STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115467	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY NURSING & REHAB CTR	**180 EPPS BRIDGE RD ATHENS, GA 30606**

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, interviews, record review, and review of the facility's policy titled, Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed, Coronavirus, the facility failed to ensure all employees were adequately screened for signs and symptoms of COVID-19 when entering the building. This deficient practice had the potential to affect the 94 residents residing in the facility. Findings Include: Review of the facility's policy titled, Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed, Coronavirus, updated 5/12/2020 revealed, Screening Employees, Faculty will actively verify absence of fever and respiratory symptoms when employees report to work-beginning of their shift. Document temperature, absence of shortness of breath, new or change in cough or sore throat . Observation of the facility's foyer on 7/24/2020 at 8:30 a.m. revealed a rolling bedside table with two-three ring binder notebooks, hand sanitizer, pens, and a thermometer. Attached to the table was a sign that documented, 1. Please stop. 2. Use hand sanitizer. 3. Sign in. 4. Complete COVID-19 Self screening temp. 5. Before leaving please check temp and record. Use hand sanitizer. Staff was not present at the time of arrival and observation of the area. The surveyor went into the hallway and obtained the attention of a staff person on the unit. On 07/24/2020 at 8:40 a.m., Licensed Practical Nurse (LPN) AA arrived and took the surveyor's temperature, asked the appropriate screening questions, and reminded the surveyor to sanitize her hands. The staff member left the surveyor unattended in the entrance to wait for the Administrator to arrive. On 7/24/2020 at 8:45 a.m., the Administrator arrived at the facility, walked past the table to the nurse's station, and retrieved a pen. The Administrator then returned to the table, completed the screening log while taking his own temperature, and then introduced himself to the surveyor. The Administrator informed the surveyor the facility census was 94 residents with six COVID positive residents in a designated unit. The Administrator stated there are currently eight staff members out of the facility who tested positive for COVID, two of which were retested and are awaiting results. The Administrator stated the facility was randomly testing staff when signs and symptoms are present. Further interview with the Administrator revealed the receptionist comes in at 8:30 a.m., and prior to that the charge nurse should be available to complete the screening process. When explained to the Administrator that staff were not present upon the surveyor's arrival to the facility, the Administrator did not respond. Interview with the Infection Control Preventionist (ICP) on 7/24/2020 at 8:54 a.m., revealed the receptionist normally completes the entrance screening. The ICP stated we had a staff member present for screening there prior to 8:30 a.m., but we changed her position so now the charge nurse is in charge of completing the screening. The ICP stated staff should not be checking themselves in. It should be monitored by another staff member. Interview with Restorative LPN Nurse AA on 7/24/2020 at 9:38 a.m., currently seated at the front of the rolling table, stated that the receptionist does the screening. The regular receptionist is off today so LPN Nurse AA was filling. LPN Nurse AA stated the receptionist conducts the screening after 8:30 a.m. and the unit nurse conducts the screening prior to the receptionist's arrival. Interview with the Director of Nursing (DON) on 7/24/2020 at 9:45 a.m., the DON stated that the receptionist arrives at 8:30 a.m. to conduct the screening. The ICP monitors the screening log. If something is missing or a staff member answers yes to any of the screening questions, then the ICP follows up with the staff member. Interview with Certified Nursing Assistant (CNA) AA on 7/24/2020 at 10:19 a.m., CNA AA stated we usually screen ourselves but the charge nurse from the previous shift is the one to check us in. Interview on 7/24/2020 at 10:24 a.m., CNA BB stated we screen ourselves unless someone was entering with us then we ask them to take our temperature for us. We fill out the log. Put on a mask and sanitize our hands. Review of the Daily Schedule Report and the Facility Employee Daily COVID-19 Symptoms Screening Sheet for July 23, 2020 through 2020 revealed discrepancies for staff that worked and staff that were screened. Further review with the ICP on 7/24/20 at 12:30 p.m. revealed the ICP confirmed that on 7/23/20, that 36 staff members had worked and only 31 staff completed the screening log. Further review revealed CNA BB, designated to the COVID unit, was not listed as having completed the log on 7/23/2020. Review of the screening log, dated 7/24/2020, revealed for the morning shift two of the 16 staff members did not complete the screening. Interview with the ICP on 7/24/2020 at 12:30 p.m., the ICP stated she reviews the logs to see if staff are completing the form and the temperatures are within range but has never reconciled the log with the staffing schedule to ensure all staff are completing the log. Interview on 7/24/2020 at 12:52 p.m., the Administrator brought a blank screening form with one staff (CNA AA) screening information on the form. The form documented the time of arrival on 7/24/2020 at 7:06 a.m. The Administrator stated the staff reported she completed the screening but was pulled by nursing staff and forgot to complete the log. The Administrator stated that it was unacceptable, and it was the facility's expectation to complete the form as soon as they are screened.

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