STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility documentation, review of the Center for Disease Control (CDC) guidelines and policies and procedures, the facility failed to maintain an effective infection control program, by having multiple staff who were either symptomatic and positive for COVID-19 or exhibited symptoms of COVID-19 and provided care to residents. As a result, the Condition of Immediate Jeopardy (IJ) was identified. Findings include: On July 1, 2020 at 1:30 p.m., the Condition of Immediate Jeopardy (IJ) was identified. The Administrator (staff #42) was informed of the facility's failure to implement infection control procedures, as multiple staff (#12, #15, #17, #21, #9, #73 and #70) who were either symptomatic (coughing, sore throat, muscle pain, headache) or who were positive for COVID-19 and symptomatic, and were permitted to work with non COVID and COVID positive residents. The Administrator presented a plan of correction on July 1, 2020 at 3:29 p.m. At 3:46 p.m., the Administrator was informed that the plan of correction needed to address additional processes, in order to correct the identified concerns. A revised plan of correction was presented on July 1, 2020 at 5:30 p.m. and was accepted at 6:13 p.m. The plan of correction included for re-education of staff regarding being sent home immediately if they reported signs or symptoms of COVID-19 at the beginning of their shift, or if they developed symptoms at any time during their shift. Staff would also receive in-service education regarding the up-dated screening process, which included having a designated employee assigned to screen staff at the start of their shift. The plan further included that the facility would continue to monitor and track staff symptoms and testing results on a line listing daily, and that the implementation of staffing mitigation strategies would be put into place to address any staffing shortages. On July 1, 2020 between 6:20-6:45 p.m., multiple staff were interviewed regarding if education had been provided pertaining to whether or not symptomatic staff were permitted to work in the facility, and the updated staff screening process. Only one of six staff members understood that symptomatic staff would not be allowed to work with residents and would be sent home. None of the staff interviewed were aware of any changes to the screening process. The Administrator was informed that the facility was not compliant with implementing their plan of correction and inservice's were initiated. On July 2, 2020 between 9:00-10:00 a.m., additional interviews were conducted with facility staff regarding the implementation of their plan of correction. Staff reported that in-services were conducted on handwashing, and donning and doffing Personal Protective Equipment (PPE), however, they had not been educated regarding the revised screening process, and staff did not have an understanding that they would be sent home if they were symptomatic for COVID-19. In addition, review of the staff screening sheets for July 2, 2020 revealed that ten staff members had documented the presence of symptoms and had been permitted to work. Only one of the ten staff members with symptoms had been sent home. In interviews with staff conducted on July 2, 2020, multiple staff reported there had been no designated individual to provide screening for staff entering the COVID unit that morning. On July 2, 2020 at 12:45 p.m., the Administrator was notified that the plan of correction needed to specifically address staff education to include the following: staff who were symptomatic were to be sent home and would not care for residents; the process for asymptomatic COVID positive staff to return to work, and that staffing mitigation strategies were in place and being implemented in the facility. The plan of correction also needed to include specific details of which staff members would be designated to screen staff during the week and on weekends/holidays, and which staff members would review and follow up on the screening results for staff who documented the presence of symptoms. A revised plan of correction was presented on July 2, 2020 at 1:35 p.m. At 3:26 p.m., The Administrator was informed that the plan of correction needed to address additional areas. On July 2, 2020 at 3:48 p.m., a revised plan of correction was presented. At 4:26 p.m., additional revisions were requested to include who would be responsible for reviewing the employee data collected on the screenings each shift and following up to ensure that symptomatic staff were sent home and removed from caring for residents, and if symptoms were consistent with the employee's baseline, documentation would be completed with detailed information before the employee would be permitted to work. This criterion was to pertain to all staff, whether entering the building through the front door or entering through the COVID unit. A revised plan of correction was presented on July 2, 2020 at 5:10 p.m. and was accepted. Multiple observations were conducted in the afternoon on July 2, 2020, of the facility implementing their plan of correction. Staff in-services were being completed and staff interviewed were knowledgeable of infection control procedures, including that symptomatic staff would not be permitted to work with residents on any unit. In addition, a designated staff member conducted the screenings, as staff arrived for their shifts. As the facility was implementing their plan of correction and staff were knowledgeable about the new processes that had been put into place, and there were no additional concerns identified, the Condition of Immediate Jeopardy was abated at 5:15 p.m. on July 2, 2020. Regarding staff who were symptomatic and/or were symptomatic and had tested positive for COVID-19, and provided care to non-COVID and COVID residents: -An entrance conference was conducted on June 30, 2020 at 9:10 a.m., with the Administrator and the Director of Nursing (DON/staff #1). The DON stated that the current census was 68. The DON also stated there had been a staffing shortage and they were currently in emergency mode for staffing. During the survey, an interview was conducted with direct care staff (staff #12), who stated they had received prior in-services regarding COVID-19 about being screened daily for signs and symptoms of illness. Staff #12 stated they were told that if they had three or more symptoms they would be sent home. Staff #12 stated that symptoms began on June .2020, which included a sore throat, cough, muscle aches, fatigue and a headache, and that he/she was tested for COVID-19. He/she said the staffing coordinator (staff #23) was told on June .2020 that he/she was having symptoms (cough, muscle pain, headache and sore throat) and asked not to work. Staff #12 stated that staff #23 said he/she was on the schedule and needed to come to work. Staff #12 stated that he/she worked that day and was screened by staff #23. Staff #12 said that staff #23 completed the documentation on the log. Staff #12 said that he/she told staff #23 that his/her symptoms were cough, muscle pain, headache and sore throat, but was sent out to work on a non-COVID unit that day. Staff #12 said that after the shift was over, he/she went for the exit screening but no one there to screen, so he/she looked at the screening log (from earlier that day) and there was a circle around the symptom of cough and a small question mark had been written next to it. Staff #12 stated the yes answer to muscle pain had also been scribbled out and the no answer had been checked instead, and there was a circle around the yes answer for headache. Review of the corresponding staff screening log for staff #12 for the day referred to in the above interview revealed the following: a question mark had been written next to the symptom of cough; the answer regarding muscle pain was yes but it had been scribbled out and a no had been marked; for headache the answer was yes but a circle had been drawn around yes and the symptom of sore throat had both the yes and the no boxes checked and both had been scribbled out. In the signature screener section, staff #23 (staffing coordinator) had signed her name. Review of the punch detail record for that date revealed that staff #12 worked a full shift. Continued in the interview staff #12 stated that the next day while being screened, he/she reported symptoms which included a cough, muscle pain, headache and sore throat, but was sent to work on a non-COVID unit again. Staff #12 stated that once on the unit, he/she reported to the nurse about feeling sick, so the nurse called the Assistant Director of Nursing (ADON/staff #33). Staff #12 stated the staffing coordinator (staff #23) texted back and said to stay and work the shift, and text her every two hours

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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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) to report his/her symptoms, which he/she did. The corresponding staff screening log for staff #12 included yes answers for cough, muscle pain, headache and sore throat. Review of the punch detail record for this same day revealed that staff #12 worked a full shift. Staff #12 further stated that the following day (June .2020) he/she also developed diarrhea and vomiting and called off sick. He/she said the next day, a text was received from staff #23 saying that he/she was on the schedule to work that afternoon/evening. Staff #12 stated that he/she texted staff #23 saying he/she still felt sick and staff #23 texted her back and said to get some rest, because he/she needed to be there. Staff #12 stated that he/she worked that afternoon/evening on a COVID unit. Staff #12 said that during the shift, he/she had another episode of diarrhea and reported it to staff #23 via text and asked to go home, but staff #23 said no, as there was no one to work the hall. Review of the staff screening log for staff #12 on that day revealed that both yes and no were marked for cough, muscle pain and headache and that sore throat was marked no and diarrhea and vomiting was marked yes. In the signature screener section, staff #23 had signed her name. The punch detail report for this date revealed that staff #12 had worked a full shift. In the interview, staff #12 further stated the next day (June .2020) he/she called off sick and went to urgent care. They did another COVID test because the results from the facility were not back yet. He/she said the physician from the urgent care told her to go home and quarantine. Staff #12 stated that he/she texted staff #23 the next day on June .2020 and told her that he/she had no taste or smell, and that urgent care said to self-quarantine. Staff #12 also stated that he/she emailed the doctor's note from urgent care to the Human Resource representative (staff #11). Staff #12 said that same day on June .2020, the Administrator said he/she had tested positive for COVID. Staff #12 said the Administrator asked if he/she was symptomatic and responded yes, and had been for a while. Staff #12 stated the Administrator said that asymptomatic COVID positive staff could work on the COVID positive unit. Staff #12 stated the Administrator also said they could make an exception for staff and to keep them informed of his/her symptoms. Staff #12 said the next day on June .2020, he/she texted staff #23 and told her that he/she had tested positive for COVID. Staff #12 stated that staff #23 said he/she was scheduled to work that day and was expected to come in. Staff #12 said that he/she told staff #23 that he/she was still symptomatic and was not working sick. -During the survey, an interview was conducted with direct care staff (staff #17). Staff #17 stated that multiple symptomatic/COVID positive staff members including his/herself have worked with non COVID residents. A follow-up interview was conducted with staff #17. Staff #17 stated that on June .2020, he/she was tested for COVID-19, along with other staff. Staff #17 said a few days later, he/she developed a fever of 100.2 degrees F, congestion, sore throat, body aches and a cough, and was scheduled to work that day. Staff #17 said that he/she texted the staffing coordinator (staff #23) and told her that he/she did not feel good and she would try to find someone else to cover his/her shift. Staff #17 stated that he/she did not hear back, so he/she went into work that day. Staff #17 stated that after he/she was screened that day, he/she spoke with the staffing coordinator (staff #23) and the DON (staff #1) about being sick. Staff #17 stated that despite his/her symptoms, staff #23 and the DON told him/her to work the floor. Staff #17 stated that he/she was sweating and weak during the shift and texted the staffing coordinator that he/she felt terrible and asked for a replacement. Staff #17 said the staffing coordinator never responded back and he/she worked over an 8 hour shift that day on a non-COVID unit. Review of the corresponding staff screening log for that day when he/she worked over an 8 hour shift, revealed that staff #17 had a fever of 100.2 degrees F, a cough, muscle pain and a headache. The log also included that a temperature greater than or equal to 100.0 degrees F was considered out of the acceptable range. Review of the punch detail record for this same date revealed that staff #17 worked over 8 hours. In the interview, staff #17 further stated after that he/she was sick for a few days and that the test results came back negative. Staff #17 said that he/she was still intermittently symptomatic and had a cough, and had not been retested . Staff #17 stated that today he/she worked on a non-COVID unit. -During the survey, an interview was conducted with a direct care staff member (staff #15). Staff #15 stated he/she started having a cough, sore throat and fever of 101 degrees F a couple of weeks ago and didn't work. Staff #15 said that he/she returned to work a couple of days later on June .2020 and since then, has continued to work with a cough, sore throat and intermittent fever. Staff #15 stated that he/she has not been tested for COVID-19. A follow-up interview was conducted with staff #15, who stated that he/she continues to have a cough, congestion and headaches. Staff #15 said that yesterday, he/she was asked to stay until registry staff arrived, and worked on both the COVID and non-COVID units. Review of the staff screening logs for June 2020 through July 2, 2020 revealed that staff #15 had reported various symptoms on multiple days, which included the following: a cough, fever, muscle pain, headache, sore throat or shortness of breath. On one day in June, staff #15 had reported shortness of breath, cough and a headache, and the original screening temperature was illegible, as it had been scribbled out and replaced with 99. According to the corresponding punch detail reports, staff #15 worked on those days in June and July when exhibiting symptoms. -During the survey, an interview was conducted with direct care staff (staff #21), who stated that on June .2020 he/she began having a headache, body aches, sore throat and chills. Staff #21 stated that he/she texted the staffing coordinator (staff #23), the Administrator and the DON to report his/her symptoms, but no one responded back. The next day, staff #21 said he/she had a fever of 100.3 degrees F, a headache, muscle pains, sore throat, chills and a cough. Staff #21 said he/she was told by staff #23 that he/she was still expected to work his/her shift that day and then worked on the COVID unit. Review of the corresponding staff screening log for that day when he/she had a fever of 100.3 and other symptoms, revealed that staff #21 had reported muscle pain, headache, sore throat and chills, when she reported to work that day. Continued in the interview, staff #21 said that a couple of days later he/she worked on a non COVID unit, but was sent home early, because of not feeling well. Review of the corresponding staff screening log for that day revealed that staff #21 had reported having a cough, fever, muscle pain, headache, sore throat and chills. The punch detail record for that date revealed that staff #21 had worked a short time that day. During the interview, staff #21 further stated that the next day June .2020, he/she worked on a non-COVID unit and still wasn't feeling well. Review of the corresponding staff screening log for that day revealed that staff #21 reported symptoms which included cough, fever, muscle pain, headache and sore throat. The punch detail record for that same day included that staff #21 worked a full shift. Continued in the interview staff #21 stated that a few days later on June .2020, he/she worked on a non-COVID unit again and was short of breath and didn't feel well. Later that afternoon, staff #21 said he/she was told by the Administrator that he/she had tested positive for COVID-19. Staff #21 stated that per the staffing coordinator, the DON and the Administrator, all COVID positive staff still needed to report to work, because that was the facility's policy. Later that same day while working, he/she texted the staffing coordinator (staff #23), the DON and the Administrator that he/she was short of breath and his/her oxygen saturation level was 88% (normal oxygen saturation level is 95-100%). Staff #21 stated that staff #23 said they did not have anyone to replace him/her and that he/she was still on the schedule for the next day June .2020. Review of the corresponding staff screening log for the day that he/she was notified of the positive test results for COVID, revealed that staff #21 had a cough, muscle pain, a sore throat, and for chills it was marked both yes and no. The punch detail record for that same day included that staff #21 worked a full shift. In the interview, staff #21 also stated that the next day he/she had a physician visit who told him/her to immediately go to the emergency room . Staff #21 said he/she texted the staffing coordinator, the DON and the Administrator and told them what the physician said and sent them a copy of the doctor's note. Staff #21 said he/she received a text from staff #23 stating that he/she needed him/her to show up for work that day. Staff #21 stated that he/she went to work as scheduled, so the next shift could be relieved. Staff #21 stated that he/she told them that they needed to find someone to take over in a couple of hours. Staff #21 stated that around noon that day, he/she texted the staffing coordinator, the DON and the Administrator and asked for someone to relieve him/her, because it hurt to breathe. Staff #21 stated the Administrator texted back saying they were trying to get someone in to relieve him/her. Staff #21 stated they never called him/her back and he/she ended up working a 12 hour shift on a non-COVID unit. Review of the corresponding staff screening logs revealed there was no screening documentation for staff #21 for that day. Review of the punch detail record for that same day revealed that staff #21 worked approximately 12 hours. On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He stated that if staff tested positive for COVID-19 but were well enough to work, they may work on the COVID unit. He said if staff are symptomatic they are asked to leave. However, he further stated that if he had to he would allow someone with a cough and fever to work on the COVID unit. He said when staff have asked him what their policy was for coming to work with symptoms, he referred them to the Human Resources representative (staff #11), because she was more familiar with that policy. An interview was conducted on July 1, 2020 at 1:37 p.m., with the Human Resource representative (staff #11). She stated that her understanding of the facility screening process included that if a staff member triggered 2-3 symptoms, they would need to consult with the DON and the Administrator for further screening. She said she believed that staff were switched to two 12 hour shifts to prevent a staffing shortage. She stated she would not consider the facility to have a staffing shortage. She stated that she knows

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) what the CDC has recommended. She said her understanding is if staff have been exposed to COVID-19 but have no symptoms, they would be screened, and allowed to work if they wore a face mask and all the appropriate PPE. She stated if a symptomatic staff member were referred to her, she would review the CDC guidelines which states that the staff member would need to be tested and to isolate, until the results are received. She said if staff came to her to ask about the facility's policy regarding working, she would direct them to speak to the DON. She stated that as far as she knows, they aren't forcing anyone with symptoms to work. She stated that COVID positive staff are allowed to work as long as they are asymptomatic, and only on the COVID unit. She said no one has been referred to her with any questions about COVID positive symptomatic staff continuing to work. She stated that she has not been made aware that symptomatic staff are working in the facility. Regarding changes to the staff screening logs: -Review of the staff screening logs for June 2020 revealed multiple alterations in the form of scribbling over, marking through, writing on top of and/or crossing out of the screening data that had been provided by facility employees which included the following: June 2 and 3: changes made to one staff's screening June 4: changes made to three staff's screenings June 5 and 7: changes made to one staff's screening June 8: changes made to three staff's screenings June 9 and 10: changes made to two staff's screenings June 11: changes made to four staff's screenings June 12: changes made to four staff's screenings June 16: changes made to one staff's screening June 17: changes made to two staff's screenings June 18 and 19: changes made to three staff's screenings June 20: changes made to one staff's screening June 21, 22 and 23: changes made to two staff's screenings June 24: changes made to six staff's screenings June 25: changes made to eight staff's screenings June 26: changes made to four staff's screenings June 27: changes made to seven staff's screenings June 28: changes made to three staff's screenings June 29: changes made to four staff's screenings June 30: changes made to six staff's screenings July 1: changes made to four staff's screenings July 2: changes made to seven staff's screenings An interview was conducted on June 30, 2020 at 2:19 p.m., with the staffing coordinator (staff #23). She stated that she does all the staffing for the nurses and the CNAs. She stated that she keeps the staff screening logs with her. She stated if an employee screens in with a temperature of 100.4 degrees F or higher or has more than 2-3 symptoms, she screens them further to see if the symptoms are normal for them. She stated that she has never altered the screening documents to make it seem like staff have no symptoms. She stated that staff are screened at the back entrance and that anyone in the facility can be a screener. Another interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that she had no idea who may have altered the screening sheets. Staff #23 stated that screeners must initial the logs when completing the screening. Regarding the facility declaration of a staffing emergency: -On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He said the facility had not reached critical staffing levels until 2 or 3 days ago (June 27 or June 28, 2020). He said the facility was looking into CNA waivers. An interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that a staffing emergency began on June 29, 2020, which caused the facility to implement 12 hour shifts for nurses and CNAs. Staff #23 stated that a staffing crisis is when the facility is using 100% registry in their building. She said the core staff have been helpful and pitched in, by taking additional shifts and working extra hours. She stated the staff are grateful for their jobs and the hours. She stated that they had 2 nurses resign, due to concerns for their health and the health of their family. On July 1, 2020 at approximately 12:20 p.m., an interview was completed with the Administrator. The Administrator said that he had not contacted the county himself for information or assistance, but stated that the DON was in contact with a staff member at the county. Another interview was conducted with the DON on July 1, 2020 at 12:30 p.m. The DON stated that he had been in contact with Epidemiology at the county office to report any new cases and to give facility updates. In a later interview at 3:56 p.m., the DON stated that he also talked to the county regarding the need for personal protective equipment (PPE), and had briefly discussed a waiver for CNAs. He said that he briefly mentioned possibly needing staffing assistance at some point, but acknowledged that there was no follow up to that conversation which occurred around June 23 or June 25, 2020. A follow up interview was conducted on July 1, 2020 at 4:01 p.m., with the DON. He stated that he and the Administrator began to have conversations about staffing on June 22, 2020. He stated they were not in crisis mode on that date, but considered what they would do in the event of a staffing shortage. He said during that week, he asked the Administrator about strategies that they would use if things went bad. The DON said that on June 23 and June 24, 2020, they were still not in crisis mode and were still considering their options. He said on June 25, he asked the Administrator that if things went bad, what were they going to do? He said he suggested that they needed to consider transferring residents out to another facility. He said on June 25, he also spoke with the county and briefly discussed the CNA waiver and mentioned the potential need for staffing assistance. The DON said that on June 26, he was more concerned and wondered if they should be reaching out to other facilities. He stated they were not short-staffed that day and they were not in crisis mode. The DON said he had another conversation with the Administrator regarding their crisis staffing plan. He said on June 27, 2020, staff began calling out sick. He said he spoke with the Clinical Resource Liaison to discuss options and about transferring residents out to other facilities, and to reach out to other facilities to get more staff. The DON further stated that on the evening of June 27, 2020, he received the results of the COVID testing for staff which had taken place on June 22, and that multiple staff had tested positive. He said that same evening, they were short staffed. He said he called out to agency staffing, but found they were requesting hazard pay of 1.5 times the normal rate or $5.00 - $10.00 more per hour. He said the Administrator hesitated to hire them based on that factor. He said a staff from another facility came in, and he also called upon existing staff to cover the other two positions. The DON said that on June 28, administrative staff decided to implement their emergency staffing plan and began having staff work two 12 hour shifts the following day. He said they called their staff that evening to let them know. He said the facility reached crisis or emergency status on June 29, 2020 (one day prior to the survey team entering the building) and that they implemented their emergency staffing plan. He stated he would provide documentation of the efforts that had been made to abate the staffing issues. A list of actions taken to abate the staffing crisis was presented by the Clinical Director (staff #57) on July 2, 2020 at 3:20 p.m. Beginning June 15, 2020, the documentation included the need for additional nurses had been discussed during a conference call. A conference call dated June 22, 2020, included the need to hire 5 nurses and 5 CNAs. Another phone conversation with corporate was done on June 22, 2020, which included discussing staffing and registry. On June 28, 2020, two area facilities were contacted regarding their ability to house additional residents, but neither of the facilities had room. On June 29, 2020 during a corporate call with the Executive Directors and Resources, the possibility of transferring residents out of the facility was again discussed. Another call on June 29, 2020 with corporate included discussing staffing, registry, and the transfer of residents. Per the documentation, a call was made to a nursing registry service on June 29, 2020, but there were no nurses available. On June 30, 2020, a medical group was contacted and a contract was signed regarding procurement of CNAs and nurses. On July 1, 2020 (the day of the IJ), two other area facilities were contacted regarding their ability to house additional residents, but neither facility had room. Also on July 1, 2020, the documentation indicated that contact was made with three nursing registries in an attempt to procure staff and that they were waiting for responses. According to the documentation, the facility had various discussions regarding staffing issues, however, no action was taken in an attempt to increase staff until June 29 and June 30, when staffing agencies were contacted. In addition, there was no evidence that the facility had reached out to the county for assistance with staffing concerns anytime from June 25 through July 2, 2020. Review of the Facility Health and Rehabilitation Facility Assessment updated on March 27, 2020, revealed if the facility needs to activate its Emergency Operations Plan, staff may be called back to work additional shifts and staff may be cross trained to help with additional tasks. The assessment included that agency personnel will be employed through contractual agreements and those staff with mild symptoms will be assigned to work with COVID-19 positive residents only. Per the assessment, the COVID-19 residents will be housed in a separate wing with dedicated staff, so that staff are not intermingling, and non-positive staff will work with non-positive residents to the extent possible. -During the survey, an interview was conducted with direct care staff (staff #9). Staff #9 stated that symptoms consistent with COVID-19 began on June .2020. Staff #9 stated that on that day, he/she told the staffing coordinator (staff # 23) and the DON of the new onset of cough and a sore throat, but was still assigned to work on a non COVID unit. Staff #9 said when screened that day, he/she answered yes to cough and sore throat. Staff #9 said that he/she was screened by housekeeping staff (staff #91) that day. During the interview, the screening log for that day was discussed. The log showed that staff #91 had signed the log for screening staff #9 that day. Further review of the log revealed the answers to cough and sore throat were marked no. Staff #9 said the housekeeping staff (staff #91) must have checked no. In an interview with staff #91, she did not recall screening staff #9 on that day. Continued in the interview, staff #9 stated that a few days later

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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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) when screened for a shift on June .2020, he/she answered yes to the screening questions regarding new onset for headache, sore throat and loss of taste and smell. Staff #9 said there were several employees saying they were having new onset of symptoms, but no one was making a big deal about it. Staff #9 said that another staff member told him/her that they were experiencing many sick staff, so they did not want any call offs. Staff #9 stated on this same day, the Administrator reported that his/her test result was positive for COVID-19, and was reassigned to work on the COVID hall. Review of the screening log for that day revealed yes for headache and sore throat, and for taste and smell a yes and a no was marked. -During the survey, an interview was conducted with direct care staff (staff #73). Staff #73 said that he/she was symptomatic (today) but was working, as they had no staff. Staff #73 said he/she was originally assigned to a non COVID hall that day, but was moved to a COVID hall. Review of the screening log for that day revealed that staff #73 answered yes to shortness of breath and yes to have you had any contact outside of the facility with someone suspected of having or diagnosed with [REDACTED].#73. Staff #73 said that he/she was sent home today due to answering yes to symptoms at screening. Staff #73 said that he/she was experiencing