STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375543	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOORELAND HERITAGE MANOR	402 SOUTHEAST 6TH STREET MOORELAND, OK 73852

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, record review and staff interviews, it was determined the facility failed to maintain CDC guidelines to aide in the prevention and spread of COVID-19 by failing to ensure: ~ appropriate personal protective equipment (PPE) was worn by staff during the provision of care to residents with a positive COVID-19 status, ~ dedicated staff cared for COVID positive residents, ~ signage was posted to alert staff of isolation precautions, ~ necessary PPE was available for COVID positive residents, ~ biohazard waste was available for PPE to be discarded and ~ policy for testing staff. The facility identified 20 residents resided in the facility and 14 residents were currently positive for COVID-19. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, . Testing for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19, in respiratory specimens can detect current infections .among residents and HCP (health care personnel) in nursing homes. The plan .should align with state and federal requirements for testing residents and HCP for [DIAGNOSES REDACTED]-CoV-2 and address: Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance) .Antibody test results should not be used to diagnose someone with an active [DIAGNOSES REDACTED]-CoV-2 infection and should not be used to inform IPC action. Process for and capacity to perform [DIAGNOSES REDACTED]-CoV-2 testing of all residents and HCP .Make necessary PPE available in areas where resident care is provided .Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room . Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use .Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown . An employee list, undated, documented ten staff members had tested positive from 05/26/20 to 08/27/20. No other documentation was provided to show when the last time all staff were tested . A resident testing time line, undated, documented eight residents tested positive on 08/24/20. Seven of the eight residents were observed to reside on the East hall and one of the resident was observed to reside on South hall. The facility identified two residents, who have never tested positive, to be on the West hall. An assignment sheet, dated 9/1, documented certified nurse aide (CNA) #1 was assigned to both South and West halls. On 09/01/20 at 9:20 a.m., the administrator was asked how many residents were currently COVID-19 positive. She stated 14. She was asked how many were negative. She stated six. She was asked how many staff were employed. She stated around 40. She was asked how many staff were currently positive. She stated one. She stated nine were positive from 08/17/20 to 08/27/20. She stated 31 were negative. At 9:43 a.m., the director of nursing (DON) was asked how frequently the staff were being tested . She stated all staff had been tested at an event in a neighboring city about three weeks ago for the antibody. She stated staff would only be tested if they were symptomatic. The administrator stated they did not have the means to test the staff. At 10:35 a.m., CNA #1 was observed coming out of a COVID-19 negative resident's room on West hall. She was observed wearing a respirator and had sanitized her hands. She was asked what residents she was taking care of. She stated positive and negative residents. At 10:40 a.m., one PPE cart was observed at the front of South hall and two red biohazard trash cans were located further down the hall. No isolation signage was observed on the hall or the COVID-19 positive resident's room. At 10:46 a.m., CNA #1 was asked what PPE she wore to take care of the negative residents on West hall. She stated she wore a respirator and gloves. She was asked what she wore to take care of the positive residents on East hall. She stated, The same. She was asked even when she transferred residents. She stated, Yes. At 10:55 a.m., the DON was asked what PPE the staff wore to care for the residents who had a positive COVID-19 status. She stated N95 with surgical mask over it, goggles, hair net, respirator and they wore a gown if a nebulizer was in use. She stated if DON or office staff were in the building, they took care of the COVID-19 negative residents on West hall. There was no observation of the DON or office staff caring for the COVID-19 negative residents. At 11:50 a.m., CNA #1 was observed to go into a COVID-19 positive resident's room on East hall. She was observed to wear her respirator and gloves. No PPE, trash cans for disposable of PPE and isolation signage was observed to be on the East hall. At 12:25 p.m., CNA #1 was asked if she knew what residents were COVID-19 positive. She stated everyone besides four residents, but she wasn't one hundred percent sure. At 1:50 p.m., CNA #1 was asked what halls she worked today. She stated she worked all halls. She was asked if she worked with the seven COVID-19 positive residents on East hall and the one COVID-19 positive resident on South hall. She stated she took care of everyone except for one of the COVID-19 positive residents on East. At 1:55 p.m., the PPE cart that was observed on the South hall was no longer there. It was observed to have been moved to the West hall. At 2:13 p.m. the DON was asked why the PPE cart was moved from the South hall to the West hall. She stated she couldn't answer. She was asked if there was a PPE cart and biohazard trash can on East hall. She stated, No. She was asked the reason. She stated, Because pretty much the whole building is COVID except for right here (she indicated West hall). She was asked if staff should wear gowns when caring for COVID-19 positive residents. She stated, No, because we thought it was a bigger cross contamination. She was asked if there was dedicated staff on West hall. She stated, Yes, at night. At 2:30 p.m., the administrator and DON were made aware of the above observations and per CDC guidelines and their resident testing time line, they currently had eight COVID-19 positive residents. They acknowledged the findings.

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