STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375299	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL TERRACE CARE CENTER	1320 NORTHEAST 1ST PLACE PRYOR, OK 74362

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 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to ensure they employed a full-time director of nursing. The administrator identified 40 residents resided in the facility. Findings: Facility staffing schedules dated, 05/29/20 through 06/19/20, did not include a designated/full time director of nursing (DON). The previous DON's last day of work was 05/28/20. On 06/19/20 at 10:00 a.m., the administrator was asked about the DON. She stated they did not have one. She stated the DON had left around the end of May, 2020. She stated they had not had a DON since that time. She stated they did have other registered nurses, but none were interested in being the DON. She stated she was at present attempting to fill the position.
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 and interview, it was determined the facility failed to ensure: ~ approprite PPE was used during the provision of care to residents quarantined, and ~ appropriate dinage was posted on quarentine rooms door. The facility identified two (#1 and #2) residents, who were quarantined in the facility. Findings: .The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP (health Care Provider) 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 . On 06/19/20 at 9:25 a.m., the administrator was asked if there were residents currently in quarantine. She stated no. At 10:55 a.m., licensed practical nurse (LPN) #1, the charge nurse, was asked if any residents were quarantined. She stated yes. She stated they had two residents quarantined. She stated resident #1 had been out to the hospital on [DATE] and was quarantined. She also stated resident #2 was a new admission to the facility on [DATE] and was quarantined. She was asked if they were quarantined in a designated area. She stated they were each in rooms without roommates. She was asked what PPE was required to enter the room and care for the resident. She stated they wore masks, gloves, and washed their hands. At 11:00 a.m., a tour of the facility was conducted. No staff were observed utilizing face shields or gowns while providing care to the resident #1 and residetn #2. There was no signage observed posted on the two residents doors to notify staff of precautions. There was no PPE visible near the residents' rooms. At 1:05 p.m., certified nurse aide (CNA) #1 was asked if any residents were quarantined. She stated yes. She stated resident #1 had been out to the hospital and was quarantined. She was asked if the resident required assistance with care. She stated yes. She was asked what PPE she used when she provided care. She stated a mask and gloves. She was asked if the facility had enough PPE. She stated yes, it was stored in a closet in the hall. At 1:35 p.m., the infection preventionist was asked what PPE staff were utilizing to provide care to the quarantined residents. She stated they should be using masks, gloves, gowns and eye protection. She was asked why there was no PPE outside the room or instructions to staff as to what was required regarding PPE. She stated there should be and she was not aware it had not been done. She was asked what PPE the facility had in stock. She stated they currently had adequate supplies of face shields, gowns, surgical masks and gloves. She stated they did not have any staff fitted for the N 95 masks at present. She was made aware staff should be utilizing full PPE due to the quarantined residents' unknown status to maintain infection control. She acknowledged the findings.

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.