

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 375365	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2020
NAME OF PROVIDER OF SUPPLIER SOUTH POINTE REHABILITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 5725 SOUTH ROSS OKLAHOMA CITY, OK 73119	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, record review and staff interviews, it was determined the facility failed to maintain CDC guidelines to aid in the prevention and spread of COVID-19 by failing to ensure appropriate transmission based precautions were implemented and all required PPE was donned for close contact of a resident with unknown COVID-19 status. The facility reported there were six residents in quarantine residing in facility. Findings: The Center for Disease Control guidance titled, Coronavirus Disease 2019 (COVID-19), documented, Managing New Admissions and Readmissions Whose COVID-19 Status is</p> <p>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 . On 09/29/20 at 1:45 p.m. CNA #1 was observed entering room [ROOM NUMBER], which was designated as a quarantine room. She was observed to be wearing an N95 mask, a gown and gloves. She was not wearing a faceshield or goggles. At 1:50 p.m., CNA #1 was asked what PPE she wore with resident care. She stated a gown, gloves and an N95 mask. She was asked if she wore a faceshield or goggles. She stated she did not wear a faceshield or goggles. She stated it was hard to find them. At 1:55 LPN #1 was observed at the nursing station on hall 600. She was observed to be wearing an N95 mask with a surgical mask and goggles. She was asked what PPE was worn for resident care. She stated a gown, gloves, an N95 mask and a faceshield or goggles. At 2:30 p.m. the DON was asked what was appropriate PPE to be worn for a resident in quarantine. She stated a gown, gloves, an N95 mask and a faceshield or goggles. The DON was informed that CNA #1 had been observed in a quarantine room without a faceshield or goggles. She was asked if the CNA had been following appropriate protocol. She stated the CNA should have been wearing a faceshield.</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.