

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 375386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2020
NAME OF PROVIDER OF SUPPLIER QUAIL RIDGE LIVING CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP 564 STATE LINE ROAD COLCORD, OK 74338	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined the facility failed to implement their infection control program to prevent the potential spread of infection for one (#3) of 4 sampled residents reviewed for infection control. The facility failed to: ~ Ensure staff members wore the appropriate personal protective equipment (PPE) in the isolation/quarantine resident rooms. ~ Ensure staff members did not wear cloth masks. The facility identified 73 residents lived in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP (health Care Provider) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . On 07/14/20 at 10:32 a.m., certified nurse aide #1 was observed outside of resident #3's room. There was a three drawer chest outside the resident's room. The certified nurse aide was wearing a cloth mask. She put on gloves and a plastic gown and entered the resident's room. There were red bags in the resident's room and she removed the gloves and gown in the resident's room. She continued to wear the cloth mask. At 10:45 a.m., the door to resident #3's door had signs explaining what personal protective equipment should be worn when entering the room. At 12:57 p.m., the director nursing was asked was personal protective equipment was required when caring for a resident in quarantine. She stated a gown, gloves, N95 mask, and a face shield or goggles. At 1:10 p.m., the certified nurse aide was asked about her cloth mask. She state one of the nurses told her it was ok to wear a cloth mask. She was asked about wearing googles/face shield when caring for a resident in isolation. She stated she was asked to work the quarantine floor when she came on and she just forgot she was supposed to wear googles or a face mask.		

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.