STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTALLA HEALTH AND REHAB	**915 STEWART AVENUE SOUTHEAST ATTALLA, AL 35954**

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** - Many	**Provide and implement an infection prevention and control program.** Based on observations, record review, and staff interviews, the facility failed to screen one (1) of one (1) visitor, who entered the facility and had potential access to 57 of 57 residents . The failure occurred during a COVID-19 pandemic. The findings include: During an observation on 07/20/2020 at 1:15 p.m., the Social Worker (SW) allowed visitor access into the building, and no screening was completed. The visitor met with staff, and had access to all resident care areas. During an interview on 07/20/2020 at 1:49 p.m., the SW stated, she forgot to complete the screening of the visitor. The Regional Nurse Consultant stated, she expected screening to be completed, immediately upon entry into the facility. Review of facility records provided by the facility, revealed, there were 54 residents confirmed positive for COVID-19, and three (3) residents laboratory results pending. Review of the facility protocol entitled, COVID-19: Screening Checklist - for Visitors and Staff, revealed, several screening questions were to be completed by the screener. The form also was to be signed and dated by the visitor or staff, as part of the screening process.

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.