OKLAHOMA
State Department
of Health

July 31, 2020

CCN: 375389
Cycle Start Date: June 23, 2020
Survey Event ID: 2JZ911

Ms. Kaitlyn Mills, Administrator
Tulsa Nursing Center
10912 East 14th Street
Tulsa, OK 74128

Dear Ms. Mills:

On **June 23, 2020**, agents from our office concluded a COVID-19 special focus survey at Tulsa Nursing Center to determine if your facility was in compliance with Infection Prevention and Control requirements. This inspection found the most serious deficiency(ies) in your facility to be:

- Deficiency level "E"; a pattern of deficiencies that constitutes no actual harm (and not immediate jeopardy), but have potential for more than minimal harm, as evidenced by the attached CMS-2567, whereby significant corrections are required.

Plan of Correction (POC)

You must submit an acceptable POC within ten calendar days of receipt of the CMS-2567. An acceptable POC shows a provider's willingness and ability to achieve and maintain compliance and to provide residents the care and services they need. An acceptable POC demonstrates correction has been, or will be achieved and makes the provider's allegation of compliance credible. An acceptable POC is required before a revisit (to verify correction) will be made. To be considered acceptable, your POC must contain the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, **evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.**

- An acceptable completion date for correction of each deficiency. Your facility is ultimately accountable for its own compliance. The POC will serve as the facility's allegation of compliance. Unless otherwise stated on the POC, the last completion date will be the date of alleged compliance.

In addition, the POC must be specific and realistic, stating exactly how the deficiency will be or was corrected.

Please submit your POC under the second column on the enclosed Form CMS-2567. Address each deficiency, and include the month, day, and year of the expected completion date in the third column. Sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Return the CMS-2567 with the POCs to:

Long Term Care Complaint and Enforcement Division
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Phone: (405) 271-6868
Fax: (405) 271-2206

If you fail to submit an acceptable POC by the due date, 42CFR488.456(b)(1)(ii) provides for termination of your Medicare and/or Medicaid agreements.

Official Notice of Remedies

Denial of Payment for New Admissions (DPNA): In accordance with statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417(b):

> *Required denial of payment. CMS does or the State must deny payment for all new admissions when—*
>
> *(1) The facility is not in substantial compliance, as defined in §488.401, 3 months after the last day of the survey identifying the noncompliance;...*

The DPNA will be effective on **September 23, 2020** unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit prior to the

effective date. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Imposition of Directed Plan of Correction (DPOC):

In accordance with 42 CFR §488.424 *Directed plan of correction*, the state survey agency is imposing a Directive Plan of Correction (DPOC). Pursuant to 42 CFR § 488.402(f) the DPOC remedy is effective 15 calendar days from the date of this enforcement letter. The effective date is not a deadline for completion of the DPOC. The DPOC may be completed before or after that date. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation attached to the following email address:

LTCEnforcement@health.ok.gov

or via regular mail to:

ATTN: Tempal Killman
Long Term Care Enforcement
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73111

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567. Please see the attached DPOC instructions for detailed guidance.

Termination of Your Medicare (and Medicaid if Applicable) Provider Agreements:

Unless your facility achieves substantial compliance before **December 23, 2020**, CMS will terminate your facility's Medicare provider agreement in accordance with the Social Security Act 1866(b)(2) and 42 CFR §488.412(d).

Filing an Appeal

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a

hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board.

Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at:

https://dab.efile.hhs.gov no later than **September 29, 2020** (60 days from the date of receipt of this letter via fax).

When using DAB E-File for the first time, you will need to create an account by:

a) clicking Register on the DAB E-File home page;
b) entering the requested information on the Register New Account form; and
c) clicking Register Account at the bottom of the form.

Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by:

a) clicking the File New Appeal link on the Manage Existing Appeals screen; then
b) clicking Civil Remedies Division on the File New Appeal screen; and
c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: https://dab.efile.hhs.gov/appeals/to_crd_instructions.

Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-

Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email or fax a copy of your request to **Leena Volmer at leena.volmer@cms.hhs.gov or (443) 380-7507.**

Please include the ***CCN 375389, CSD-June 23, 2020***, and your facility's name to the subject line of your email or fax to identify your facility.

If you choose, you may waive your right to a hearing. Your waiver of the right to a hearing should be sent Leena Volmer. In accordance with §498.20, the failure to request a hearing will render the survey findings and imposed remedies final and binding.

Informal Dispute Resolution

In accordance with 42 CFR §488.331, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833 and the Oklahoma IDR Process for Medicare/Medicaid Certified Facilities.

The IDR request must be submitted within ten calendar days from receipt of the Statement of Deficiencies (CMS-2567). This is the same requirement for submitting an acceptable Plan of Correction (POC). Failure to submit a completed IDR Request Form and supporting documentation within this timeframe waives your right to the IDR. Failure to

complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR

may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care (SQC) or immediate jeopardy (IJ);
- Remedy (ies) imposed by the Department;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have any questions, please contact me at (405) 271-6868.

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.07.31 12:12:21 -05'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure: DPOC

OKLAHOMA
State Department
of Health

Tier 1 DPOC F880

Facility Name:	**Tulsa Nursing Center**
Issue Date:	**7-31-2020**
CCN:	**375389**
CSD:	**6-23-2020**
Survey Date:	**6-23-2020**

Directed Plan of Correction (DPOC) for Root Causes Analysis and Performance Improvement of Infection Prevention and Control System – Tier 1

Oklahoma State Department of Health/Protective Health Services/Long Term Care

In accordance with 42 CFR §488.424 *Directed plan of correction*, the Oklahoma State Department of Health (OSDH) directs your facility to conduct a *Root Causes Analysis* and *Performance Improvement* of your Infection Prevention and Control (IP&C) system. That will include:

- An immediate review of F880 to mitigate the cited specific IP&C Deficient Practices.
- Adopt or develop a written, measurable format to objectively and routinely observe employee IP&C performance.
- Conduct a measurable *baseline* appraisal of employee IP&C work performance and employee conformance with your current IP&C system.
- Review, and revise as indicated, facility resources (Structures) including policies, procedures and your Facility Assessment.
- Design and provide in-service training for all applicable staff and their supervising staff.
- Conduct scheduled, measurable *follow-up* supervision and work performance appraisal of employee conformance with your IP&C system.
- Conduct an evaluation of the effectiveness and efficiency of your IP&C system.

Per 42 CFR §488.402(f), this remedy is effective 15 calendar days from the date of the letter imposing this DPOC. This Directed Plan may be completed before or after that date.

The survey agency is not authorized to conduct a revisit until a completed approved Tier 1 DPOC is submitted to: LTCEnforcement@health.ok.gov.

Retain a copy of all the records created for this DPOC for review by facility Administration, QA&A/QAPI Committee, governing body representative, by surveyors during the revisit, and for future employee orientation and training.

A DPOC is not complete until the facility has performed the actions listed in the Required Action and Records section below and submitted records in 3 phases according to the following benchmarks:

Phase 1: Provide documentation requested in required actions 1 – 4 within 10 calendar days of the Tier 1 DPOC issue date (at the top of this page).

Phase 2: After completion of required action 9 and prior to staff in-service training required in action 10, obtain survey agency approval of your training Syllabus by emailing the Syllabus to LTCEnforcement@health.ok.gov.

Do not submit records of required actions 5 – 14 until all have been completed.

Phase 3: Submit records of completion of required actions 5 – 14, with the Tier 1 DPOC Deliverables Checklist (last page of this document) as cover to LTCEnforcement@health.ok.gov.

Required Action and Records

Phase 1: The facility is directed to provide items 1 – 4 listed below with the facility's plan of correction, within 10 calendar days of the DPOC issue date at the top of page 1.

1. The name and contact information for your Governing Body Representative;
2. The names and positions of staff who will conduct the Root Cause Analysis. This will include staff that:
    a. Adopt or develop a written measurable Infection Prevention and Control (IP&C) performance evaluation tool for baseline and post improvement employee evaluation;
    b. Conduct baseline observations and evaluate staff conformance with IP&C;
    c. Review and use the suggested RCA resources (links provided below) and other RCA and Continuous Quality Improvement resources as indicated;
    d. Review for structural (resources) constraints and limitations including facility policies and procedures connected to facility IP&C care and services, sufficient staff, staff knowledge and skills, supervision, delegation, records, equipment, supplies, building layout, etc.;
    e. Revise, create or add needed instructions (processes) to improve facility IP&C care and services;
    f. Review and revise the Facility Assessment as necessary;
    g. Conduct training in new or revised IP&C or other policies and procedures, use of new equipment, and other changes;
    h. Conduct post-training observations and supervise and evaluate staff conformance with IP&C.
    i. Review all changes for effectiveness and efficiency in providing IP&C care and services;
3. An estimated timeline to complete the Directed Plan; and
4. Immediate mitigation of the specific IP&C deficient practices cited at F880 (this information is required for an acceptable plan of correction).

Complete required actions 5 – 9 below.

5. Develop a measureable IP&C employee performance evaluation format/template and conduct an IP&C performance evaluation.
6. Summarize your baseline IP&C performance evaluation.
7. List facility clinical, communications, records, personnel and/or other procedures that will be reviewed in the RCA. Facility personnel procedures that will be reviewed in the RCA may include: new employee appraisal, new employee orientation and training; ongoing in-service training; delegation and employee supervision and work performance appraisal.
    a. Conduct the RCA. **You must use and submit at least a Cause and Effect diagram (fishbone) and 5 Whys.**
    b. When a task is delegated to an employee, how does the delegator – Administrator, DON, RN, Charge Nurse, etc. **ensure** the employee is competent and has resources including time, equipment, and as-needed assistance from other employees?
8. Summarize your RCA conclusions, your completed fishbone, 5 Whys, and if applicable, other RCA methods used.
9. List improvements in facility clinical, communication, records personnel and/or other procedures necessitated by the RCA.
    a. Develop training content based on the RCA. For IP&C training will include lecture, hands-on training, and return demonstration.

Phase 2: Prior to in-service training, submit a Syllabus/Outline/Agenda for IP&C to LTCEnforcement@health.ok.gov. This document will be forwarded to the Survey Agency Contact or Designee for review.

The Syllabus, Outline or Agenda must be approved prior to completion of required actions 10 - 14 by the survey agency contact or designee:

Survey Agency Contact:

Paula Terrell, Manager of Survey
Long Term Care/Oklahoma State Department of Health
405-271-6868
paulart@health.ok.gov

10. Create a written reference document. This document must be readily accessible to all staff after training is completed.
    a. Power Point may be used by the trainer; however, Power Point slides alone will not be accepted as this reference document.
    b. Create a pre-test and post-test.
    c. Record the names and positions of the employees to be trained.
    d. Create a Sign-in list.
11. Summarize pre-test results.
12. Summarize post-test results.

   a. Record the facility response if an employee fails the post-test.
13. Summarize follow-up employee supervision and work performance appraisals.
   a. Use your written baseline IP&C performance evaluation tool and create a supervision/evaluation schedule.
   b. Identify supervisors who will perform follow-up supervision and/or evaluation.
   c. Schedule and conduct an RCA committee review of the follow-up.
   d. Document when employees were observed and whether staff followed new procedures. If not, what immediate corrective action did the supervisor take?
14. Evaluate this DPOC including input from Administrator, DON, and Infection Preventionist:
   a. Upon completion of the foregoing instructions, the administrator and DON will consult with staff and submit an evaluation of this DPOC. The evaluation will include:
      i. Your perception of the value of the DPOC for your residents and staff;
      ii. An estimate of the cost to the facility to complete this DPOC;
      iii. Suggestions to help CMS and the state survey agency improve the usefulness of such DPOC.

Phase 3: This DPOC will be completed when all required actions 1 - 14 have been completed and records delivered via email to LTCEnforcement@health.ok.gov. A revisit will not be conducted until completion.

Please be aware, there is no deadline for completion of required actions and records 5 – 14, however when F880 is cited with scope and severity of D or above, one of four Denial of Payment for New Admissions (DPNA) effective dates will be imposed if the facility does not achieve substantial compliance before the discretionary denial of payment for new admissions (DPNA) effective dates, 15-days, 30-days, or 45-days, from the DPOC issue date, or a mandatory DPNA that will be in effect 3 months after the finding(s) of substantial noncompliance as stated in the enforcement notice that accompanied the issuance of this DPOC.

Below are resource links and the Tier 1 DPOC Deliverables Checklist. Please attach your Checklist as cover for records delivered to the state survey agency via email at: LTCEnforcement@health.ok.gov.

Resources

CMS: *Guidance for Root Cause Analysis (undated)*
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Five Whys Tool for Root Cause Analysis
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf
How to Use the Fishbone Tool for Root Cause Analysis
https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fishbonerevised.pdf

Institute for Healthcare Improvement (IHI): http://www.ihi.org/
QI Toolkit
http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
5 Whys Tool
http://www.ihi.org/resources/Pages/Tools/5-Whys-Finding-the-Root-Cause.aspx
QI Toolkit Cause and Effect (fishbone) Diagram
http://www.ihi.org/resources/Pages/Tools/CauseandEffectDiagram.aspx
Root Causes Analysis - RCA-2
http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx
Tapping Frontline Knowledge
http://www.ihi.org/resources/Pages/Publications/TappingFrontlineKnowledge.aspx

CMS Infection Prevention and Control (IP&C) Guidance
QSO 20-14-NH: https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

COVID-19 Facility Self-Assessment
Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings
https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf
Long term care facility – Infection control self-assessment worksheet:
https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19
https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf

Infection Prevention and Control Training Resources
Job Aid YouTube:
– Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
– Clean Hands - https://youtu.be/xmYMUly7qiE
– Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
– Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw
– Lessons - https://youtu.be/YYTATw9yav4

OKLAHOMA
State Department
of Health

Tier 1 DPOC Deliverables Checklist

Date	Item	Tier 1 DPOC Checklist: Deliverables Required Before a Revisit Will Be Authorized
	1	Name and Contact Information for your Governing Body Representative.
	2	Names and positions of staff who will conduct the Root Causes Analysis.
	3	An estimated timeline to complete this Directed Plan.
	4	Immediate mitigation of the specific IP&C Deficient Practices cited at F880.
	5	Your employee IP&C evaluation format with measurable performance criteria.
	6	**Summary** of your baseline, measured employee performance evaluations.
	7	List of facility procedures to be reviewed.
	8	**Summary** of RCA conclusions, fishbone, 5 Why's and other RCA techniques used.
	9	A list of improvements necessitated by the RCA.
	10	Syllabus, outline, or agenda. **THIS MUST BE APPROVED BY THE SA/CMS CONTACT BEFORE PROVIDING THE TRAINING.**
	11	**Summary** of pre-test results.
	12	**Summary** of post-test results**.**
	13	**Follow-up schedule and Summary** of follow-up employee supervision and work performance appraisal.
	14	Administrator's and DON's Evaluation of this Directed Plan.
For faster review, please IDENTIFY EACH SUBMISSION WITH THE NUMBER ON THIS CHECKLIST.		

Survey Agency Contact:
Paula Terrell
Manager of Survey
Long Term Care/Oklahoma State Department of Health
405-271-6868
paulart@health.ok.gov

Infection Prevention and Control (IP&C) Is Everyone's Job.
***No One* Wants a Patient, Coworker, Friend or Family to Be Harmed by Germs.**
Observed IP&C Error - Turn in to Infection Preventionist

Name		Date		Time		Location	

	Incorrect Hand Hygiene		***Incorrect Linen Handling***
	Incorrect PPE		***Incorrect Infectious Waste Handling***

Reminders from the CMS Infection Prevention and Control Survey Pathway

Hand Hygiene

- Hand hygiene, before & after contact with the resident - **even if gloves are used**.
- Alcohol-based hand rub (ABHR) is readily available.
- Wash hands with soap & water when their hands are visibly soiled.
- Wash hands after caring for a resident with known or suspected C. difficile, norovirus, or COVID-19.
- After contact with blood, body fluids, or visibly contaminated surfaces or other objects & surfaces.
- After removing personal protective equipment (e.g., gloves, gown, facemask).
- Before performing an aseptic task.
- Resident hand hygiene is performed after toileting & before meals.

PPE

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
- Gloves are changed & hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care.
- A gown is worn for direct resident contact if the resident has uncontained secretions or excretions;
- A facemask is worn if within 6 feet of a resident with new cough or symptoms of a respiratory infection.
- Mouth, nose, & eye protection is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids;
- PPE is appropriately discarded after resident care, prior to leaving room.
- PPE supplies are readily accessible.
- Don gloves & gowns before contact with the resident and/or his/her environment while on contact precautions;
- Don facemask within 6 feet of a resident on droplet precautions; don a fit-tested N95 or higher level respirator prior to room entry of a resident on airborne precautions.
- Dedicate or use disposable noncritical resident-care equipment. If not available, then clean & disinfect equipment according to manufacturers' instructions with an EPA-registered disinfectant between residents.
- Clean & disinfect objects and surfaces that are touched frequently & close to the resident with an EPA-registered disinfectant for healthcare use at least daily & when visibly soiled.

Linen Handling

- Use standard precautions (i.e., gloves) and minimal agitation for contaminated linen.
- Hold contaminated linen and laundry bags away from clothing & body.
- Contain contaminated linen where collected. Sort & rinse only in the contaminated laundry area
- Double bag linen if outside of the bag is visibly contaminated or wet.
- Transport contaminated & clean linens in separate carts.
- Transport clean linens by methods that ensure cleanliness.
- Mattresses, pillows, bedding, & linens are clean & in good condition.
- Laundry bags are closed with no loose items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375389	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TULSA NURSING CENTER	10912 EAST 14TH STREET TULSA, OK 74128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the State Agency on behalf of the Centers for Medicare and Medicaid Services (CMS) on June 23, 2020. Total residents: 90 The following abbreviations were used in this text: CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse HCP - healthcare personnel PPE - personal protective equipment	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375389	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TULSA NURSING CENTER	10912 EAST 14TH STREET TULSA, OK 74128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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	375389	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TULSA NURSING CENTER	10912 EAST 14TH STREET TULSA, OK 74128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2	F 880		

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure residents, whose health was compromised due to receiving dialysis, were quarantined due to the COVID-19 pandemic for eight (#1, #2, #3, #4, #5, #6, #7, and #8) of eight residents whose records were reviewed for infection control. The facility identified eight residents who left the facility to receive dialysis.
Findings:

The Centers for Disease Control guidance titled, Preparation for Covid 19 in Nursing Homes, documented, Creating a plan for managing new admissions and readmissions "...Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP 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 can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission..."

1. Resident #1 had diagnoses which included

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F 880	Continued From page 3	F 880		

end stage renal disease. Resident #10 was the resident's roommate. They resided on C hall.

A physician order, dated 01/20/20, documented the resident received dialysis on Tuesday, Thursday, and Saturday.

2. Resident #2 had diagnoses which included chronic kidney disease stage five. The resident resided on F hall.

A physician order, dated 05/28/20, documented the resident received dialysis Monday, Wednesday, and Friday.

3. Resident #3 had diagnoses which included end stage renal disease. Resident #11 was the resident's roommate. They resided on E hall.

A physician order, dated 11/18/20, documented the resident received dialysis Monday, Wednesday, and Friday.

4. Resident #4 had diagnoses which included end stage renal disease. Resident #13 was the resident's roommate. They resided on the E hall.

A physician order, dated 11/08/19, documented the resident received dialysis Tuesday, Thursday, and Saturday.

5. Resident #5 had diagnoses which included end stage renal disease. Resident #12 was the resident's roommate. They resided on E hall.

A physician order, dated 05/19/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

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F 880	Continued From page 4	F 880		

6. Resident #6 had diagnoses which included stage three chronic kidney disease. The resident resided on F hall.

A physician order, dated 01/13/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

7. Resident #7 had diagnoses which included end stage renal disease. Resident #9 was the resident's roommate. They resided on C hall.

A physician order, dated 04/30/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

8. Resident #8 had diagnoses which included end stage renal disease. The resident resided on C hall.

A physician order, dated 05/07/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

On 06/23/20 at 9:45 a.m., a tour of halls C, E, and F were conducted. Signage was not observed on any resident doors which indicated the residents were on any precautions, isolation, or quarantine.

On 06/23/20 at 1:30 p.m., the DON/Infection Control Preventionist provided a list of residents who left the facility to receive dialysis.

She was asked what type of precautions the residents who received dialysis were on. She stated the residents wore masks to and from the dialysis facility and the facility communicated weekly with the dialysis staff.

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F 880	Continued From page 5	F 880		

At 1:40 p.m., CNA #1 was asked what hall she was assigned. She stated F hall. She was asked what precautions the residents who received dialysis were on. She stated none of the residents on F hall were on isolation or quarantine. She stated they utilized masks and gloves.

At 1:43 p.m., CNA #2 was asked what hall she was assigned. She stated E hall. She was asked what precautions the residents who received dialysis were on. She stated none of the residents on E hall were on isolation or quarantine.

At 1:47 p.m., LPN #1 was asked what hall she was assigned. She stated F hall. She was asked if any residents were in quarantine or isolation. She stated no.

At 1:50 p.m., LPN #2 was asked what hall she was assigned. She stated E hall and she was also covering C hall until the assigned nurse returned. She was asked if any residents on E or C hall were in quarantine or isolation. She stated no. She stated if a resident was on isolation or quarantine they would have a sign on their door indicating the precaution and a bin outside the door with PPE.

At 1:53 p.m. CNA #3 was asked what hall she was assigned. She stated C hall. She was asked what precaution the residents who received dialysis were on. She stated none of the residents on C hall were in isolation or quarantine and staff utilized masks and gloves when they provided care.

At 1:57 p.m., the DON/Infection Control

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F 880	Continued From page 6 Preventionist was asked why residents who left the facility to receive dialysis were not quarantined. She stated they did not have a quarantine plan in place for dialysis residents.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7230	A. BUILDING: _____ B. WING _____	06/23/2020

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LL000	Initial Comments On 06/23/20, the Oklahoma State Department of Health completed a COVID-19 Focused Survey to determine if the facility was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Total residents: 90 The following abbreviations were used in this text: CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse HCP - healthcare personnel PPE - personal protective equipment	LL000		
LL810	310:675-7-17.1(a) INFECTION CONTROL The facility shall have an infection control policy and procedures to provide a safe and sanitary environment. The policy shall address the prevention and transmission of disease and infection. The facility, and its personnel, shall practice the universal precautions identified by the Centers for Disease Control. All personnel shall demonstrate their knowledge of universal precautions through performance of duties.	LL810		

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LL810	Continued From page 1 This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents, whose health was compromised due to receiving dialysis, was quarantined due to the COVID-19 pandemic for eight (#1, #2, #3, #4, #5, #6, #7, and #8) of eight residents whose records were reviewed for infection control. The facility identified eight residents who left the facility to receive dialysis. Findings: The Centers for Disease Control guidance titled, Preparation for Covid 19 in Nursing Homes, documented, Creating a plan for managing new admissions and readmissions "...Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP 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 can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission..." 1. Resident #1 had diagnoses which included end stage renal disease. Resident #10 was the resident's roommate. They resided on C hall. A physician order, dated 01/20/20, documented the resident received dialysis on Tuesday, Thursday, and Saturday. 2. Resident #2 had diagnoses which included	LL810		

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LL810	Continued From page 2	LL810		

chronic kidney disease stage five. The resident resided on F hall.

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3. Resident #3 had diagnoses which included end stage renal disease. Resident #11 was the resident's roommate. They resided on E hall.

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A physician order, dated 05/19/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

6. Resident #6 had diagnoses which included stage three chronic kidney disease. The resident resided on F hall.

A physician order, dated 01/13/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

7. Resident #7 had diagnoses which included

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LL810	Continued From page 3	LL810		

end stage renal disease. Resident #9 was the resident's roommate. They resided on C hall.

A physician order, dated 04/30/20, documented the resident received dialysis on Monday, Wednesday, and Friday.

8. Resident #8 had diagnoses which included end stage renal disease. The resident resided on C hall.

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On 06/23/20 at 9:45 a.m., a tour of halls C, E, and F were conducted. Signage was not observed on any resident doors which indicated the residents were on any precautions, isolation, or quarantine.

On 06/23/20 at 1:30 p.m., the DON/Infection Control Preventionist provided a list of residents who left the facility to receive dialysis.

She was asked what type of precautions the residents who received dialysis were on. She stated the residents wore masks to and from the dialysis facility and the facility communicated weekly with the dialysis staff.

At 1:40 p.m., CNA #1 was asked what hall she was assigned. She stated F hall. She was asked what precautions the residents who received dialysis were on. She stated none of the residents on F hall were on isolation or quarantine. She stated they utilized masks and gloves.

At 1:43 p.m., CNA #2 was asked what hall she was assigned. She stated E hall. She was asked

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LL810	Continued From page 4 what precautions the residents who received dialysis were on. She stated none of the residents on E hall were on isolation or quarantine. At 1:47 p.m., LPN #1 was asked what hall she was assigned. She stated F hall. She was asked if any residents were in quarantine or isolation. She stated no. At 1:50 p.m., LPN #2 was asked what hall she was assigned. She stated E hall and she was also covering C hall until the assigned nurse returned. She was asked if any residents on E or C hall were in quarantine or isolation. She stated no. She stated if a resident was on isolation or quarantine they would have a sign on their door indicating the precaution and a bin outside the door with PPE. At 1:53 p.m. CNA #3 was asked what hall she was assigned. She stated C hall. She was asked what precaution the residents who received dialysis were on. She stated none of the residents on C hall were in isolation or quarantine and staff utilized masks and gloves when they provided care. At 1:57 p.m., the DON/Infection Control Preventionist was asked why residents who left the facility to receive dialysis were not quarantined. She stated they did not have a quarantine plan in place for dialysis residents.	LL810		