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 _____	07/10/2020

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.** 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 for residents exposed to COVID-19 positive residents for six (#4, 5, 6, 7, 8, and #9) of eight residents observed who had been exposed to COVID-19 positive residents. The administrator designee identified eight residents who had been exposed to COVID positive roommates; ~ ensure COVID-19 positive staff were not allowed to continue to work and care for COVID-19 positive and exposed residents for two (CNA (certified nurse aide) #1 and #2) of six employees who tested positive for COVID-19. ~ ensure staff were knowledgeable of which residents were COVID-19 positive on the COVID positive unit for three (CNA #3, #4, and CMA (certified medication aide) #1) of three staff members observed who worked the COVID positive unit; and ~ ensure staff donned/doffed PPE (personal protective equipment) appropriately between COVID-19 positive and exposed residents for two (#2 and #3) of two exposed residents who resided on the COVID positive unit. The administrator designee identified two residents who had been exposed to COVID positive roommates who residents on the COVID positive unit. The administrator designee identified 15 residents who resided on the COVID positive unit. The administrator designee identified 73 residents who resided in the facility. Findings: A CDC (Centers for Disease Control and Prevention) website article, updated 06/22/20, titled, Preparing for COVID-19 in Nursing Homes, documented: .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 .gowns, gloves, and eye protection (i.e., face shield or goggles) . As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test . A CDC website article, updated on 04/30/20, titled, Strategies to Mitigate Healthcare Personnel Staffing Shortages, documented: .There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations. For example, if, despite efforts to mitigate, HCP (health care personnel) staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that HCP with suspected or confirmed COVID-19 could return to work before the full Return to Work Criteria have been met . A facility policy titled, Transmission-Bases Precautions For Known or Suspected COVID-19 (and) Undiagnosed Respiratory Infections, documented: .(Named facility) has a responsibility to ensure the safety of all residents and staff in the facility. During the COVID-19 outbreak the facility will follow recommended Transmission-Based Precautions for known or suspected cases of COVID-19 and undiagnosed respiratory infections . On 07/10/20, the following observations and interviews were obtained during the survey. At 8:15 a.m., the DON (director of nurses) stated CNA #2 received positive COVID-19 results on 07/03/20. She stated the CNA was allowed to continue to work through part of the next week. She stated she needed the additional staff and she reviewed the CDC guidance and thought it was acceptable. She stated the staff member only worked on the COVID-19 positive unit. The DON stated CNA #1 also worked the COVID-19 positive unit on the evening shift of 07/09/20. She stated the staff member had been identified as positive. The DON stated all of the residents who resided on the COVID-19 positive unit had a confirmed positive result. At 8:45 a.m., CNA #3 and CMA #1 were observed while they worked on the COVID-19 positive unit. CNA #1 was observed to exit the room of a positive resident, discard her gloves, wash her hands, and don new gloves. She then entered the room of exposed residents #2 and #3 wearing the same gown. She observed each resident and talked to them. She then exited the room and then discarded her gloves and washed her hands. CNA #1 and CMA #1 stated all of the residents on the COVID unit were positive for COVID-19. They stated they could wear the same respirator, gown, and face shield from one positive resident to the next. They stated they changed their gloves and washed their hands between all residents. They stated if their gown became soiled they would change them. CMA #1 stated CNA #2 had tested positive for COVID-19 and continued to work the unit. She stated the staff member worked at least two to three days after he received the positive test result. At 10:30 a.m., the administrator designee stated the facility received CNA #1's positive COVID result between 2:30 to 3:00 p.m. on 07/09/20. She stated the staff member was allowed to continue to work her shift from 2:00 p.m. to 10:00 p.m. on 07/09/20 on the COVID-19 positive unit. She stated the DON approved the staff member to work. She stated the facility received CNA #2's positive COVID result between 3:00 to 3:30 p.m. on 07/03/20. She stated the resident was approved to work the following shifts: 07/03/20 2:15 p.m. to 6:00 a.m., 07/04/20 2:15 p.m. to 10:00 p.m., 07/05/20 2:00 p.m. to 6:00 a.m., 07/06/20 2:00 p.m. to 10:00 a.m., 07/08/20 2:00 p.m. to 10:00 p.m. She stated the DON approved the staff member to work all of the identified shifts. She stated the staff member was only assigned to work the COVID-19 positive unit. At 11:00 a.m., the DON stated CNA #1 and #2 were not approved to work any further shifts until she received approval from the OSDH LTC (Oklahoma State Health Department-Long Term Care) department. At 11:15 a.m., the DON was asked why CNA #1 and #2 were allowed to work the COVID positive unit when they had tested positive for COVID-19 themselves. She stated she didn't have enough staff to work so she had approved them to work. She was asked what action she had taken to obtain sufficient staffing for the facility. She stated she had requested and received some additional staff from the four agencies they had contracts with. She stated she had asked staff to work overtime hours. She stated the former DON had returned to work, the activities and restorative aides had also been assigned to care for residents. She stated they had placed ads in the local newspaper to try and hire new nursing staff. She stated the facilities two sister homes had ongoing staffing issues and were not able to provide assistance. At 11:20 a.m., it was determined during interviews with the administrator designee and RN (registered nurse) #1 that the COVID-19 positive unit had two exposed residents (#2 and #3) residing in the same room on the unit. They revealed an additional six (#4, 5, 6, 7, 8, and #9) residents were residing in private rooms on the halls with all other presumed negative residents. They stated the exposed residents had not been placed on any type of transmission based precautions. They stated they had not thought about it. At 11:25 a.m., observations were conducted of CNA #3 and #4 on the COVID-19 positive unit. CNA #4 was observed to exit a positive resident's room, discard his gloves, wash his hands and don clean gloves. He then entered into the exposed residents' room, resident #2 and #3, wearing the same gown. He walked up to resident #3's recliner and talked to the resident. He then exited the room, discarded his gloves and washed his hands. CNA #3 and #4 stated all of the residents on the unit had confirmed positive COVID-19 results. At 11:27 a.m., the administrator designee and RN #1 were notified of the observations of staff wearing the same PPE between positive residents' rooms and the exposed residents' room. They were notified the staff did not know the two residents did not have a confirmed positive test. They stated they had just received results and the residents both had confirmed negative results. They stated they were in the process of moving the two exposed/negative residents off the unit and into a private room. They stated the residents would be placed on droplet precautions. At 12:45 p.m., the DON stated she again was not allowing any positive staff to return to work. She stated she would reach out to the health department and seek approval. She was notified two exposed residents had been placed on the COVID-19 positive unit. She was notified the COVID positive staff she had assigned to the unit had provided care to both

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

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 _____	**07/10/2020**

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	(continued... from page 1) positive and exposed/unknown COVID status residents. She acknowledged the concerns.