STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375417	A. BUILDING _____ B. WING _____	**10/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTHAVEN NURSING HOME	**1215 SOUTH WESTERN STILLWATER, OK 74074**

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 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 four (#1, 2, 3, and #4) of four sampled residents. The facility failed to ensure the staff: a) stored and used gloves from appropriate sources, not from the staff's uniform pocket; wore face shields when providing care; b) wore N-95 mask correctly; and c) changed gloves and completed hand hygiene as required. Findings: The Center for Disease Control guidance titled, Preparing for Covid-19 in Nursing Homes, .Reinforce adherence to standard IPC (infection prevention control) measures including hand hygiene and selection and correct use of personal protective equipment (PPE) .Remove and discard gloves before leaving the patient room or care area and immediately perform hand hygiene . 1. On 10/07/20 at 11:02 a.m., on hall two, certified medication aide (CMA) #3 put gloves in her pocket, she put an isolation gown on, then reached into her pocket and retrieved a pair of gloves and put them on. She did not don a face shield. She entered resident #3's room to provide care; after she left the room she was asked what she had done for the resident. She stated she helped the resident remove her jacket. The CMA did not wear a face shield while providing care to the resident. At 11:08 CMA #3 put on an isolation gown and again retrieved gloves from her pocket and donned the gloves, she did not put on a face shield prior to entering resident #4's room with certified nurse aide (CNA) #2. CNA #2 stated they assisted the resident to bed. The CMA did not wear a face shield when she provided care to the residents and obtained gloves from her pocket under her isolation gown rather than from a box of gloves. At 2:00 p.m., CMA #3 stated she did not normally put gloves in her pocket. She stated she did not wear a face shield because she left it on the other hall. At 4:36 p.m., the infection preventionist (IP) stated the staff should not get gloves and put in their pocket to use. The IP stated the staff were encouraged to wear face shields. 2. On 10/07/20 at 12:03 p.m., on hall one, licensed practical nurse (LPN) #2 was wearing a surgical mask under an N-95 mask. The LPN stated he had been fit tested for the N-95 mask and had received education on how to wear the mask. At 4:36 p.m., the IP stated a surgical mask should not be worn under the N-95 mask. 3. On 10/07/20 at 11:31 a.m., on hall one, LPN #1 wiped down a stick (An assistive device used to help her don/doff shoe covers.) she used to apply her shoe covers; donned gloves without cleaning hands; entered resident #2's room. She moved some food containers on the bedside table; reached into her pocket under her isolation gown and pulled out the keys to the treatment cart and asked an employee in the hall to get her something out of the cart. The LPN did not change her gloves or perform hand hygiene and continued to obtain the resident's finger stick blood sugar. The LPN placed the glucometer outside the resident's room on the handrail; she removed her PPE and picked up the glucometer took it to the treatment cart; put on one glove and cleaned the stick she was using to don and doff her shoe covers, cleaned her shield, removed the one glove she had on and touched her scrubs, the keys to the cart and got into the treatment cart and retrieved a paper barrier and placed it on top of the treatment cart. The LPN did not perform hand hygiene when she left the resident's room or after cleaning her face shield or assistive device. She did not clean/disinfect the handrail she had placed the glucometer on in the hall. At 11:43 a.m., LPN #1 stated she should not have gotten in her pocket with her gloves on and handed the keys to the other employee. She stated she should have performed hand hygiene when she left the resident's room before she touched anything else. At 12:27 p.m., on the COVID unit, CNA #1 left resident #1's room; removed PPE, used hand sanitizer and donned a new pair of gloves and disinfected her face shield with Clorox wipes, removed her gloves. She did not perform hand hygiene. The CNA poured drinks for resident #1 and donned PPE and entered resident #1's room. The CNA removed the PPE prior to exiting the resident's room. She did not wash or use hand sanitizer upon leaving the resident's room. She donned new pair of gloves, disinfected the face shield, removed gloves, and did not perform hand hygiene with either hand sanitizer or soap and water. She touched a cabinet in the nurses' station and a mask she was given to give to another employee. At 12:48 p.m., CNA #1 stated she did not clean her hands because she only handed the resident a cup of coffee and turned off her call light. She stated she did not think about cleaning her hands after disinfecting her face shield.

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