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 _____	10/13/2020

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 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. The facility failed to: ~ Ensure staff wore appropriate PPE when providing direct care to one (#6) resident in quarantine of three residents who were reviewed and in quarantine; ~ Ensure staff disinfected shared resident equipment between uses; ~ Ensure staff completed hand hygiene as required; ~ Ensure residents were thoroughly monitored for all possible symptoms of COVID-19 that are documented on the CDC website for three (#1, #2, and #3) of three residents who were reviewed for symptom monitoring; ~ Ensure staff did not obtain their own temperature and staff/visitors were thoroughly screened for all possible symptoms of COVID-19 that are documented on the CDC website; and ~ Ensure a disinfectant listed on the EPA List N was utilized to disinfect the facility floors. Findings: The Centers for Disease Control guidance, titled Preparing for COVID-19 in Nursing Homes, documented, .Screen visitors for fever .symptoms consistent with COVID-19, or known exposure to someone with COVID-19 . Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature* and document absence of symptoms consistent with COVID-19 . Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment . Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP should wear 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 when caring for these residents . Actively monitor all residents upon admission and at least daily for fever .and symptoms consistent with COVID-19 . 1. On 10/13/20 at 12:40 p.m., CNA #1 and LPN #1 were observed to enter resident #6's room who was in quarantine. CNA #1 and LPN #1 wore face masks and donned gloves. The DON knocked on the door, looked in, and closed the door. When LPN #1 exited the room she was asked what care had been provided to resident #6. She stated they repositioned her in bed. She stated the resident required two person assistance. At 12:45 p.m., the DON was asked what PPE was utilized for direct resident care for those in quarantine. She stated gown, gloves, face mask, and face shield. She was asked why staff had not worn the appropriate PPE when repositioning resident #6. She stated the staff should have worn full PPE. At 2:42 p.m., the infection preventionist was asked what PPE staff were to don when they provided direct resident care such as repositioning. She stated they were to utilize face shields, face masks, gloves, and gowns. She was asked if the facility had adequate amounts of PPE. She stated yes. 2. On 10/13/20 at 11:25 a.m., LPN #1 was observed to obtain a blood glucose on resident #4. She exited the room and placed the glucometer on top of the treatment cart. She was not observed to disinfect the glucometer. She proceeded down the hall to resident #5's room. She sanitized her hands, donned gloves, obtained a lancet, and placed a test strip into the glucometer. She knocked on resident #5's door, announced she was there to obtain his blood glucose, and entered the room. LPN #1 was asked to accompany the surveyor into the hall. She was asked how often glucometers were disinfected. She stated she had disinfected the glucometer before she obtained resident #4's blood glucose. She stated she was going to disinfect it after she had obtained resident #5's blood glucose. She stated she disinfected the glucometer after every two residents. She was asked why she had not disinfected the shared glucometer after each resident use. She stated she should have disinfected the glucometer after she used it on resident #4. At 2:52 p.m., the infection preventionist was asked how often shared glucometers were to be sanitized. She stated after each resident use. At 3:05 p.m., the DON was asked when glucometers were to be disinfected. She stated between each resident. 3. On 10/13/20 at 11:45 a.m., LPN #1 was observed to don gloves and obtain a blood glucose on resident #5. She was observed to return to the treatment cart in the hallway, obtain an insulin pen and alcohol pad, closed the treatment administration record book, and entered the resident's room. She was not observed to perform hand hygiene or change her gloves after she had obtained the blood glucose and before she had administered insulin. She was asked when hand hygiene was to be performed when obtaining blood glucose and administering insulin. She stated she obtained the blood glucose, administered insulin, and then would remove gloves and sanitize her hands. At 2:52 p.m., the infection preventionist was asked when staff were to perform hand hygiene when obtaining blood glucose and administering insulin. She stated the staff were to perform hand hygiene after obtaining the blood glucose and before administering insulin. At 3:05 p.m., the DON was informed a staff member was not observed to perform hand hygiene between obtaining a blood glucose level and administering insulin to a resident. She stated the staff member should have performed hand hygiene after the blood glucose and before administering insulin. 4. On 10/13/20 at 8:50 a.m., the DON was asked where resident monitoring for COVID-19 was documented. She stated the nurses documented temperatures and symptom monitoring on a screening tool form. Review of the screening tool form for resident #1, resident #2, and resident #3 did not reveal the residents had been monitored for all possible symptoms of COVID-19. The form documented, .Do you have a new onset headache or in the last few days .Do you have body aches that are new or in the last few days .Are the resident's eyes red rimmed .Do you feel different than normal .Is the resident more lethargic than normal .Have you had a change in your ability to smell or taste .Do you have any tightness or pressure in your chest that is new . On 10/13/20 at 2:52 p.m., the infection preventionist was asked why residents were not monitored for all possible signs of COVID-19. She stated she thought the nurses were monitoring and documented in the progress notes. She was asked for documentation of symptom monitoring in the progress notes. By the end of survey no further documentation had been provided. At 3:05 p.m., the DON was asked why residents were not monitored for all possible symptoms of COVID-19. She stated they needed to update the screening tool form. 5. On 10/13/20 at 8:45 a.m., upon entrance to the facility the surveyor was asked to fill out a visitor screening tool form. The form had a space to document the visitors temperature and asked the following information with a space to indicate 'yes' or 'no'. ~ Fever of 100.4 F within the last 14 days; ~ Cough/shortness of breath; ~ Pneumonia/flu-recent; ~ Have traveled out of the state in the last 14 days; ~ Have been in contact with anyone who has lab confirmed Novel Coronavirus within 14 days of symptom onset; and ~ What county the visitor is from. The surveyor was not asked about other symptoms of COVID-19. At 9:28 a.m., therapy #1 was observed to enter the facility, stop at the screening table, obtain her own temperature and sign the staff form with her name on it. The nurse was observed to write on the form as well. The staff screening tool asked for the following information with a space to indicate 'yes' or 'no'. ~ Fever of 100.4 F within the last 14 days; ~ Cough/shortness of breath; ~ Pneumonia/flu-recent; ~ Have traveled out of the state in the last 14 days; ~ Have been in contact with anyone who has lab confirmed Novel Coronavirus within 14 days of symptom onset; ~ What county they are from. The bottom half of the form had 14 lines to document the date, temperature when they entered the facility, temperature mid shift, temperature when they left, new symptoms of cough, shortness of breath, new onset of fever, and the nurses initials. At 9:29 a.m., LPN #1 was asked when staff were monitored for symptoms since there were 14 lines to document the temperature and date but only one set of questions at the top of the form where they were to indicate 'yes' or 'no'. She stated the staff answered the questions at the top of the form once when they first started their work week. She stated they utilized the spaces at the bottom of the form each day after to document the temperature. At 12:16 p.m., CNA #1 was observed to enter the facility and obtain her own temperature. She was asked if she had just arrived for work. She stated she had arrived at 5:45 a.m. and had just

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) returned from lunch. She was asked what the screening process was for staff when they arrived to work. She stated, I get my temp, get my mask, get report, clock in, and get to work. At 12:53 p.m., therapy #2 entered the facility, obtained her own temperature, documented the temperature in the screening log, and entered the nurses station. She was asked what the screening process was when she arrived at the facility. She stated her temperature was taken, she sanitized her hands, and she began visiting residents. She was asked who obtained her temperature. She stated she took her own temperature. At 1:43 p.m., CNA #4, CNA #5, and CMA #2 were observed to enter the facility. They were observed to take their own temperature, document in the log, and walk to the time clock. A nurse was observed to walk to the screening table. CNA #4 was asked what the screening process consisted of when she arrived to work. She stated their temperature was taken. She was asked who obtained their temperature. She stated they obtained their own temperature and the nurse signed off on it. CNA #5 was asked where symptom screening was documented. She stated if she had a high temperature or had any symptoms she would not come into work. She stated they only answered the questions at the top of the form every couple of weeks. CMA #2 was asked what the screening process consisted of. She stated they took their own temperature and sometimes the nurse would obtain it. At 2:52 p.m., the infection preventionist was asked what the process was for staff screening before their shift. She stated when they arrived to work their temperature was taken and the questions on the form were asked. She was asked why all symptoms of COVID-19 were not listed on the staff/visitor screening forms. She stated she did not know. She was asked how often staff were screened for symptoms of COVID-19. She stated they changed the form out every 14 days. She stated if they developed symptoms after initially answering the questions at the top of the form the staff member was to notify the nurse. She was asked who obtained the oncoming staffs' temperatures. She stated they tried to have the nurse obtain it. She stated, We always encourage the nurse to do it. At 3:05 p.m., the DON was asked why staff/visitors were not screened for all symptoms of COVID-19 and why staff were not screened for symptoms daily and obtained their own temperature. She stated the staff were inserviced on what symptoms to report to the nurse and they answered the screening questions once a week. She stated the nurse was to obtain the oncoming staffs' temperature. 6. On 10/13/20 at 11:46 a.m., the housekeeping supervisor was asked what disinfectant was utilized on the facility's floors. She provided a chemical cleaner which did not have an EPA number on it. She was asked why a List N disinfectant was not utilized on the floors. She stated they sometimes utilized the peroxide disinfectant but the floor cleaner provided was the one they primarily utilized for the floors. At 3:05 p.m., the DON was asked why the facility did not utilize a List N disinfectant for the floors. She stated she did not know.