous place outside the resident's room such as the door or on the wall next to the doorway identifying the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering .Make PPE readily available near the entrance to the resident's room . 1. On 07/29/20 at 10:00 a.m., a tour of hall 300 was conducted. The DON identified 18 confirmed COVID-19 positive residents resided on hall 300. The double doors to the hall were observed to be closed. There was no signage posted on the double doors which indicated the type of precautions the residents were on. At 10:05 a.m., upon entrance to the hall the first room on the right, room [ROOM NUMBER], was observed to have plastic sheeting, split up the middle, hanging on the door frame. A resident was observed in bed by the window. The right side of the sheeting was observed to be tucked behind the handrail on the hallway and the left side of the sheeting was observed to move. A box fan was observed by the window of the resident's room, adjacent to the doorway, which was blowing toward the plastic sheeting and felt in the hallway. The doors to the residents' rooms were observed to have a pink sign which stated transmission based precautions and a sign which documented the required PPE for each resident cohort group. The type of precaution was not specified on the sign. Midway down the hall was signage which indicated the order for donning/doffing PPE. At 10:12 a.m., CNA #3 was observed to exit room [ROOM NUMBER] wearing full PPE. She was observed to move a chair in the hall and placed it outside of room [ROOM NUMBER]. She then obtained a trash bag from the cart in the hallway and entered room [ROOM NUMBER] with the trash bag and a package of wipes. She then exited the room and entered room [ROOM NUMBER]. She exited room [ROOM NUMBER] and placed trash in the trash recepticle outside of the room. She then entered room [ROOM NUMBER], exited the room, and moved the chair she had placed outside of room [ROOM NUMBER] into room [ROOM NUMBER]. She was not observed to change her gloves or perform hand hygiene. At 10:18 a.m., CNA #3 was asked how often she changed her gloves and performed hand hygiene. She stated they were to change their gloves and sanitize their hands between each resident. She was asked why she had not changed her gloves or sanitized her hands between each resident. She stated she was going to wash her hands. She removed her gloves and washed her hands in the designated employee supply/breakroom in room [ROOM NUMBER] which was located approximately midway down the hall. She was asked what precautions the residents on hall 300 were on. She stated they were positive for COVID-19. At 10:19 a.m., CMA # 1 was observed in room [ROOM NUMBER] which was not occupied by a resident. He was asked what the room was used for. He stated they utilized the room as a breakroom, to store extra PPE, and to don/doff PPE. At 10:20 a.m., CNA #2 was observed to remove her jumpsuit in the staff breakroom, room [ROOM NUMBER]. She carried the jumpsuit down the hall past room [ROOM NUMBER], which had the fan blowing and the plastic tucked behind the handrail, to the entrance of the hall, and hung the jumpsuit on the wall by a blue gown. She was not observed to sanitize her hands or disinfect her goggles after hanging the jumpsuit and before exiting the hall. At 10:33 a.m., CMA #1 was asked why a jumpsuit and a gown was hanging by the entrance to the hall. He stated, So they can put them back on when they come back. At 12:01 p.m., CNA #3 was observed to wear an N95 mask over a surgical mask. She was asked why she wore the N95 over the surgical mask. She stated she wore both for extra protection. She stated she had not been fit tested for the N95 mask. At 12:06 p.m., the noon meal service was observed. CNAs #2, #3, and #4 were observed to deliver disposable containers to the residents on hall 300. They were not observed to change their gloves or perform hand hygiene between residents. At 12:09 p.m., LPN #1 was asked why staff removed their PPE in room [ROOM NUMBER] and then exit the unit. He stated they were to remove PPE by the entrance/exit doors to the hall. He was asked why the gown and jumpsuit was hung in the hallway. He stated they were not to reuse PPE. He stated the gown was hanging in the hall when he arrived on duty. He stated they had plenty of PPE. At 2:19 p.m., the DON and MDS coordinator were asked how often staff were to perform hand hygiene. The DON stated between each resident. The DON was asked why staff were observed to remove their PPE in room [ROOM NUMBER] and walk down the hall to exit the COVID-19 positive unit. She stated they were to remove PPE by the exit doors. She was asked why a staff member hung the jumpsuit up to reuse when they returned to the hall. She stated she did not know they were reusing PPE. She was asked if they had enough PPE. She stated

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) yes. She was asked why a staff member was observed to wear an N95 mask over a surgical mask. She stated she did not know. She stated she had asked a staff member why they wore it that way and the staff member told her for extra protection. She stated she educated the staff member on proper use of PPE but did not know they were still wearing the N95 over the surgical mask. The DON and MDS coordinator were asked why signage had not been posted on residents' doors on hall 300 to indicate the specific precautions residents were on and PPE usage. The MDS coordinator stated they had signs posted but they must have been taken down. They were asked why the box fan was blowing into the hallway and the plastic was tucked behind the handrail in room [ROOM NUMBER]. They stated they did not know why. 2. On 07/29/20 at 9:31 a.m., hall 100 was observed. The DON identified hall 100 as the quarantine hall. She stated the residents were in quarantine and their COVID-19 status was unknown due to possible exposure to a positive roommate or their COVID-19 test had inconclusive result. room [ROOM NUMBER] was observed to have a sign on the door which documented the following: ~ Pink-last tested positive; ~ Purple-unknown; and ~ Green-last tested negative. The hall was observed to have three bins which contained PPE. One was observed at the front of the hall, one was observed midway down the hall, and one was observed toward the end of the hall. The resident rooms were observed to have purple or green signage which documented 'Transmission Based Precautions' and a sign which indicated what PPE was to be utilized for each resident cohort group. There were no signs observed which indicated the specific type of precaution or the appropriate donning/doffing of PPE. The residents' rooms were not observed to contain biohazard containers. Staff were only observed to utilize facemasks and gloves. They were not observed to wear gowns, faceshields or goggles. At 9:46 a.m., CNA #7 was observed to physically assist resident #10 to her chair in her room. She was observed to only wear a surgical mask. At 10:53 a.m., RN #1 was asked what the different colors of signs indicated. She stated a purple sign indicated the resident had a COVID-19 positive test result, a pink sign indicated the COVID status was undetermined, and a green sign indicated the resident was negative for COVID-19. She was asked if there were COVID-19 positive residents on hall 100. She stated she thought the signs were wrong. She was asked what precautions residents on hall 100 were on. She stated they were on standard precautions. She stated staff were to utilize good hand hygiene and wear masks. She was asked what PPE was utilized for residents whose COVID-19 status was unknown. She stated, We have gowns if needed but they're not mandatory. At 11:08 a.m., CNAs #1 and #7 were observed to enter resident #16's room. CNA #1 wore a facemask and goggles and CNA #7 wore a facemask. At 11:11 a.m., CNA #7 was observed to exit the residents room with a clear trash bag of linens. She was observed to carry the bag down the hall and sanitize her hands. CNA #1 was observed to wash her hands in the resident's room. CNA #1 was asked what care they had provided resident #16. She stated incontinent care. She was asked what PPE was to be utilized for a resident whose COVID-19 status was unknown. She stated they were to utilize a mask. She stated they only had to wear goggles or gowns if the resident was positive for COVID-19. She stated, We don't know if they have it or not so they just say we can wear what we want to wear. At 11:40 a.m., the DON and MDS coordinator were asked what precautions the residents on the 100 hall were on. The MDS coordinator stated they were on contact/droplet precautions. She was asked what PPE was to be utilized for residents in quarantine whose COVID-19 status was unknown. She stated for direct care or close contact staff were to wear mask, gown, faceshield/goggles, and gloves. At 12:15 p.m., CNA #1 was observed to enter resident rooms on hall 100 to gather trash and disposable lunch containers. She was asked when biohazard bags/boxes were used on hall 100. She stated they only used them if a resident was COVID-19 positive. She showed the surveyor two biohazard boxes in the biohazard room on hall 100. She stated, We don't need them right now. At 2:19 p.m., the DON was asked why signage was not posted on resident doors on hall 100 to indicate the specific precautions the residents were on. The DON stated they had signs posted which documented transmission based precautions. 3. On 07/29/20 at 9:31 a.m., a tour of the quarantine hall was conducted. The following rooms were observed to be occupied by two residents: ~ room [ROOM NUMBER] - resident #1 and resident #2; ~ room [ROOM NUMBER] - resident #3 and resident #4; ~ room [ROOM NUMBER] - resident #5 and resident #6; ~ room [ROOM NUMBER] - resident #7 and resident #8; ~ room [ROOM NUMBER] - resident #9 and resident #10; and ~ room [ROOM NUMBER] - resident #11 and resident #12. At 1:23 p.m., the DON was asked why residents in quarantine were roomed together. She provided the following rationales: ~ room [ROOM NUMBER] - resident #3 and resident #4 each had different roommates. She stated their roommates tested positive on the same day and they moved resident #4 into the room with resident #3. She stated resident #4 and resident #3's test results both came back inconclusive, they had been retested , and were pending results; ~ room [ROOM NUMBER] - resident #5 and resident #6 each had different roommates. She stated their roommates tested positive on the same day and they moved resident #5 and resident #6 into the same room. She stated their test results were inconclusive, had been retested , and were pending results; ~ room [ROOM NUMBER] - resident #7 and resident #8 were roommates. She stated resident #8 had been admitted to the hospital and was quarantined for 14 days on hall 300 when he was readmitted on [DATE]. They then moved resident #8 into his previous room with resident #7. She stated their test results were inconclusive, had been retested , and results were pending; ~ room [ROOM NUMBER] - resident #9 and resident #10 were roommates before testing. She stated their tests were inconclusive and had been retested with pending results; and ~ room [ROOM NUMBER] - resident #11 tested positive on 07/16/20 and was moved to hall 300. Resident #12's test was inconclusive, was retested , and results were pending. On 07/28/20 resident #11 tested negative for COVID and was moved into the room with resident #12. The DON was asked what the criteria was to determine roommates for residents who were in quarantine. She stated they required a negative COVID test and she would need to ask the MDS coordinator how roommates were determined. At 5:04 p.m., the MDS coordinator provided the following rationale for resident #1 and resident #2: ~ room [ROOM NUMBER] - resident #1 tested negative on 07/07/20 and resident #2's test revealed a sample error. On 07/13/20 resident #1's test had an inconclusive result and resident #2's results were negative. She stated they have both been retested and results were pending. She was asked why residents who were not former roommates were quarantined in the same room. She stated they thought they could place residents whose COVID status was unknown in rooms together. A tour of the quarantine hall with the MDS coordinator revealed four unoccupied resident rooms on hall 100. She stated they would utilize the rooms instead of placing residents together. 4. On 07/29/20 at 10:51 a.m., RN #1 was observed to enter resident #16's room on the quarantine hall. She was observed to turn the nebulizer machine off and remove the nebulizer facemask. She was observed to place the nebulizer mask with attached reservoir in a clear plastic bag, tie the bag, and place it on the bedside table. She was not observed to rinse and let the reservoir dry. She was observed to wear a surgical mask. She was asked if she had been fit tested for an N95 mask. She stated yes and pulled an N95 mask from her pocket. She stated she wore it at times. She was asked why resident #16 was on the quarantine hall. She stated possible exposure because his roommate had tested positive. She was asked when she utilized an N95 mask rather than a surgical mask. She stated she used the N95 if she provided incontinent care or bathed a resident. At 11:05 a.m., RN #1 was observed to enter resident #8's room. She was observed to place medication in the nebulizer reservoir, place the nebulizer facemask on the resident, and started the machine. The resident's roommate, resident #7, was in the bed by the door. RN #1 did not pull the privacy curtain or close the door to assist in the possible transmission of COVID-19 during the breathing treatment. At 11:22 a.m., RN #1 was observed to enter resident #8's room and turn the nebulizer off. She was observed to remove the nebulizer mask, placed it in a clear plastic bag, tied the bag closed, and placed it on the nightstand. She was not observed to rinse or dry the mask/reservoir. She was not observed to disinfect surfaces. She was asked why she had not closed the privacy curtain or disinfected room surfaces after administering a breathing treatment to a resident whose COVID-19 status was unknown. She stated she did not know. She was asked why the mask/reservoir had not been rinsed and dried for resident #8 and resident #16. She stated they were changed out every seven days and as needed. At 11:40 a.m., the DON was asked what precautions were taken when a resident received a breathing treatment whose COVID-19 status was unknown. The DON stated staff were to wear gowns, masks, gloves, and faceshield. The DON was asked why privacy curtains were not utilized and the area disinfected after a breathing treatment was administered. She stated the nurse did not have long term care experience and did not know. 4. On 07/29/20 at 9:00 a.m., the staff/vendor screening form was observed. The form had a place for name, date, and temperature. The form asked the following: ~Are you experiencing shortness of breath; ~Do you have a new or change in cough; and ~Do you have a sore throat. At 11:54 a.m., a phlebotomist was observed on the COVID hall 300. She was asked if she had been screened before entry into the facility. She stated she usually took her own temperature. She stated, I didn't do it today. Review of the screening log did not reveal the phlebotomist's name. At 12:26 p.m., the MDS coordinator was asked what the screening process consisted of for staff and vendors. She stated they went through the screening at the front door. She was asked where screening for medical professionals, such as phlebotomist and hospice personnel, were documented. She stated on the same sheet the staff used. She was asked who allowed the phlebotomist to enter the facility. She stated she would find out. She was asked why the phlebotomist had not been screened prior to entry to the facility. She stated, Was she not? She may have been, she was in the DON's office. At 1:07 p.m., two outside vendors were observed working on the ice machine in the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) dining room. They were asked what screening they did before they entered the facility. They stated staff obtained their temperature at the front door and told them they could enter through the back door. They were asked if they were asked any questions about symptoms. They stated no. Review of the screening log did not reveal the vendors had been screened. At 1:12 p.m., LPN #2 was asked who allowed the ice machine vendors access into the facility. She stated she had let them in. She was asked what screening process they had completed. She stated she obtained their temperature and asked if they had any upper respiratory symptoms. She was asked where she documented the screening. She stated she did not document the screening. At 1:56 p.m., CNA #6 was observed to enter the facility and walk to the nurses station where the time cards were kept. She obtained her time card, walked down hall 200, and then walked back to the table with the screening log. She was asked who obtained her temperature. She stated, I took my own. At 2:00 p.m., LPN #3 had entered the facility and was asked who had taken her temperature. She stated, I took it. At 2:05 p.m., RN #2 entered the facility and signed in on the screening log. She was observed to obtain her own temperature. She was asked who obtained the staff's temperatures when they came on shift. She stated, ADON, DON, I did my own today, the administrator wanted me to do it. At 2:16 p.m., the MDS coordinator stated the lab supervisor was the phlebotomist who was in the facility. She stated she contacted the lab supervisor and she stated she had not signed in or taken her temperature in the facility but she had taken it before entering the facility. The name of the lab supervisor was not the same name as the phlebotomist who had been observed on the COVID hall. The MDS coordinator stated she assumed two phlebotomist had been in the facility and neither were screened. She stated nurses and CMAs were allowed to obtain their own temperatures but staff were to obtain everyone else's. At 2:19 p.m., the DON was asked why staff/vendors were not screened for all symptoms of COVID-19 and their temperature obtained by a staff person. She stated they would need to update the form and set up a different screening process.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure resident representatives and residents were notified of confirmed COVID-19 cases in the facility for four (#11, #13, #14, and #15) of four sampled residents whose records were reviewed for notification of COVID-19. This had the potential to affect all 64 residents who resided in the facility. Findings: On 07/29/20 at 9:00 a.m., the DON identified 18 residents and two staff members who were currently confirmed COVID-19 positive. She was asked when the first COVID-19 positive case had occurred. She stated the first positive case was a resident who had been tested on [DATE] and the facility received positive results on 07/02/20. Review of the clinical record for resident #11, #13, #14, and #15 did not reveal families had been notified when the facility had confirmed positive COVID-19 residents and staff. On 07/29/20 at 3:30 p.m., the administrator was asked who was responsible to notify residents and resident representatives of COVID-19 positive results or three or more residents or staff with new onset of respiratory symptoms within 72 hours of one another. She stated social services, the nurses, and the activity director divided up a list and made contact with families. She was asked when the families had been notified. She stated as soon as they had received positive results. She was asked who had been notified. She stated all resident representatives had been notified when they had conducted facility wide testing. She stated following the initial test results they only notified the representative/family of the resident who tested positive. She was asked why all residents and resident representatives had not been notified when there were confirmed positive COVID-19 cases in the facility. She stated she did not know it was a regulation to notify them.