STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375102	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CIMARRON NURSING CENTER	**905 BEALL ROAD KINGFISHER, OK 73750**

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 and interview, it was determined the facility failed to: ~ ensure appropriate PPE was worn by staff during the provision of care to seven of seven quarantined residents whose COVID-19 status was unknown; and ~ ensure two of seven residents whose COVID status was unknown were placed in private rooms. The facility identified seven residents who resided in the facility and were in quarantine. 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 N-95 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 07/08/20 at 9:40 a.m., the DON was asked how many residents the facility had in quarantine. She stated seven. She was asked if all the residents in quarantine were in private rooms. She stated five were in private rooms and two were quarantined together. The DON was asked if two residents of unknown COVID status should be quarantined together. She stated, No. She was asked if the facility was observing appropriate infection control by having two residents of unknown COVID status rooming together. She stated, No. The DON was asked what PPE the staff wore when caring for residents in quarantine. She stated face masks, gowns and gloves. She was asked if the masks were N-95 masks. She stated no they were procedure masks. She was asked if the staff wore a face shield with the masks. She stated no they had not been using face shields. At 11:05 a.m., a quarantine room was observed to have two residents rooming together whose COVID status was unknown. The DON stated one of the residents had been admitted the day before and the other was a resident who had left the facility for a physicians appointment and had returned. At 12:20 p.m., the DON and administrator were asked why the staff had not been using face shields with their masks. The administrator stated that had been told it was not necessary.

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