STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375312	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RUTH WILSON HURLEY MANOR	**7 NORTH COVINGTON COALGATE, OK 74538**

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 maintain an infection control program and implement measures to provide a safe environment to help prevent the development and transmission of COVID-19 for two (#1 and #2) of three residents sampled for infection control. The facility failed to ensure: a) N95 masks and face shields were worn in the rooms of quarantined residents, b) cloth masks were not worn by direct care staff, and c) residents were spaced at least six feet apart and wore masks while out of their rooms. The infection preventionist (IP) reported two residents were quarantined and on droplet precautions. The DON reported there were no residents who were COVID-19 positive in the facility and had a census of 41 residents. 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 . HCP 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. Guidance on extended use and reuse of facemasks is available. 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 . The Center for Disease Control guidance titled, Coronavirus Disease 2019 (COVID-19), documented, .Social Distancing .Keep Your Distance to Slow the Spread .to practice social or physical distancing stay at least 6 feet (about 2 arms' length) from other people. On 06/12/20 at 8:20 AM, an observation was made of the facility's supply of personal protective equipment (PPE). The supply included gowns, gloves, surgical masks, disposable shields, and N95 respirators. The IP stated the PPE supply was better than it had been and was adequate for the need. The number of N95 masks was observed to be approximately 220. The IP stated the staff had been fit tested on [DATE]. The IP stated everyone wore N95 masks for a week after the facility was notified of a resident and a staff member's positive test results. The IP stated the staff were not wearing N95 masks at the present time for the two residents in quarantine. On 06/12/20 at 8:30 AM, an observation was made of the director of nurses (DON) walking down the residents' hallway wearing a cloth mask. On 06/12/20 at 8:35 AM, an observation was made of resident #1 in her room from the hallway. Signage on the door documented droplet precautions. The PPE station outside the resident's door did not contain N95 mask and face shields or goggles. On 06/12/20 at 8:37 AM, an observation was made of three residents in the new wing lobby area without mask on. They were seated at a folding table approximately 3' wide x 8' long. One resident was at the end of the table and the other two were seated across from each other about midway at the table. There was no food on the table. On 06/12/20 at 8:38 AM, an observation was made of resident #2 in his room from the hallway. Signage on the door documented droplet precautions. The PPE station outside the resident's door did not contain N95 mask and face shields or goggles. On 06/12/20 at 8:40 AM, an observation was made of certified medication aide (CMA) #1 wearing a cloth mask while preparing medications at a resident's doorway. The CMA stated she was not wearing an N95 mask or shield with the quarantined residents. She stated she did not know she should not wear a cloth mask. On 06/12/20 at 8:42 AM, an observation was made of a laundry staff member wearing a cloth mask while retrieving dirty laundry from a bin in the hallway. On 06/12/20 at 8:45 AM, an observation was made of the three residents at the table in the lobby area without mask seated less than six feet from each other. The residents were not interviewable. At that time certified nurse aide (CNA) #1 was asked why the residents did not have masks on. She said she did not know and asked CNA #2 why the residents did not have a mask on. CNA #2 stated she did not know why the residents did not have masks on. CNA #3 walked up and said the residents had just got through eating and they had not brought their mask with them. CNA #2 went and got the residents a mask and put it on them. The residents were observed to wear the masks for the remainder of the time the surveyor was on the unit. On 06/12/20 at 8:55 AM, an observation was made of CMA #2 wearing a cloth mask while preparing medications at a resident's doorway. The CMA stated she did not know she should not be wearing a cloth mask. She said she wore the cloth mask in the quarentined residents' rooms and did not wear a shield. On 06/12/20 at 8:56 AM, an observation was made of licensed practical nurse (LPN) #1 wearing a cloth mask. She stated she was not told she could not wear a cloth mask. She stated she had not been wearing an N95 mask and face shield when in the residents' rooms who were quarantined. On 06/12/20 at 8:56 AM, an observation was made of cook assistant #1 and #2 while in the kitchen. One of the cook assistant's mask was below her nose. On 06/12/20 at 9:29 AM, an observation was made of the laundry. The laundry aide stated she wore a cloth mask without a face shield or goggles, gloves, and sleeveless plastic apron when handling the dirty laundry. During the observation of the laundry, the laundry supervisor came in and pointed out the long sleeve plastic gowns and face shields which were readily available with the other PPE. He stated the laundry personal should wear the long sleeve gowns and face shield while handling the dirty laundry. On 06/12/20 at 9:39 AM, the DON and IP were interviewed. The DON stated they should have been wearing the N95 masks and face shields while giving care to the residents who are quarantined. She stated they would work on keeping the residents spaced better and remind them to wear their masks.

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