

Delivery Via Email: exec@villagesatsouthernhills.com; don@villagesatsouthernhills.com

August 9, 2021

CCN: 375546

Cycle Start Date: July 21, 2021

Survey Event ID: Q5VK11

Mr. Lee Sudbeck, Administrator
The Villages at Southern Hills
5721 S Lewis Ave
Tulsa, OK 74105

Dear Mr. Sudbeck:

On **July 21, 2021**, agents from our office concluded a COVID-19 special focus survey in conjunction with a complaint investigation at The Villages at Southern Hills 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 Enforcement Division
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406

Phone: (405) 426-8200

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 **October 21, 2021** 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 Directed 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 Division
Oklahoma State Department of Health
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406**

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 **January 21, 2022**, 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 **October 8, 2021** (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 375546, CSD-July 21, 2021, 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) 426-8200 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
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406

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) 426-8200.

If you have any questions, please contact me at (405) 426-8200 or by email at LTCEnforcement@health.ok.gov.

Sincerely,

Katie Stagner
Digitally signed by Katie Stagner
Date: 2021.08.09 08:59:37 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure: DPOC

Tier 1 DPOC F880

Facility Name/License #: The Villages at Southern Hills/CC7207

Issue Date: 08/09/21

CCN: 375546

CSD: 07/21/21

Survey Date: 07/21/21

Directed Plan of Correction (DPOC) Tier 1

Overview for Completing the Directed Plan of Correction

The Oklahoma State Department of Health (OSDH) in accordance with **42 CFR §488.424 Directed Plan of Correction**, directs your facility to conduct *Root Causes Analysis* (RCA) and *Performance Improvement* of your Infection Prevention and Control (IP&C), as a result of deficient practice(s) cited at F880.

In accordance with **42 CFR §488.402(f) (1) & (4)**, this remedy is effective **15 calendar days from the date of this enforcement letter**. The DPOC may be completed before or after 15 days and must be completed within **30 calendar days** of receipt of the 2567 and the Issue Date on this enforcement letter.

There are 3 phases to the Directed Plan of Correction with 9 Action Items. A DPOC is not complete until the facility has completed and submitted all 9 Action Items listed in this notice.

Title the submittal by Action Item and include the Tier 2 DPOC Deliverables Checklist (last page of this document).

Required Action and Records **Step by Step Instructions**

Phase 1: Includes Action Items #1 through #4

Submit documentation of required Action Items #1 – #4 for the Tier 1 DPOC Issue Date within **10 calendar days** (with the POC). Details specific to Action Items #1 – #4 are noted on the Tier 2 DPOC Deliverables Checklist.

Phase 2: Includes Action Items #5 through #7

Action Item #5 – Develop/access a Monitoring Tool for tracking and observation of staff infection prevention and control practices, related to the deficient practice finding(s).

Action Item #6 – Conduct a **Root Cause Analysis** (RCA) on the findings of the deficient practice and submit a summary of the RCA. (See the Quality Improvement Resources.)

Action Item #7 – Develop a Syllabus/Outline for staff training(s) that address the outcome(s) of the RCA related to the deficient practice finding(s). **The Syllabus must be approved by OSDH LTC prior to Phase 3 submission.**

Phase 3: Includes Action Items #8 and #9

Action Item #8 – Submit a staff training outcome(s) summary.

Action Item #9 – Submit an evaluation of the Directed Plan of Correction (DPOC.)

The State Survey Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC's completion in accordance with the specifications described in this notice.

Documents may be submitted prior to the **30 day** deadline from when the DPOC was issued. However, when F880 is cited with scope and severity of D or above; Denial of Payment for New Admissions (DPNA) will be imposed, if the facility does not achieve substantial compliance before the discretionary DPNA effective dates. The DPOC is an enforcement remedy and may initiate termination if not completed prior to the designated termination date.

The hyperlink to "Quality Improvement Resources" includes guidance and tools that may assist with completing the Directed Plan of Correction and developing an effective Infection Prevention and Control Plan. **NOTE: Please review the Resources.**

Quality Improvement Resources Link:

<https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/protective-health/long-term-care-services/Quality%20Improvement%20Resources%2010315.pdf>

DIRECTED PLAN OF CORRECTION CHECKLIST

Tier 1 DPOC Deliverables Checklist

Facility Name: _____

CCN Number/License Number: _____

F880 Cited – Survey Date: _____

Date DPOC was issued: _____

Date	Item	Tier 1 DPOC Checklist:
Phase 1		
	1	Name and contact Information for your Governing Body Representative
	2	Names, Credentials and positions of staff who will conduct the Root Causes Analysis
	3	An estimated timeline of Directed Plan of Correction completion
	4	Immediate mitigation of the specific IP&C Deficient Practices cited at F880
Phase 2		
	5	Monitoring Tool
	6	Summary of RCA
	7	Syllabus of staff training APPROVAL REQUIRED BEFORE PROVIDING THE TRAINING
Phase 3		
	8	Summary of training outcomes
	9	Evaluation of DPOC process

Submit all documentation and questions specific to the Action Items and Directed Plan of Correction to: LTCEnforcement@health.ok.gov.

Please identify each submitted Action Item by number.

INVESTIGATIVE REPORT

Facility: The Villages at Southern Hills
Address: 5721 S Lewis Ave.
City, State, Zip: Tulsa, OK 74105
Provider #: 375546
Complaint #: OK00055931
Investigation Date(s): 07/19/2021, 07/20/2021, and 07/21/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide adequate care to prevent unavoidable weight loss.	US
2. The facility failed to ensure residents were not given unnecessary medications.	US

☐ Violation (s) unrelated to this complaint were also cited during the investigation.

An unannounced on-site investigation was initiated 07/19/2021 at 9:15 a.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to concerns related to unavoidable weight loss was conducted.

Residents were being care for by staff. Residents were clean and groomed. There were no odors in the facility. Call lights were being answered promptly. Staff were assisting residents with activities of daily living. At the noon meal residents were observed being assisted or prompted by staff to eat.

The residents stated the food at the facility was good and snacks were available. Residents identified as requiring supplements stated they received those supplements. The staff were knowledgeable of who needed supplements and the residents whose weights were being watched.

Progress notes documented changes in resident conditions were reported to physicians. Weight records documented residents were weighed as ordered. Care plans documented assessments of potential and actual weight loss as well as interventions. Grievances and Resident Council minutes did not document complaints regarding weight loss.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to concerns related to unnecessary medications was conducted.

Residents were being care for by staff. Residents were clean and groomed. There were no odors in the facility. Call lights were being answered promptly. Staff were assisting residents with activities of daily living.

Residents stated their needs were met and staff were attentive to concerns and changes in their health. Residents stated they received their prescribed medications. Staff stated family and representatives were notified of changes in the resident's condition, new orders, and medications.

Progress notes documented phone calls to physicians with changes in condition, and any new orders received. Orders documented physician orders and updated orders. Medication administration records documented the dosage given, time given, and the order the medication administration was following. Pain assessments were documented pre and post pain medication administration. Progress notes and care plan meeting reports documented notifications to family and representatives of changes in condition and changes in medications. Grievances and Resident Council minutes did not document complaints regarding medication administration.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read 'Leasa Welch', written over a horizontal line.

Leasa Welch, RN

Date report completed: 07/22/2021

INVESTIGATIVE REPORT

Facility: The Villages at Southern Hills
Address: 5721 South Lewis Ave
City, State, Zip: Tulsa, OK, 74105
Provider #: 375546
Complaint #: OK00056710
Investigation Date(s): 07/19/21, 07/20/21, and 07/21/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to provide adequate discharge planning.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Monday, July 19, 2021 at 9:15 a.m.

A sample of three residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to discharge planning was conducted.

Three residents were observed the day of their discharge from the facility. One sampled resident was observed during the instruction process of discharge. Another sampled resident was observed receiving a walker from an equipment company prior to discharge.

The residents and family stated the facility arranged for home health services and equipment as ordered by the physician. The discharge planner stated physician orders and resident information was sent to providers for care needs at home. The discharge planner stated five pharmacies were called before locating a wheelchair for one sampled resident.

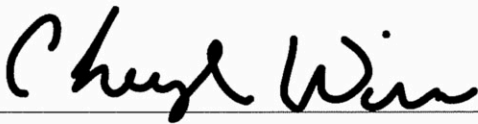
The residents' clinical records documented discharge instructions for follow up appointments, medications, equipment ordered, and a discharge summary. Grievances and resident council minutes were reviewed and did not document concerns regarding discharge.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Cheryl Winn", is positioned above a horizontal line.

Cheryl Winn RN

Date report completed: 07/22/2021

INVESTIGATIVE REPORT

Facility: The Villages at Southern Hills
Address: 5721 S Lewis Ave.
City, State, Zip: Tulsa, OK 74105
Provider #: 375546
Complaint #: OK00057345
Investigation Date(s): 07/19/21, 07/20/21, and 07/21/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to provide adequate care to treat residents with respect and dignity.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 07/19/2021 at 9:15 a.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to concerns related to unavoidable weight loss was conducted.

Residents were being cared for by staff. Residents were clean and groomed, there were no odors in the facility, and call lights were being answered promptly. Staff were assisting residents with activities of daily living. The facility was busy and staff appeared unhurried.

The residents stated the staff were courteous and respectful. The staff stated the residents' needs were the top priority of the care. The staff stated respect and dignity were strongly emphasized by the administration.

Incidents reports and concerns documented one incident regarding respect and dignity. The facility conducted a thorough investigation. The staff member was suspended during the investigation, and educated on respect and dignity upon returning to work. The incident was resolved to the resident and family's satisfaction. Resident Council minutes did not document complaints regarding respect or dignity.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read 'Leasa Welch', written over a horizontal line.

Leasa Welch, RN

Date report completed: 07/22/2021

INVESTIGATIVE REPORT

Facility: The Villages at Southern Hills
Address: 5721 South Lewis Ave
City, State, Zip: Tulsa, OK 74105
Provider #: 375546
Complaint #: OK00057350
Investigation Date(s): 07/19/21, 07/20/21, and 07/21/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to follow infection control practices per COVID-19 guidance.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Monday, July 19, 2021 at 9:15 a.m.

A sample of four residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F880 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Cheryl Winn", is written over a horizontal line.

Cheryl Winn RN

Date report completed: 07/22/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375546	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/21/2021
NAME OF PROVIDER OR SUPPLIER THE VILLAGES AT SOUTHERN HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 5721 S LEWIS AVE TULSA, OK 74105		
(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 Oklahoma State Department of Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on 07/19/21, 07/20/21, and 07/21/21 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. Complaints #OK00057350, #OK00057345, #OK00056710, and #OK00055931 were investigated in conjunction with this survey.	F 000			
F 880 SS=E	Total residents: 107 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 providing services under a contractual	F 880			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375546	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/21/2021
NAME OF PROVIDER OR SUPPLIER THE VILLAGES AT SOUTHERN HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 5721 S LEWIS AVE TULSA, OK 74105		
(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 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. Personnel must handle, store, process, and	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375546	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/21/2021
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F 880	Continued From page 2 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: a. ensure staff wore face masks according to the Centers for Medicare & Medicaid Services (CMS) guidelines to prevent the development and transmission of COVID-19; and b. ensure COVID-19 screening was completed upon entry and exit to the facility per policy. The administrator identified 107 residents who resided in the facility. Findings: CDC (Centers for Disease Control) guidance, updated on 04/06/21, titled "Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19, "...Correct and consistent mask use is a critical step everyone can take to reduce their risk of getting and spreading COVID-19...Masks should a) Completely cover the nose and mouth. b) Fit snugly against the sides of the face and should not have any gaps. c) Be handled only by the ear loops, cords, or head straps (not by the surface of the mask)..." A facility policy for Coronavirus Management documented for a negative/clean unit the staff	F 880			

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F 880	Continued From page 3 must wear a surgical mask, gown, eye protection, and gloves for standard precaution. The policy documented the office staff was to wear a surgical mask on the negative/clean unit. The policy documented if the office staff were alone in the office they could remove their mask, but if anyone entered the office and would be within six feet a mask must be reapplied. The policy further documented the staff were to utilize the visitor screening tool and maintain a visitor screening log. The policy documented staff were to ensure screening of everyone who entered the building. The policy documented staff would be screened by a screener who had been trained in the screening process and self-screening should not be done. The policy documented if the staff leave the facility grounds and return, they must be re-screened. 1. Resident #6 was admitted to the facility on 12/21/20 with diagnoses which included adult failure to thrive, pain, and a pressure ulcer to the sacral region. A quarterly assessment, dated 06/26/21, documented the resident was cognitively alert in daily decision making skills and required extensive assistance from staff with most activities of daily living (ADLs). On 07/19/21 at 12:15 p.m., licensed practical nurse (LPN) #1 was observed at a medication chart preparing medications. Her face mask was positioned below her chin. The LPN was interviewed. The LPN continued the interview with her face mask below her chin. The LPN walked down the hall and entered the room of resident #6 to administer medication. The LPN	F 880			

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F 880	Continued From page 4 continued to wear her face mask below her chin after entering the resident's room. 2. On 07/19/21 at 11:43 a.m., a resident was observed sitting in a wheelchair in the business office. The discharge planner was standing beside the resident talking with her face mask below her chin. Two staff members sitting across the desk from the resident were not wearing face masks. At 12:05 p.m., certified nurse aide (CNA) #1 was observed walking in the hallway, was in and out of resident rooms, and was delivering meal trays. The CNA's face mask was positioned below her nose. At 12:14 p.m., CNA #2 was observed walking down the resident hall with her face mask positioned below her nose. At 12:47 p.m., LPN #1 was sitting at a desk in the resident hall talking on a cell phone with her mask below her chin. At 12:48 p.m., LPN #1 was interviewed regarding wearing her face mask below her chin. The LPN stated she was told she could pull her mask down when sitting at her desk in the hall if no one was around within six feet. The LPN stated she should have positioned her face mask covering her mouth and nose during the interview at 12:15 p.m. At 1:05 p.m., CNA #1 was interviewed regarding her face mask positioned below her nose. The CNA stated her mask falls down sometimes and pulled her mask up and down to demonstrate.	F 880			

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F 880	Continued From page 5 On 07/20/21 at 8:35 a.m., the door screener staff #1 was sitting at the desk with his face mask below his chin. The screener screened three visitors with his mask below his chin. At 12:10 p.m., the administrator stated non-compliance with infection control practices, such as staff use of personal protective equipment (PPE), would be handled in the same manner as any resident care concern. The administrator stated staff would be given a verbal and/or written warning, would be re-education, and possibly terminated. The administrator stated the infection preventionist was responsible for monitoring compliance, but all administrative staff monitor. On 07/21/21 at 10:15 a.m., the discharge planner was interviewed. During the interview the discharge planner answered the telephone pulling her face mask down to talk. The discharge planner continued the interview with her face mask hanging from one ear. 3. On 07/19/21 at 4:00 p.m., no staff was observed at the COVID-19 door screener desk. At 4:05 p.m., the receptionist was interviewed regarding the absence of staff at the screening desk. The receptionist said, "I don't know anything about that." At 4:05 p.m., the director of nurses (DON) stated the concierge staff working the door screener desk left around 3:00 p.m. The DON stated the receptionist was to cover the screening desk when screening staff were not available. At 4:06 p.m., CNA #3 was observed entering the	F 880			

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F 880	Continued From page 6 facility without being screened. The CNA was asked if she had just entered the building. The CNA stated yes as she continued walking. The Manager on Duty standing at the desk stated she was just going to clock in first. At 4:20 p.m., the DON stated staff entering the facility should be screened at the desk before entering the facility. On 07/20/21 at 11:31 a.m., the infection preventionist (IP) stated visitors would be screened upon entry to the facility. The IP stated if a visitor left the building/property and re-entered the same day a temperature should be obtained upon re-entry. The IP reviewed the screening logs she had provided and stated the log for the previous day did not document a date or time for the screenings completed. On 07/21/21 at 8:35 a.m., the assistant administrator stated the two concierge staff working as the COVID-19 door screeners on 07/19/21 had not completed their competency for screener at that time. The assistant administrator stated the staff should have been supervised. At 10:20 a.m., a visitor was observed entering the building and walked passed the screener without being screened. The screener was observed attending to her cell phone. The visitor stated he visited his wife daily. The visitor stated he sometimes would leave the facility and return the same day. The visitor stated he was never re-screened upon re-entry. At 11:15 a.m., the DON reviewed the 07/19/21 COVID-19 screening log for the facility. She stated the identified staff members with time	F 880			

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F 880	Continued From page 7 clock stamps entering or exiting the building from 3:00 p.m. to 4:00 p.m. were not documented on the screening log.	F 880			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILLAGES AT SOUTHERN HILLS

5721 S LEWIS AVE
TULSA, OK 74105

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CC7207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/21/2021
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LL810	Continued From page 1 a. ensure staff wore face masks according to the Centers for Medicare & Medicaid Services (CMS) guidelines to prevent the development and transmission of COVID-19; and b. ensure COVID-19 screening was completed upon entry and exit to the facility per policy. The administrator identified 107 residents who resided in the facility. Findings: CDC (Centers for Disease Control) guidance, updated on 04/06/21, titled "Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19, "...Correct and consistent mask use is a critical step everyone can take to reduce their risk of getting and spreading COVID-19...Masks should a) Completely cover the nose and mouth. b) Fit snugly against the sides of the face and should not have any gaps. c) Be handled only by the ear loops, cords, or head straps (not by the surface of the mask)..." A facility policy for Coronavirus Management documented for a negative/clean unit the staff must wear a surgical mask, gown, eye protection, and gloves for standard precaution. The policy documented the office staff was to wear a surgical mask on the negative/clean unit. The policy documented if the office staff were alone in the office they could remove their mask, but if anyone entered the office and would be within six feet a mask must be reapplied. The policy further documented the staff were to utilize the visitor screening tool and maintain a	LL810		

Oklahoma State Department of Health

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LL810	Continued From page 2 visitor screening log. The policy documented staff were to ensure screening of everyone who entered the building. The policy documented staff would be screened by a screener who had been trained in the screening process and self-screening should not be done. The policy documented if the staff leave the facility grounds and return, they must be re-screened. 1. Resident #6 was admitted to the facility on 12/21/20 with diagnoses which included adult failure to thrive, pain, and a pressure ulcer to the sacral region. A quarterly assessment, dated 06/26/21, documented the resident was cognitively alert in daily decision making skills and required extensive assistance from staff with most activities of daily living (ADLs). On 07/19/21 at 12:15 p.m., licensed practical nurse (LPN) #1 was observed at a medication chart preparing medications. Her face mask was positioned below her chin. The LPN was interviewed. The LPN continued the interview with her face mask below her chin. The LPN walked down the hall and entered the room of resident #6 to administer medication. The LPN continued to wear her face mask below her chin after entering the resident's room. 2. On 07/19/21 at 11:43 a.m., a resident was observed sitting in a wheelchair in the business office. The discharge planner was standing beside the resident talking with her face mask below her chin. Two staff members sitting across the desk from the resident were not wearing face masks. At 12:05 p.m., certified nurse aide (CNA) #1 was	LL810		

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LL810	Continued From page 3 observed walking in the hallway, was in and out of resident rooms, and was delivering meal trays. The CNA's face mask was positioned below her nose. At 12:14 p.m., CNA #2 was observed walking down the resident hall with her face mask positioned below her nose. At 12:47 p.m., LPN #1 was sitting at a desk in the resident hall talking on a cell phone with her mask below her chin. At 12:48 p.m., LPN #1 was interviewed regarding wearing her face mask below her chin. The LPN stated she was told she could pull her mask down when sitting at her desk in the hall if no one was around within six feet. The LPN stated she should have positioned her face mask covering her mouth and nose during the interview at 12:15 p.m. At 1:05 p.m., CNA #1 was interviewed regarding her face mask positioned below her nose. The CNA stated her mask falls down sometimes and pulled her mask up and down to demonstrate. On 07/20/21 at 8:35 a.m., the door screener staff #1 was sitting at the desk with his face mask below his chin. The screener screened three visitors with his mask below his chin. At 12:10 p.m., the administrator stated non-compliance with infection control practices, such as staff use of personal protective equipment (PPE), would be handled in the same manner as any resident care concern. The administrator stated staff would be given a verbal and/or written warning, would be re-education, and possibly terminated. The administrator	LL810		

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LL810	Continued From page 4 stated the infection preventionist was responsible for monitoring compliance, but all administrative staff monitor. On 07/21/21 at 10:15 a.m., the discharge planner was interviewed. During the interview the discharge planner answered the telephone pulling her face mask down to talk. The discharge planner continued the interview with her face mask hanging from one ear. 3. On 07/19/21 at 4:00 p.m., no staff was observed at the COVID-19 door screener desk. At 4:05 p.m., the receptionist was interviewed regarding the absence of staff at the screening desk. The receptionist said, "I don't know anything about that." At 4:05 p.m., the director of nurses (DON) stated the concierge staff working the door screener desk left around 3:00 p.m. The DON stated the receptionist was to cover the screening desk when screening staff were not available. At 4:06 p.m., CNA #3 was observed entering the facility without being screened. The CNA was asked if she had just entered the building. The CNA stated yes as she continued walking. The Manager on Duty standing at the desk stated she was just going to clock in first. At 4:20 p.m., the DON stated staff entering the facility should be screened at the desk before entering the facility. On 07/20/21 at 11:31 a.m., the infection preventionist (IP) stated visitors would be screened upon entry to the facility. The IP stated if a visitor left the building/property and re-entered	LL810		

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LL810	Continued From page 5 the same day a temperature should be obtained upon re-entry. The IP reviewed the screening logs she had provided and stated the log for the previous day did not document a date or time for the screenings completed. On 07/21/21 at 8:35 a.m., the assistant administrator stated the two concierge staff working as the COVID-19 door screeners on 07/19/21 had not completed their competency for screener at that time. The assistant administrator stated the staff should have been supervised. At 10:20 a.m., a visitor was observed entering the building and walked passed the screener without being screened. The screener was observed attending to her cell phone. The visitor stated he visited his wife daily. The visitor stated he sometimes would leave the facility and return the same day. The visitor stated he was never re-screened upon re-entry. At 11:15 a.m., the DON reviewed the 07/19/21 COVID-19 screening log for the facility. She stated the identified staff members with time clock stamps entering or exiting the building from 3:00 p.m. to 4:00 p.m. were not documented on the screening log.	LL810			



OKLAHOMA
State Department
of Health

Delivery via email to: exec@villagesatsouthernhills.com; don@villagesatsouthernhills.com

August 31, 2021

CCN: 375546

Survey Event ID: Q5VK11

Mr. Lee Sudbeck, Administrator
The Villages At Southern Hills
5721 S Lewis Ave
Tulsa, OK 74105

Dear Mr. Sudbeck:

On **July 21, 2021**, a complaint investigation and a COVID-19 Focused Survey were completed at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 16, 2021**. 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.**

We will conduct a revisit at your facility to verify that substantial compliance has been achieved and maintained. If we find that your facility is in substantial compliance with all requirements, we will certify your facility for further participation in the Medicaid program. However, if your facility has failed to achieve substantial compliance, the remedy(ies) will continue until such time as you achieve substantial compliance.

If you have any questions, please contact this office at (405) 426-8200.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.08.31 09:07:11 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care Enforcement
Oklahoma State Department of Health

enc

Health.Ok.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Oklahoma State Department of Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on 07/19/21, 07/20/21, and 07/21/21 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. Complaints #OK00057350, #OK00057345, #OK00056710, and #OK00055931 were investigated in conjunction with this survey.	F 000	Preparation and execution of this Plan of Correction are not an admission or agreement of the truth in the statement of deficiencies. This Plan of Correction is prepared solely as it is required by state and federal law. Please accept this Plan of Correction as our Credible Allegation of Compliance.		
F 880 SS=E	Total residents: 107 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 providing services under a contractual	F 880	Corrective Measures for identified residents: 1. LPN #1, CNAs #1/#2/#3 and Door Screener were immediately in-serviced on proper Infection Control policies regarding appropriate mask wearing and screening requirements. 2. All residents have the potential to be affected. 3. All Staff will be in-serviced regarding wearing the appropriate PPE while working in the facility. All staff have also been in-serviced on proper Door Screening Protocol. 4. The DON/ICP/designee will audit staff for door screening protocols and appropriate PPE to include wearing face mask correctly 3x's per week and ongoing. Results will be reviewed in monthly QAPI meeting to ensure compliance.	8-16-21	

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.

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NAME OF PROVIDER OR SUPPLIER THE VILLAGES AT SOUTHERN HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 5721 S LEWIS AVE TULSA, OK 74105		
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F 880	Continued From page 1 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. Personnel must handle, store, process, and	F 880			

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F 880	Continued From page 2 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: a. ensure staff wore face masks according to the Centers for Medicare & Medicaid Services (CMS) guidelines to prevent the development and transmission of COVID-19; and b. ensure COVID-19 screening was completed upon entry and exit to the facility per policy. The administrator identified 107 residents who resided in the facility. Findings: CDC (Centers for Disease Control) guidance, updated on 04/06/21, titled "Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19, "...Correct and consistent mask use is a critical step everyone can take to reduce their risk of getting and spreading COVID-19...Masks should a) Completely cover the nose and mouth. b) Fit snugly against the sides of the face and should not have any gaps. c) Be handled only by the ear loops, cords, or head straps (not by the surface of the mask)..." A facility policy for Coronavirus Management documented for a negative/clean unit the staff	F 880			

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F 880	Continued From page 3 must wear a surgical mask, gown, eye protection, and gloves for standard precaution. The policy documented the office staff was to wear a surgical mask on the negative/clean unit. The policy documented if the office staff were alone in the office they could remove their mask, but if anyone entered the office and would be within six feet a mask must be reapplied. The policy further documented the staff were to utilize the visitor screening tool and maintain a visitor screening log. The policy documented staff were to ensure screening of everyone who entered the building. The policy documented staff would be screened by a screener who had been trained in the screening process and self-screening should not be done. The policy documented if the staff leave the facility grounds and return, they must be re-screened. 1. Resident #6 was admitted to the facility on 12/21/20 with diagnoses which included adult failure to thrive, pain, and a pressure ulcer to the sacral region. A quarterly assessment, dated 06/26/21, documented the resident was cognitively alert in daily decision making skills and required extensive assistance from staff with most activities of daily living (ADLs). On 07/19/21 at 12:15 p.m., licensed practical nurse (LPN) #1 was observed at a medication chart preparing medications. Her face mask was positioned below her chin. The LPN was interviewed. The LPN continued the interview with her face mask below her chin. The LPN walked down the hall and entered the room of resident #6 to administer medication. The LPN	F 880			

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F 880	Continued From page 4 continued to wear her face mask below her chin after entering the resident's room. 2. On 07/19/21 at 11:43 a.m., a resident was observed sitting in a wheelchair in the business office. The discharge planner was standing beside the resident talking with her face mask below her chin. Two staff members sitting across the desk from the resident were not wearing face masks. At 12:05 p.m., certified nurse aide (CNA) #1 was observed walking in the hallway, was in and out of resident rooms, and was delivering meal trays. The CNA's face mask was positioned below her nose. At 12:14 p.m., CNA #2 was observed walking down the resident hall with her face mask positioned below her nose. At 12:47 p.m., LPN #1 was sitting at a desk in the resident hall talking on a cell phone with her mask below her chin. At 12:48 p.m., LPN #1 was interviewed regarding wearing her face mask below her chin. The LPN stated she was told she could pull her mask down when sitting at her desk in the hall if no one was around within six feet. The LPN stated she should have positioned her face mask covering her mouth and nose during the interview at 12:15 p.m. At 1:05 p.m., CNA #1 was interviewed regarding her face mask positioned below her nose. The CNA stated her mask falls down sometimes and pulled her mask up and down to demonstrate.	F 880			

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F 880	Continued From page 5 On 07/20/21 at 8:35 a.m., the door screener staff #1 was sitting at the desk with his face mask below his chin. The screener screened three visitors with his mask below his chin. At 12:10 p.m., the administrator stated non-compliance with infection control practices, such as staff use of personal protective equipment (PPE), would be handled in the same manner as any resident care concern. The administrator stated staff would be given a verbal and/or written warning, would be re-education, and possibly terminated. The administrator stated the infection preventionist was responsible for monitoring compliance, but all administrative staff monitor. On 07/21/21 at 10:15 a.m., the discharge planner was interviewed. During the interview the discharge planner answered the telephone pulling her face mask down to talk. The discharge planner continued the interview with her face mask hanging from one ear. 3. On 07/19/21 at 4:00 p.m., no staff was observed at the COVID-19 door screener desk. At 4:05 p.m., the receptionist was interviewed regarding the absence of staff at the screening desk. The receptionist said, "I don't know anything about that." At 4:05 p.m., the director of nurses (DON) stated the concierge staff working the door screener desk left around 3:00 p.m. The DON stated the receptionist was to cover the screening desk when screening staff were not available. At 4:06 p.m., CNA #3 was observed entering the	F 880			

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F 880	Continued From page 6 facility without being screened. The CNA was asked if she had just entered the building. The CNA stated yes as she continued walking. The Manager on Duty standing at the desk stated she was just going to clock in first. At 4:20 p.m., the DON stated staff entering the facility should be screened at the desk before entering the facility. On 07/20/21 at 11:31 a.m., the infection preventionist (IP) stated visitors would be screened upon entry to the facility. The IP stated if a visitor left the building/property and re-entered the same day a temperature should be obtained upon re-entry. The IP reviewed the screening logs she had provided and stated the log for the previous day did not document a date or time for the screenings completed. On 07/21/21 at 8:35 a.m., the assistant administrator stated the two concierge staff working as the COVID-19 door screeners on 07/19/21 had not completed their competency for screener at that time. The assistant administrator stated the staff should have been supervised. At 10:20 a.m., a visitor was observed entering the building and walked passed the screener without being screened. The screener was observed attending to her cell phone. The visitor stated he visited his wife daily. The visitor stated he sometimes would leave the facility and return the same day. The visitor stated he was never re-screened upon re-entry. At 11:15 a.m., the DON reviewed the 07/19/21 COVID-19 screening log for the facility. She stated the identified staff members with time	F 880			

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F 880	Continued From page 7 clock stamps entering or exiting the building from 3:00 p.m. to 4:00 p.m. were not documented on the screening log.	F 880			