STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375353	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENBRIER NURSING HOME	1119 EAST OWEN K GARRIOTT ROAD ENID, OK 73701

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 observations, interviews, and record reviews, it was determined the facility failed to: ~ implement infection prevention and control practices to prevent the potential development and transmission of COVID-19; ~ ensure appropriate transmission based precautions were implemented and all required PPE (personal protective equipment) was provided and/or donned for close personal contact/care of residents with unknown COVID-19 status for five (#1, 3, 4, 5, and #6) of six residents observed on the quarantine isolation unit. The facility administrator identified eight residents who had admitted /readmitted to the facility within the last 14 days; ~ ensure residents were provided and encouraged to use face masks/coverings when in the common areas of the facility; ~ ensure staff had access to and/or knowledge of how to access additional PPE supplies at all times; ~ ensure staff practiced appropriate hand hygiene practices for three (CNA (certified nurse aide) #1 and #2 and PTA (physical therapy assistant) #1) of five staff observed during the provision of care/services; and ~ ensure staff were knowledgeable of what the EPA (environmental protection agency) approved contact time was for the disinfectant in use against COVID-19. The facility administrator identified 104 residents who resided in the facility. Findings: A CDC (Centers for Disease Control and Prevention) website article, updated 05/19/20, documented: .HCP (health care personnel) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others .Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility . A CDC website article, updated 06/22/20, titled, Preparing for COVID-19 in Nursing Homes, documented: .Reinforce adherence to standard infection prevention and control measures including hand hygiene .Make necessary PPE available in areas where resident care is provided .Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff .Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles) . Use an EPA-registered disinfectant from List Nexternal icon on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use . 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. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . The EPA website documented the disinfectant Virex had a ten minute contact time to ensure efficacy against COVID-19. On 07/06/20, a tour of the facility was conducted. The following observations and interviews were obtained: At 9:50 a.m., there were four residents observed in a common area of the facility without face masks on. At 9:55 a.m., the quarantine isolation step down unit was observed. The ADON/IP (assistant director of nurses/infection preventionist) stated all the residents who resided on the unit were newly admitted /readmitted to the facility within the last 14 days. She stated the residents would remain on quarantine on the unit for 14 days prior to being relocated to the skilled unit, long term care, or the assisted living facility. There were eight residents who resided on the unit who were new admissions/readmissions. Only resident #2 and #3 had transmission based precautions posted outside of their room doors. Only resident #2 and #3 had isolation carts with PPE located outside of their rooms. The carts did not have N95 or higher level respirators or surgical face masks or eye protection. At 10:02 a.m., PTA #1 and CNA #2 were observed to assist resident #1 up to her wheelchair and to transfer the resident to a common dining area to weight the resident. Both staff members had on cloth masks. PTA #1 was not observed to wear any gloves. Both staff members did sanitize their hands prior to transferring the resident and after providing assistance. Neither staff member was observed to don a gown during close personal contact with the resident in order to safely transfer the resident to and from her wheelchair. At 10:03 a.m., a sign was observed posted outside of resident #3's room. The sign documented, Full Precautions. At 10:06 a.m., CNA #1 was observed at the nurse's station wearing a cloth mask. He stated all residents who resided on the unit were newly admitted /readmitted within the last 14 days. He stated the residents resided on the unit in order to ensure they completed the required 14 day quarantine. He was asked what PPE was required to provide close personal care for the residents on the unit. He said, It is weird now. We used to close the doors and wear full PPE. He was asking why resident #3 was on full precautions. He stated he thought she had a wound infection requiring contact precautions. He was asked what PPE he donned to provide care to resident #3. He stated he donned gloves, his cloth mask, and a gown if the resident was incontinent. CNA #2 stated resident #3 was on full contact precautions for a wound infection and [MEDICAL CONDITION] ([MEDICAL CONDITION], a bowel bacterial infection). She then said, We were told we didn't need full PPE because the residents tested negative before they came here. CNA #1 and #2 stated for all other residents on the quarantine step down unit they were only required to wear their cloth masks and gloves. They both stated they had never been provided with eye protection. CNA #2 stated the facility had provided N95 respirator masks after the initial lock down. She stated the facility returned to cloth mask use after the facility wide testing was completed in May. At 10:24 a.m., LPN (licensed practical nurse) #1 was observed to enter resident #4's room to provide him his medication. She entered the resident's room with the medication in a small plastic cup. She entered the room wearing only a cloth mask and no gloves. She provided the resident his medications and then washed her hands in his bathroom and exited the room. She was asked what type of PPE was required for entering the room of a resident on quarantine with unknown COVID status and providing medications. She stated the administrative staff instructed her she only needed to wear her cloth mask. She stated she would also wear gloves if she was providing close personal care. She was asked what type of transmission precautions were the residents on who resided on the quarantine unit. She stated the residents were on contact precautions. She stated this meant she needed to wear her cloth mask and only needed to wear gloves if she was touching the resident. She further stated the facility administrative staff stopped requiring the use of full PPE approximately one month prior to the survey. She stated the facility had occasionally provided surgical masks in the past. She stated cloth masks have always been provided on the step down unit. She was asked if she had access to a sufficient amount of PPE to provide care to the residents. She said, Honestly, No. She further said, I don't even know if it's stored in the building. We have to call the administrator. She stated housekeeping did ensure the two isolation carts on the east quarantine hall were stocked with PPE. At 10:35 a.m., CNA #1 was observed to don gloves, without washing his hands. He then entered resident #2's room to assist him to the restroom wearing his cloth masks and gloves. He washed his hands after he discarded his gloves and exited the resident's room. PTA #1 and CNA #2 were observed in the hallway assisting resident #1 with ambulation. CNA #2 was observed to follow the resident with a wheelchair while she ambulated with her walker and PTA #1. CNA #2 had gloves and her cloth mask on. PTA #1 was wearing only her cloth mask. PTA #1 was observed to touch the resident's arm and back to assist her to a seated

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) position in her wheelchair. She allowed the resident to rest for a few minutes. She then used her bare hands again to assist the resident to stand. She placed one bare hand under the resident's left arm pit and the other bare hand on the resident's left arm. She stood close to the resident with her clothing touching the resident's clothing. Neither staff member was observed to wear a gown. At 10:42 a.m., CNA #1 stated he was not sure where additional PPE was stored. He stated he called housekeeping if he needed additional supplies. He stated he did not know what action he would take if housekeeping was not at the facility or available. At 10:52 a.m., a resident was observed ambulating in the hallway on the skilled unit with an unknown PT staff member. The resident was not observed to wear a mask. RN (registered nurse) #1 stated he was assigned to the quarantine unit and the skilled unit. He was asked what PPE was required to provide close personal care to the residents on the quarantine unit. He said, Nothing specific really. Staff have always just worn a mask on the unit. He then stated for close personal care staff should wear a mask and gloves. He stated the facility only provided cloth masks to staff members each day. He stated they were laundered each night. He stated he chose to provide his own surgical mask daily. He was asked how he would obtain additional PPE if he needed it. He said, Don't know how to get PPE or where it is stored. At 11:05 a.m., CNA #1 and #2 were observed to enter into resident #5's room with a lift. They donned gloves without washing their hands first and then entered the resident's room. They were observed wearing only gloves and cloth masks. They did not don a a gown or eye protection. They transferred the resident into a wheelchair and then CNA #2 exited the room with the same gloved hands. She transported the resident through the common dining room area, she passed by the skilled nurse's station, and then wheeled the resident onto a transport van. She discarded her gloves and sanitized her hands after she completed the transport. CNA #1 discarded his gloves and washed his hands after assisting with the lift transfer. At 11:23 a.m., PTA #1 as observed while she assisted resident #6 with ambulating with her walker. She had on a cloth mask and no gloves. She was observed to touch the resident's bare arms and back with her bare hands. She assisted the resident to return to her room and transferred her into her recliner. She did not have a gown on. She then exited the resident's room and washed her hands at the nurse's station and then assisted another resident on the quarantine unit with ambulation. At 11:30 a.m., there were four residents observed in a common area of the long term care unit with no face masks in place. At 11:45 a.m., a meeting was held with the administrator and ADON/IP. The administrator stated the facility disinfectant used against COVID-19 was vital oxide. They were asked what the contact time was for vital oxide. They both stated they were not sure. The administrator called the housekeeping supervisor and asked her what was the contact time for the disinfectant the facility used. She stated she did not know. The administrator then contacted the environmental director. He stated the vital oxide disinfectant was used as a fogger treatment. He stated the facility used Virex to disinfectant high touch surfaces and other surface areas. He stated the contact time was one minute. The EPA registration number was entered into the EPA website. The EPA website identified the product was approved for COVID-19, but the contact time was ten minutes. The administrator and ADON/IP acknowledged the staff needed training to ensure they understood what contact time was and what the approved time was per the EPA. They were asked how the facility ensured staff had access to sufficient amount of PPE at all times. The administrator stated there was a small amount of PPE located in supply closets in the facility. She stated then half of the supply was stored in the central supply office and the other half of the supply was stored in another locked area. She stated the administrator, maintenance, and a nurse was always on call to provide more PPE if needed. She stated the facility had recently been provided with a new delivery of PPE. She stated the facility had at least a seven day supply of gowns, disposable eye protection, KN95s and surgical masks, and gloves. They were notified the staff did not know where or how to obtain additional PPE supplies if they needed. The administrator stated the staff had access to obtain additional supplies. She stated the staff had a key to central supply at all times. She was reminded staff interviewed were not aware of this. They were asked what type of transmission based precautions were the quarantine residents on. The ADON/IP stated the residents were on droplet precautions. She stated the staff members had a sufficient supply of masks. They were notified the staff on the quarantine unit were only observed wearing cloth masks. They were notified of the CDC guidelines for required PPE for residents on quarantine due to new admission/readmission, including appropriate face masks, gowns, gloves, and eye protection. They stated the staff had not been provided eye protection, but there was a sufficient supply in storage. The ADON/IP stated she was aware staff were required to wear gloves, gowns and a masks to provide care/services to residents on the step down unit. She was notified again this was not observed. They were notified of additional observations of staff on the step down unit. They were notified staff were not observed to practice appropriate hand hygiene and a staff member was observed touching a resident with her bare hands. They were notified staff were observed providing close personal care without gowns. They acknowledged the concerns. They were notified of observations of residents in common areas without face masks. They stated they had not required residents to wear masks in common areas and were not aware this was a CDC guideline.