STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375554	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAINT SIMEONS EPISCOPAL HOME	3701 MARTIN LUTHER KING JR BLVD TULSA, OK 74106

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 implement their infection control program to prevent the potential spread of infection for five of s seven sampled residents who were reviewed for infection control. The facility failed to: ~ initiate transmission based precautions and quarantine for one (#7) of one residents who received [MEDICAL TREATMENT] outside of the facility and whose COVID status was unknown; ~ ensure residents who had possible exposure to COVID-19 were quarantined for 14 days for (#2 and #3) of two residents reviewed for potential exposure; ~ ensure residents who developed symptoms were quarantined for 14 days for two (#1 and #6) of two residents reviewed for the development symptoms; and ~ ensure staffs' proper use of face masks and hand hygiene/cough etiquette was performed. This had the potential to affect all 65 residents who 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. Depending on the prevalence of COVID-19 in the community, 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. 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 Centers for Disease Control guidance, regarding donning PPE, documented, .Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin . 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 .Before moving from work on a soiled body site to a clean body site .After touching a patient or the patient's immediate environment .After contact with blood, body fluids, or contaminated surfaces .Immediately after glove removal . 1. Resident #7 had [DIAGNOSES REDACTED]. A physician order, dated 01/19/18, documented the resident received outpatient [MEDICAL TREATMENT] three times a week. On 07/07/20 at 9:43 a.m., resident #7 was observed in her wheel chair coming out of home four into the main common area on the memory care unit. She was observed to wear a cloth mask which covered her mouth but was under her nose. The DON stated resident #7 received [MEDICAL TREATMENT]. The resident's room was observed in home four of the memory care unit. The room was not observed to have signage posted to indicate quarantine/isolation precautions or a bin with PPE. The room was observed to contain two beds. At 9:45 a.m., the DON was asked if resident #7 had a roommate. She stated yes. At 12:24 p.m., resident #7 was observed eating at a dining room table in home four. She was distanced from other residents. On 07/07/20 at 1:34 p.m., the infection preventionist was asked what precautions resident #7 was on. She stated the resident was screened every time she left the facility to go to [MEDICAL TREATMENT]. She was asked why resident #7 was not quarantined. She stated she was not aware the resident required quarantine. At 2:15 p.m., resident #7 was observed sitting in the common area eating a piece of pie. She was not six feet from the resident to her right. The activity director moved resident #7 but she was then not six feet from the resident to her left. On 07/07/20 at 2:43 p.m., the DON was asked why resident #7 was not quarantined upon return from [MEDICAL TREATMENT]. She stated the [MEDICAL TREATMENT] unit was protected and they took precautions. She stated the [MEDICAL TREATMENT] facility reported they did not provide services to residents who were COVID positive. She was asked why resident #7 had a roommate. She stated she has had the same roommate since before the pandemic. 2. Review of the respiratory surveillance line list documented resident #2 had possible exposure to COVID-19 on 06/23/20 and resident #3 had direct exposure to COVID-19 on 07/02/20. ~ Resident #2 had [DIAGNOSES REDACTED]. A nurse note, dated 06/23/20 at 12:31 a.m., documented a new order was received to obtain a COVID test due to possible exposure. A nurse note, dated 06/23/20 at 1:34 p.m., documented, .Spoke with (name withheld) (POA) regarding resident's new orders to be Covid tested today due to roommate having S&S. Resident continues to exhibit no S&S . A nurse note, dated 06/26/20 at 11:39 a.m., documented, .Resident removed from isolation d/t Negative Covid 19 results (received) by (name withheld) ADON, Resident showered and in Common area of Home #3 . ~ Resident #3 had [DIAGNOSES REDACTED]. A nurse note, dated 07/02/20 at 12:38 p.m., documented the resident had been moved to the isolation wing on the memory care unit for isolation protocol. A nurse note, dated 07/06/20 at 10:32 a.m., documented, .Resident's COVID test results came back notified (sic). Resident was given a shower and moved back to her original room . On 07/07/20 at 9:50 a.m., the isolation wing on the memory care unit was observed. Resident #2 and resident #3 were not observed to reside on the isolation unit. At 10:35 a.m., the isolation wing on the memory care unit was observed. Resident #3 was observed on the isolation wing. CNA #1 was asked why resident #3 was in isolation. She stated she was told the resident had to return to quarantine. At 10:37 a.m., LPN #1 was asked why resident #3 was in isolation. She stated the ADON instructed her to move the resident back to the isolation wing due to new guidelines. She stated the resident was removed from isolation to her previous room on 07/06/20 after receiving negative COVID-19 test results. A nurse note for resident #3, dated 07/07/20 at 10:38 a.m., documented, .Resident was moved back to Isolation Unit per facility protocol at 10:35 a.m. On 07/07/20 at 1:34 p.m., the infection preventionist was asked what criteria was met for a resident to be removed from isolation/quarantine. She stated they were to be in quarantine for 14 days and be symptom free. She was asked why resident #3 had been removed from quarantine before 14 days. She stated she did not know why. She was asked why resident #2 had been removed from quarantine before 14 days. She stated he tested negative for COVID-19. On 07/07/20 at 2:43 p.m., the DON was asked why resident #2 had been removed from isolation/quarantine before 14 days was completed. She stated resident #2 and his roommate, resident #1, tested negative for COVID-19. She stated resident #2 was a possible exposure from symptoms resident #1 had experienced. She stated resident #1 was diagnosed with [REDACTED]. She was asked why resident #3 was removed from the isolation wing on 07/06/20 after being placed in isolation for exposure on 07/02/20. She stated the resident's possible exposure was on 06/25/20. She stated once they were made aware of the possible exposure they placed the resident on the isolation wing and was tested on [DATE]. She stated they had received negative COVID results on 07/06/20 and removed the resident from isolation on that day. She was asked why resident #3 was on the isolation wing currently. She stated to complete a 14 day isolation. She stated, We prematurely took her out. 3. Review of the respiratory surveillance line list documented resident #1 had a cough and unspecified 'other' symptoms on 06/23/20. The respiratory line list documented resident #6 had a fever and shivering on 07/02/20. ~ Resident #1 had [DIAGNOSES REDACTED]. A nurse note, dated 06/23/20 at 11:51 a.m., documented the resident was observed coughing, his eyes were red, and had a temperature of 98.0. The note documented the physician ordered a chest x-ray a COVID-19 test, and [MEDICATION NAME] as needed. A nurse note, dated 06/23/20 at 2:59 p.m., documented a COVID-19 swab was completed by the ADON and the chest x-ray results revealed no acute abnormality. An x-ray report, dated 06/23/20, documented, .Reason for exam: Cough .EXAM: CHEST 1 VIEW .Impression: 1. No acute abnormality. 2. Mild cardiac enlargement with diffuse interstitial prominence which is

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) thought to be chronic . A nurse note, dated 06/24/20 at 11:07 a.m., documented, .Resident cont on Isolation in room, alert x 1, coughing at times, eyes red, Temp 98.4 .pending Covid 19 results, no other S/S of discomfort observed or reported . A molecular lab report, dated 06/25/20, documented, H. influenzae was detected at a high level and S. epidermidis was detected at a low level. A nurse note, dated 06/25/20 at 4:55 p.m., documented, .Results from respiratory tested (sic) (received). H. Influenzae present .Still awaiting Covid test results. Resident remains afebrile . A nurse note, dated 06/25/20 at 10:48 p.m., documented, .Resident conts to be flushed in face and redness in eyes. Resident coughing during this shift, prn [MEDICATION NAME] given. Resident congested .Resident started [MEDICATION NAME] 500/125 this evening for H. influenza (sic). Still awaiting covid results. Afebrile . A nurse note, dated 06/26/20 at 1:00 p.m., documented, .Negative Covid 19 results per (name withheld) ADON .Resident removed from Isolation precautions, no cough observed while completing assessment, Cont on [MEDICATION NAME] 500mg d/t H Influenza (sic) . ~ Resident #6 had [DIAGNOSES REDACTED]. A nurse note, dated 07/02/20 at 9:59 p.m., documented, .CNA notified this nurse that (resident's name withheld) was shivering. This nurse went to check (resident's name withheld) temperature and noticed she had a runny nose and temp was 101.1. (Physician name withheld) has been notified via qliq, (Physician name withheld) responded 'Check for covid and isolate till back.' . A nurse note, dated 07/03/20 at 9:27 p.m., documented, .Resident is awaiting, covid results, no changes in symptoms, will continue to monitor . A nurse note, dated 07/07/20 at 4:44 a.m., documented, .Res cont on ISO, covid test pending, no runny nose, resp un labored, res shriving (sic) off an on throughout the night, right corona (sic) light pinkish colored .temp 97.7 . A nurse note, dated 07/07/20 at 9:19 a.m., documented, .Resident's COVID results were negative. Resident will shower and be moved back to her former room this shift . On 07/07/20 at 9:50 a.m., the isolation wing on the memory care unit was observed. The DON was asked how many residents resided on the isolation wing. She stated two. She stated resident #6 had mild symptoms but tested negative for COVID and was being moved back to her room today. She was asked how long resident #6 had been in isolation. She stated six days. At 9:58 a.m., LPN #1 was observed to enter the isolation wing and don PPE. She was observed to enter resident #6's room with CNA #1. At 10:04 a.m., LPN #1 was observed to doff PPE and push resident #6's broda style chair out of the isolation wing into the main common area of the memory care unit. She placed the resident more than six feet away from another resident who was across the room. At 10:35 a.m., resident #6 was observed to be on the isolation wing in memory care. CNA #1 was asked why resident #6 was back on the isolation wing. She stated she was told the resident had to return to isolation. At 10:37 a.m., LPN #1 was asked why resident #6 had returned to the isolation wing. She stated the ADON instructed her to return the resident to the isolation wing to complete 14 days of quarantine. She stated the resident had a fever and was tested for COVID last week. She stated they received negative results today which was why she had removed the resident from isolation. At 1:34 p.m., the infection preventionist was asked what criteria had been met to remove resident #1 and resident #6 from isolation before 14 days. She stated she did not know why they were taken out of isolation. A nurse note, dated 07/07/20 at 1:44 p.m., documented, Resident moved back into precautionary isolation unit due to new guidelines . On 07/07/20 at 2:43 p.m., the DON was asked why resident #1 was removed from quarantine on 06/26/20. She stated they had obtained a COVID test which was negative. She stated the resident had a respiratory illness. She was asked what symptoms resident #6 had experienced. She stated shivering but was afebrile. She was asked what criteria resident #6 met to be removed from the isolation wing on 07/07/20. She stated they had received negative COVID test results on 07/07/20 and the resident was asymptomatic. She was asked why resident #6 was returned to the isolation wing. She stated she would need to check. 4. On 07/07/20 at 9:37 a.m., the memory care unit was observed. CNA #4 was observed sitting across from a resident at a table. They were not six feet apart. CNA #4's facemask was observed below her chin and was not covering her nose or mouth. She was observed to obtain a cup of cranberry juice from the refrigerator and give it to the resident. She was observed to then place face mask over her nose and mouth and wash her hands. At 10:04 a.m., LPN #1 was observed to discard her surgical mask after she had dropped it on the floor in the isolation wing. She was observed to push a resident from the isolation wing into the main common area on the memory care unit. She was observed to walk through the common area to the nurse's station and sanitize her hands. She was then observed to walk around the nurse's station to the ADON's office and obtain/don a face mask. At 10:17 a.m., CNA #2 was observed to exit room [ROOM NUMBER]. Her face mask was observed to only cover her mouth with her nose exposed. She was observed to walk down the hallway, past the common areas to a hand washing sink, and wash her hands. At 10:19 a.m., CNA #2 was observed to walk back down the hall. Approximately mid-way down the hall, her mask was observed to cover her nose and mouth. At 10:43 a.m., CNA #4 was observed to sit across the table from a resident. They were not observed to be six feet apart. CNA #4's face mask was observed to be under her chin. She was observed to put something in her mouth and cough into her right fist. At 10:45 a.m., CNA #4 was observed to place her face mask over her nose and mouth. At 11:57 a.m., CMA #2 was observed assisting a resident with the noon meal. Her face mask was observed to only cover her mouth. At 12:01 p.m., CNA #1 was observed in resident #6's room on the isolation wing. She was observed to cover the resident with a blanket, place a fall mat by the bed, lower the bed, place the call light on the bed, push the mechanical lift out of the room, obtain sanitizing wipes, and sanitized the lift. She was observed to walk to resident #3 who was sitting at a table in the common area and throw her disposable lunch container into the trash. She was then observed to assist resident #3 in her wheel chair to her room. She obtained an incontinence pad, placed it on the bed, and shut the door. CNA #1 was not observed to perform hand hygiene or change her gloves between encounters with resident #6 and resident #3. At 12:21 p.m., CNA #1 was asked how often she changed her gloves. She stated she changed her gloves if she showered a resident or provided incontinent care. She was asked how often she performed hand hygiene. She stated, Every time I'm done touching anything. She was asked why she had not changed her gloves between encounters with resident #6 and resident #3. She stated, I forgot I needed to between them. She was asked when the last time she had performed hand hygiene and changed her gloves. She stated when she had returned from her break at approximately 11:30 a.m. At 12:21 p.m., CNA #1 was observed on the isolation wing. The bottom strap of her face mask was observed to hang freely below her chin. She was asked why her mask was not properly secured with both straps. She stated it was suffocating her. On 07/07/20 at 1:34 p.m., the infection preventionist was asked who monitored to ensure face masks were properly worn by staff. She stated anyone walking around doing rounds was to monitor. She stated if they observed masks not properly placed they inserviced that staff member. She was asked how hand hygiene and cough etiquette were monitored. She stated the staff were instructed to cough into their elbow, wash their hands with soap and water, and sanitize their hands after each resident encounter. She stated the nurses monitored the staff. At 2:25 p.m., CNA #1 was observed to ask a staff member for a urinal to empty resident #3's catheter bag. She was observed to wash her hands and don gloves before entering the resident's room. She was then observed to exit the room, open the door to the isolation wing, obtain the urinal from the CNA, reenter the resident's room, and empty the catheter bag into the urinal. She was not observed to wash her hands or change her gloves before the encounter. At 2:30 p.m., CNA #1 exited resident #3's room, removed her gloves, and washed her hands. She was observed to move her gown aside and obtain a pair of gloves from her pocket and don them. She was asked why she kept gloves in her pocket. She stated she wanted to make sure she had them available. At 2:49 p.m., the DON was asked how staff were monitored to ensure masks were properly worn and hand hygiene/cough etiquette were performed. She stated random rounds were conducted by the clinical educator and the infection control nurse.