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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER<br><b>375246</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                   | (X3) DATE SURVEY COMPLETED<br><b>06/16/2020</b> |
| NAME OF PROVIDER OF SUPPLIER<br><b>SHAWNEE CARE CENTER</b>   |   | STREET ADDRESS, CITY, STATE, ZIP<br><b>1202 WEST GILMORE<br/>SHAWNEE, OK 74804</b> |   |
| 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<br><br><b>Level of harm - Minimal harm or potential for actual harm</b><br><br><b>Residents Affected - Some</b>             | <p><b>Provide and implement an infection prevention and control program.</b><br/> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b><br/> 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. The facility failed to ensure: a) residents wore face coverings while out of their rooms, b) residents were spaced apart and not crowded together, c) face shields were worn over the surgical masks while caring for residents who were on quarantine status, and d) staff members wore their face masks over their mouth and nose. The administrator (adm) reported zero residents were COVID-19 positive, four residents were on quarantine status, and 71 residents resided in the facility. 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 . 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. The Center for Disease Control guidance titled, How to Wear Cloth Face Coverings documented, .Cloth face coverings are NOT surgical masks or N-95 respirators. Surgical masks and N-95 respirators must be reserved for healthcare workers and other medical first responders, as recommended in CDC guidance. Wear your Face Covering Correctly .Put it over your nose and mouth and secure it under your chin. Try to fit it snugly against the sides of your face .Wear a face covering to help protect others in case you're infected but don't have symptoms . On 06/16/20 at 8:40 AM, a group of five residents were observed coming up the hall in their wheelchairs toward the dining room. None of the residents were wearing face coverings. At that time the adm was asked why the residents were not wearing face masks. She stated she did not think they were supposed to wear them unless there was COVID in the building. On 06/16/20 at 8:54 AM through 9:07 AM, during a tour of the north hallway observations were made of the stations outside the doors of the four residents who were being quarantined. The stations contained surgical masks, gloves, and gowns. Goggles or face shields were not included at the stations. There were signs on the doors to check at the nurse station before entering room. There was no signage to address what kind of precautions needed to be taken or what personal protective equipment was required. On 06/16/20 at 9:07 AM, licensed practical nurse (LPN) #1 was observed to take off her cloth mask; put on a new surgical mask and gloves; and enter the quarantined resident's room with a cup of medications. At 9:10 the LPN was observed to come out of the room without her gloves and mask, use hand gel, and then put on her cloth mask. The LPN walked down the hall and stopped to talk to a resident who was standing in her doorway. The LPN's mask was below her nose. On 06/16/20 at 9:21 AM, LPN #1 was observed in the north lobby area feeding a resident, who was seated in a wheelchair, a cup of crushed medications with a spoon. The LPN was bent over close to the resident's face. The LPN was talking to the resident, trying to convince her to take her medication. The LPN's mask was below her nose. The LPN finished feeding this resident at 9:26 AM. Between 9:21 AM and 9:35 AM, during the north lobby observation, 12 residents were in the lobby with no masks on. They were side by side in their wheelchairs and/or sitting on the two couches. The residents were within arms reach of each other. On 06/16/20 at 9:35 AM, RN #1 was asked what PPE was required to be worn in the quarantined rooms. She stated a surgical mask and gloves. She stated if contact care was provided a gown was also worn. The RN was asked if the staff ever wore N95 masks or face shields. She said she had never had to wear an N95 or a face shield. On 06/16/20 at 9:50 AM, on the north hall, certified nurse aide (CNA) #1 and #2 were observed entering into a resident's room. CNA #2 was wearing her face mask below her nose. On 06/16/20 at 10:07 AM, on the south hall, six residents were observed sitting in the lobby. Two male residents were seated on the couch within arms reach of each other. Two female residents were seated on a loveseat together. None of the residents were wearing face coverings. On 06/16/20 at 10:13 AM, on the south hall, CNA #3 was wearing her cloth mask below her nose. On 06/16/20 at 10:50 AM, in the south lobby, a group of ten residents were not wearing masks and were in arms reach of another resident. On 06/16/20 at 12:00 PM, the administrator was interviewed. She stated she did not know the staff had to have N95 masks and face shields for the residents in quarantine. She stated she was receiving PPE from the medical emergency response center (MERC), but had not received any N95 masks and had not been fit tested . She stated she did not realize face shields were needed to go over the surgical masks. She said she had a good supply of face shields. On 06/16/20 at 12:23 PM, LPN #2 stated one of the quarantined residents was a new resident who had been admitted the day before. She confirmed the resident had an order for [REDACTED].</p> |  |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  |   | TITLE (X6) DATE  |   |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.