STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, review of the facility's Infection Control policies and procedures, review of the facility's Emergency Preparedness Plan and an interview with the local public health department nurse and a nurse practitioner, the facility failed to prevent an infection control system failure when employees and a surveyor entered the facility by using 3 of 3 facility entrances, which did not have Covid-19 screening stations, and accessed resident hallways and common areas without being screened for the COVID-19 virus. Staff also failed to apply personal protective equipment (PPE) before they entered the designated Covid-19 unit and did not remove PPE when they exited the unit. These system failures occurred during the Covid-19 pandemic and had the likelihood to affect all residents in the facility. A total of 71 of 95 residents tested positive for the COVID-19 virus as of April 22, 2020. Immediate Jeopardy began on [DATE]9/20 when observations and staff interviews revealed employees and a surveyor used three different entrances to enter the facility that did not have an identified Covid-19 screening station and they were not screened prior to accessing resident hallways and common areas. Staff also were observed to enter the facility's designated COVID unit without applying PPE and did not remove PPE when they exited the unit. The Immediate Jeopardy was removed on 5/3/20 when the facility implemented an acceptable crediable allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of F that is not Immediate Jeopardy to ensure monitoring systems put in place are effective. Findings included: The facility's Infection Control Policies and Procedures, dated revised July 2014, were reviewed and revealed they were not updated to include the Centers of Disease and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) guidance to prevent the spread of the COVID-19 virus. The Infection Control policies did not contain specific guidelines on screening employees and visitors for the Covid-19 virus or maintaining transmission-based precautions in the COVID-19 designated unit. The facility's Emergency Preparedness Plan (EPP) for Pandemic Influenza-Covid-19, dated as revised March 2020, revealed employees and visitors should be evaluated daily for symptoms, and staff were to self-assess and report symptoms of COVID-19 before reporting to work. The EPP specified standard and droplet precautions were to be used when staff were in close contact with residents. The local health department conducted an onsite visit at the facility on 0[DATE]4/20. Review of the health department's report revealed staff members were going between the facility's COVID unit and the Non-COVID unit, staff on the COVID unit utilized the same time clock as the other staff and the time clock was not disinfected between uses, and staff on the COVID unit removed their PPE at the unit's front lobby entrance and then exited the facility through the front lobby, which was accessible to residents and other staff, instead of using the exit door on the unit. The report specified the health department recommended facility staff be cohorted to work either on the facility's COVID unit or the Non-COVID unit and the staff on the COVID unit have a time clock designated for their use or for them to use paper time sheets. The report noted how the health department staff were working daily with the Director of Nursing to identify strategies regarding PPE, infection control, staffing, and the cohorting of staff. The health department report revealed a daily surveillance report on the facility's COVID positive staff was conducted which identified staff were working while exhibiting symptoms of the [MEDICAL CONDITION]. The health department discussed with the Director of Nursing (DON) the importance of a proper screening process. The health department report noted guidance was given and it was disregarded. On 4/20/20 at 1:23 pm a phone interview was conducted with the local public health department nurse who visited the facility on 0[DATE]4/20. The health department nurse stated the health department was working with the facility and made an onsite visit to the facility on [DATE]. After the visit, the health department nurse stated she discussed the following recommendations with the DON; to limit access into the facility to the use of only one entrance, perform the COVID screening process upon entry into the building and develop a system for the staff, who worked on the COVID unit, to be able to clock in so they did not have to use the time clock located in the front lobby area. The health department nurse stated on 4/20/20 the facility reported that 62 residents and 26 employees tested positive for COVID. On [DATE]9/20 at 7:10 am attempts to open the facility's front entrance by a surveyor revealed the entrance was locked. Nurse #1, who was wearing an isolation gown and mask, was observed to enter the front lobby area, unlock the front door and allowed the surveyor to enter the facility without screening her for the [MEDICAL CONDITION]. Nurse #1 stated she needed to run out to the parking lot to get her face shield and left the surveyor alone in the lobby area. Nurse #1 was observed to exit the facility and went to the parking lot. Observations of the front lobby area revealed there was no COVID screening station, PPE or personnel. Signage was observed on a small table in the lobby which requested visitors to wear a mask and use hand sanitizer. On [DATE]9/20 at 7:15 am, Nurse #1 was observed to reenter the facility and stated to the surveyor, need to get you screened. Nurse #1 then escorted the surveyor, who was not wearing any PPE and who had not been screened, through a plastic partition to the left of the lobby. The plastic partition was approximately 40-50 feet from the facility's front entrance and no precautionary signage was present. Nurse #1 was asked why the plastic partition was in place and she stated it was the entrance to the facility's COVID unit. Without another spoken word, Nurse #1 requested the surveyor to go back through the plastic partition, utilize the front entrance to exit the facility and to use the second door on the right to reenter the facility. In the process of leaving the COVID unit no PPE was observed on either side of the unit's plastic partition. On [DATE]9/20 at 7:20 am, observations of the side entrance that Nurse #1 directed the surveyor to use to reenter the facility (the employee entrance for the Non-COVID unit) revealed it was unlocked. Observations inside this unlocked entrance revealed there was no screening station, PPE or personnel. Nursing station-1 was observed on the right side of the hallway with four resident rooms between the entrance and the nursing station and closed double doors were observed straight ahead. A staff member who was walking by the surveyor was informed a nurse instructed her to enter through the side entrance to be screened, and the staff member directed the surveyor to the double doors straight ahead. Signage on the double doors read Authorized staff only. PPE on, no exceptions. Enhanced droplet and contact precautions. Nurse #1 was observed, through a window pane in one of the doors, at a nurse's station. The surveyor returned to the Non-COVID unit side entrance to wait for Nurse #1. Nurse #1, wearing a gown and mask, approached the surveyor from the left hallway (went to the front entrance lobby) and escorted the surveyor to the Caf room, that was located near the front lobby. Nurse #1 and the surveyor walked past five resident room to get to the Caf' room. During an interview with Nurse #1 on [DATE]9/20 at 7:30 am, Nurse #1 stated she was trained the COVID screening included a questionnaire and temperature check, and employees were screened at the nursing station of the COVID unit or the Non-COVID unit. Nurse #1 stated on [DATE]9/20, the PPE she was wearing was applied after she reported to work on the facility's COVID unit. Nurse #1 stated on [DATE]9/20, she did not remove her PPE when she exited the COVID unit, walked through the unit's plastic partition to enter the front lobby to let the surveyor into the facility and then exit the facility. Nurse#1 stated she was taking the surveyor through the COVID unit to conduct a screening at the nursing station. When Nurse #2 entered the Caf room, Nurse #1 stated Nurse #2 was there to perform the surveyor's screening. During a follow-up phone interview with Nurse #1 on 5/5/20 at 6:35 pm, she stated on [DATE]9/20 no one was at the front lobby entrance to screen employees or visitors, and she did not know where to locate the front lobby's thermometer or

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) screening forms when she let the surveyor enter the facility, so she did not screen the surveyor. On [DATE]9/20 at 7:30 am, while the surveyor was sitting in the Caf room, a resident, who was not wearing a mask, was observed in a wheelchair propelling himself from the front entrance lobby area toward the Non-COVID hallway. On [DATE]9/20 at 7:40 am, Nurse #2, who had a gown and mask on, was observed to enter the caf room and screened the surveyor. Nurse #2 monitored the surveyor's temperature and completed a COVID screening questionnaire on the surveyor. Nurse #2 stated she had worked the COVID unit during the night shift. During a phone interview with Nurse #2 on 5/5/20 at 2:59 pm, Nurse #2 stated she walked through the front entrance lobby partition from the Covid-19 unit to conduct a COVID screening on the surveyor on [DATE]9/20 at 7:40am. Nurse #2 stated she removed her mask and gown prior to exiting the Covid-19 unit and applied a new gown and mask upon entering the front entrance lobby. On [DATE]9/2020 at 8:18 am, the Director of Nursing (DON) provided a map of the facility and explained the closed double fire doors on the back and mid hallway and a plastic partition, the infection control barrier, at the front lobby entrance separated the COVID unit from the Non-COVID unit. The DON noted the Non-COVID unit (Nurse's Station #1) consisted of resident rooms 35-68 and the COVID unit (Nurse's Station #2) consisted of resident rooms 1-34 and resident rooms 61-66. On [DATE]9/20 at 8:47 am, Nurse Aide (NA) #1 was observed standing at a medication cart outside of room [ROOM NUMBER] on the Non-COVID unit. NA #1 was not wearing any PPE and entered resident room [ROOM NUMBER]. NA #1 was heard talking with a resident in room [ROOM NUMBER]. NA #1 was observed to exit the room and then asked Nurse #3 to take her temperature. Nurse #3 was observed to take NA #1's temperature at the medication cart. NA #1 then walked down the hallway past resident rooms to nursing station-1. NA #1 obtained a gown and mask at the nurse's station, put the PPE on and completed a COVID screening form. NA #1 left the screening form in a 3-ring binder at nursing station-1. No staff member was observed to review her COVID screening form. NA #1 was interviewed on [DATE]9/20 at 8:50 am. NA #1 stated she had just arrived at work and entered the facility through the Non-COVID employee side entrance. NA #1 stated staff who worked on the facility's Non-COVID unit were to report to nursing station-1 to complete a screening form that was located in a notebook and have their temperature checked. During another interview with NA #1 on 5/5/20 at 5:37 pm, she stated on [DATE]9/20 she was at the medication cart waiting for the nurse to take her temperature when the resident in room [ROOM NUMBER] called out. NA #1 stated she entered the room, prior to being screened, and asked the resident what he needed. NA #1 stated when she reported to work on [DATE]9/20 there was no screening station or PPE at the Non-COVID unit side entrance. NA #1 stated she was educated on completing the form when she reported to work, but no one was reviewing her screening forms at the time she completed the form. NA #1 explained if she had an elevated temperature or answered, yes, to any of the questions on the screening form, she was to inform the closest nurse. NA #1 further stated [DATE]9/20 was her last day working with the Non-COVID residents. She stated the residents on the Non-COVID unit who re-tested positive were moved to the COVID unit, and she was reassigned to help on the COIVD unit. An interview with Nurse #3 was conducted on [DATE]9/20 at 9:05 am. Nurse #3 stated the employee and visitor COVID screening process started in March 2020. Nurse #3 stated staff working on the Non-COVID unit used the employee side entrance to enter the unit, and when staff reported to work, they were to come to the nursing station-1 for a temperature check and to complete the COVID screening questionnaire. A follow up phone interview on 5/5/20 at 5:55 pm was conducted with Nurse #3. Nurse #3 stated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) usually reviewed the screening forms, but any nurse could review the screening forms when staff had a temperature greater than 100 and having any respiratory signs or symptoms when reporting to work. Nurse #3 stated the Non-COVID unit side entrance did not have PPE or a screening station. Nurse #3 explained the decreased number of residents on the non-COVID unit since [DATE]9/20 was due to some of the residents on this unit started to exhibit elevated temperatures, tiredness, and required [MED]gen therapy. The residents on this unit were retested and some tested positive and were moved to the facility's COVID unit. On [DATE]9/20 at 10:19 am, an observation of the COVID unit revealed there was no PPE available at any of the unit's entry points. The unit's side employee entrance did not have a designated screening station. Upon entering this employee side entrance, the unit's nursing station was observed approximately 15 feet from the entrance. Resident room [ROOM NUMBER] was observed to be to the left of this side entrance/exit door (if exiting the unit). Containers of PPE were observed in front of the unit's nursing station and inside a small office located to the left of the nursing station. An interview conducted on [DATE]9/20 at 10:30 am with Nurse #4. Nurse #4 stated he utilized the employee side entrance to enter the COVID unit when he came to work. He explained on [DATE]9/ 20 he entered the unit not wearing any PPE and his temperature was checked and he competed the screening form at the unit's nursing station. Nurse #4 stated after he completed the screening process, he exited the unit through the plastic partition and went to the lobby to clock in at the time clock. He then re-entered the COVID unit and applied a gown and mask at the unit's nursing station. Nurse #4 stated at the end of his shift, he removed his PPE in the bathroom that was approximately 15 feet from the unit's plastic partition, washed his hands and exited the unit through the plastic partition. Nurse #4 stated he then clocked out using the time clock in the front lobby area and exited the facility through the front door. During an interview with Nurse Aide #2 on [DATE]9/20 at 12:00 pm, Nurse Aide #2 stated when she came to work on [DATE]9/20 she used the employee side entrance to enter the COVID unit. NA #2 stated after she performed hand hygiene, she applied a gown, mask, and face shield. NA #2 explained she then exited the COVID unit, wearing her PPE and without being screened and she walked to the time clock located in the front lobby area to clock in. NA #2 noted no resident care was provided before walking to the time clock. After she clocked in, she returned to the unit's nursing station to complete the COVID screening process which included having her temperature checked and completing the screening form. NA #2 stated she often checked her own temperature. NA #2 stated education in-services were conducted on how to remove PPE before exiting the COVID unit and how to reapply PPE before re-entering the unit. On [DATE]9/20 at 12:35 pm, the plastic partition between the front lobby and the COVID unit was observed with a second piece of clear plastic hanging over the large slit in the plastic partition and a sign was at the top left corner of the partition that read No entry beyond this point. The COVID unit was located beyond the partition. An employee time clock was observed outside the administrative assistant's office door in the front lobby. The plastic partition for the COVID unit was approximately 27 feet from the time clock. The time clock was accessible to staff who did not work on the COVID unit and to residents who were in the front lobby. An interview with the administrative assistant was conducted on 4/20/20 at 3:05 pm. The administrative assistant stated there was a staff member assigned to work as the administrative assistant from 8:30 am to 9:30 pm daily, who was responsible for conducting the COVID screening on employees and visitors who entered the facility through the front entrance. She stated between the hours of 9:30 pm and 8:30 am the front entrance was to be locked and a nurse was to respond to the entrance's door bell and screen all staff and visitors who were attempting to enter the facility. She stated all employees and visitors who entered through the facility's front entrance were to be screened by having their temperature taken and completing the screening questionnaire. The administrative assistant explained If a question was answered yes on the screening form or the person's temperature was greater than 100 degrees Fahrenheit, the employee or visitor was referred to the DON, Assistant DON (ADON), or the first or second shift supervisor. The administrative assistant stated there were no personnel screening employees at the two side employee entrances and employees who entered through the side entrances were screened at the nursing stations on each unit. In a follow up phone interview on 5/5/20 at 6:05 pm, the administrative assistant stated she was expected to monitor the front entrance and perform the COVID screenings along with her normal duties as the administrative assistant. She stated the two new responsibilities did not require a lot of extra work due to the limitations of visitors in the facility and noted only a few venders entered through the front entrance. The administrative assistant stated when she took breaks the Administrator and the Human Resource Coordinator monitored the front entrance. An interview was conducted with the DON at 9:18 am on [DATE]9/20. The DON stated the employee and visitor screening process started in March 2020 and required staff upon reporting to work to complete a COVID screening questionnaire and to have their temperature checked. The DON stated a COVID screening books was located at the front lobby entrance, as well as, at nursing stations 1 and 2. The DON stated the licensed nurse was responsible for reviewing an employee's screening form to determine if the employee could enter the building for work. The DON explained an employee who worked during the 11:00 pm to 7:00 am shift on 4/3/20, who was screened, went to the emergency roiagnom on [DATE] and tested positive for COVID. She specified on 4/9/20, a resident tested COVID-19 positive while in the hospital after experiencing a fall at the facility. The DON stated she contacted the local Public Health Department, who recommended all residents and employees be tested for the [MEDICAL CONDITION] on [DATE]0/20. The DON stated residents were tested on [DATE] and [DATE]1/20 and the last results of these tests were reported on [DATE]3/20 and [DATE]4/20. The facility's original COVID unit consisted of rooms 1-8 and was closed off to other areas by a plastic partition, which separated the front entrance lobby and the COVID unit, and a set of fire doors between rooms [ROOM NUMBERS]. The facility received the residents test results over a 4-day span and the COVID unit expanded to include 60 of the 90 residents who

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) tested positive. On [DATE]9/20, the facility census specified 54 of the 82 residents tested positive for COVID, and the DON noted some residents were transferred to the hospital over the weekend. No deaths were reported by the DON on [DATE]9/20. The DON stated employee/visitor COVID screening forms were in a notebook located at nursing station on the COVID unit and the employees used the unit's key pad side entrance when reporting to work on the unit. The DON stated COVID screening notebooks were located at nursing station on the Non-COVID unit. Staff who worked on the Non-COVID unit were to use the unit's key pad side entrance to enter the unit when they reported to work. The DON explained that staff were required to perform a COVID screening which included; completing the screening form and having their temperature taken at the nursing station. The DON stated the licensed nurse was responsible for reviewing an employee's screening form to determine if the employee could report to work. Personal protective equipment was located at the nursing station for the staff working on the Non-COVID unit. During an interview with the DON on [DATE]9/20 at 12:40 pm, the DON stated the employees completed the COVID screening form prior to starting to work, and if any questions were answered yes, the employees took their form to the nurse. The DON stated staff had received educational in-services on the screening process. During an interview with the DON on [DATE]9/20 at 1:21 pm, the DON stated the COVID unit staff exited the unit's plastic partition that separated the COVID-19 unit and the front lobby entrance to use the time clock in the lobby at the beginning and the end of their shift. During another interview with the DON on [DATE]9/20 at 2:12 pm, the DON stated linen barrels and trash barrels were at nursing station-2 and in the hallways of the COVID unit for isolation gowns and trash. She specified staff removed PPE prior to exiting the COVID unit through the plastic partition at the front lobby entrance or at unit's side entrance. The DON stated that she and the ADON were monitoring the PPE practices of the staff. During a follow up interview with the DON on 5/5/20 at 12:55 pm, the DON stated on [DATE]9/20 there was no screening stations located at the side entrance for the Non-COVID unit and a screening book was used at the unit's nursing station. The DON stated staff working on the Non-COVID unit entered the facility through either the unit's employee side entrance or the front lobby entrance and screened themselves. She explained that ADON and herself were responsible for checking the screening forms. The DON explained on [DATE]9/20 staff who worked on the Covid unit were required to wear a face shield, N-95 mask, gowns and gloves when they provided resident care. The DON stated the employees who worked on this unit were to use the unit's side entrance near nursing station-2 to enter the facility, applied PPE located at the nursing station or in the nursing coordinator's office and conducted the COVID screening. Upon completion of the COVID screening, the staff on the COVID unit walked through the plastic partition barrier to the lobby to use the time clock and returned to the unit for work. The DON noted the employees removed the PPE at the end of the shift and used the time clock in the front lobby to clock out. The DON stated on 4/20/20 the COVID employees began recording the time they worked on paper time sheets instead of using the time clock in the front lobby. The DON noted the public health department mentioned on [DATE]4/20 about getting another time clock for the COVID unit and wanted to keep the staff on this unit on one side of the facility and suggested the COVID staff only used the unit's side entrance to enter and exit the facility. The DON reported there had been 15 COVID related resident deaths as of 5/5/20. The DON answered; Don't Know when asked why the Health Department recommendations on [DATE]4/20 regarding the time clock and the reduction in employee and visitor entrances were not implemented. The DON stated on 5/2/20 the facility started the 24-hour employee coverage at the front entrance and required all employees to use to the facility's front entrance for COVID screening when they reported to work. The resident surveillance information forms provided on [DATE]9/20 was reviewed on 4/20/20. This review revealed 60 of the 95 residents, who were tested , from 4/07/20 through [DATE]1/20 tested positive. The first resident that tested positive for COVID was on 4/7/20 while hospitalized . The resident surveillance information form provided on 5/5/20 revealed twenty-four residents on the Non-COVID unit were retested on [DATE], and 11 of the 24 residents tested positive. The employee surveillance information forms provided on [DATE]9/20 were reviewed on 4/20/20. This review revealed 21 of 95 employees, tested positive for COVID and the first employee that tested positive for COVIID-was on 4/7/20. The remaining staff were tested from [DATE]1/20 through [DATE]4/20 and some results were pending. The employee surveillance information forms provided on 5/5/20 revealed 28 of the 88 employees listed were positive for the [MEDICAL CONDITION]. On [DATE]9/20 at 2:50 pm, an interview was conducted with the Administrator. The Administrator stated the COVID screening process started on 3/13/20 for all employees and visitors and was conducted at the front lobby entrance and at the two nursing stations. The Administrator explained all staff and visitors were to be screened with a questionnaire and have their temperature checked when they entered the facility. On 4/28/20 at 9:52 am, a phone interview was conducted with the DON. The DON stated on 4/28/20 she was working at the facility and was asymptomatic after testing positive for Covid-19. The DON stated she used the facility's Non-COVID employee side entrance to report to work since it was the closest entrance to her office which was located on the Non-COVID unit. She explained she wore a gown and a N-95 mask when she left her office. She stated she refrained from interacting with residents who were not COVID positive. The DON stated on [DATE]9/20 she completed the screening process at nursing station-2 and could not explain why her screening form was located in the notebook on the Non-COVID unit on [DATE]9/20. The DON reported since [DATE]9/20 the 24 residents on the Non-COVID unit were retested on the physician's recommendation, and 11 of the 24 residents tested positive for having the [MEDICAL CONDITION] and were moved to the facility's COVID unit. An interview was conducted with the Nurse Practitioner (NP) on 5/5/20 at 11:21am. The NP stated that some residents who initially tested negative for COVID-19 developed symptoms and were retested . Some of the residents, who were retested , tested positive and were moved to the facility's COVID unit. During a follow up interview with the Administrator on 5/5/20 at 1:41 pm, the Administrator stated she was not present on [DATE]4/20 when the local Health Department visited the facility. The administrator explained on [DATE]9/20 the front lobby entrance doors remained locked and employee, visitors and vendors were to be screened at the front lobby entrance by a designated employee from 8:00 am to 9:00 pm. The Administrator stated after 9:00 pm, nursing staff from either unit could answer the front lobby entrance. She explained if a nurse, who worked on the COVID unit answered the front lobby doorbell, the nurse was to remove PPE before exiting through the unit's plastic partition to answer the door. The Administrator stated on [DATE]9/20 the employees, who worked on the COVID unit, were screened at nursing station-2, and employees were to enter the facility by using the unit's side entrance. The Administrator explained, when an employee entered the COVID unit, the screening process was completed. The Administrator was unsure if PPE was applied by staff in the COVID unit before or after they walked to the time clock in the front lobby to clock in. The Administrator stated employees were to remove PPE before exiting through the unit's plastic partition to use the time clock in the front lobby. The Administrator stated the DON was providing continuous education to the employees on COVID changes. The Administrator explained on 05/03/20 the facility was able to make contact the company to lock the two key pad side entrances, and the facility started allowing staff and visitors access only into the facility through the facility's front entrance. The Administrator was notified by phone of the immediate jeopardy on 5/2/20 at 11:45am. On 5/2/20 at 9:57 pm the facility provided the following credible allegation of Immediate Jeopardy removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; All residents have the potential to be affected. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Screening stations were consolidated to screening station in main lobby for screening of all employees and visitors. All exterior doors including front entrance are secure keypad entry only. Signage was placed on all doors to alert all staff and visitors to use front entrance only for mandatory screening at beginning of shift and / or visit to facility. Screening station will have a designated staff member assigned 24 hours per day. The Designated screening staff member will reconcile screens as they are completed with the daily staffing schedule to ensure all staff listed are screened upon arrival for work. A group of 4 designated staff members assigned to complete screens have been educated the Director of Nursing to notify the Director of Nursing, Administrative Nurse on call and/or facility administrator for any screen with temp noted greater than 100.0 and / or yes to any listed symptoms. Upon notification of positive screen (temperature greater than 100.0 and / or yes to any listed symptoms) the Director of Nursing, Administrative Nurse on Call and / or facility Administrator will advise the employee of their ability to work. Employees noted with positive screen (temperature greater than 100.0 and / or yes to any listed symptoms) will be sent home and will not be allowed to return to work until at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and at least 7 days have passed since symptoms first appeared as per the CDC return to work guidance for essential workers. If employee screen is negative (temperature not greater than 100.0 and no to any listed symptoms) and they are assigned to the non Covid unit they are to clock in for the day and report to their assigned area after applying full PPE. PPE for staff assigned to non Covid unit will maintained in front lobby at screening location. If employee screen is negative

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) (temperature not greater than 100.0 and no to any listed symptoms) and they are assigned to the Covid unit they are not to utilize the time clock, they are to utilize a paper clock correction form for their shift. Staff assigned to work on the Covid unit are to apply PPE (gown, mask and face shield) prior to entering the Covid unit. Gloves are applied prior to providing direct resident care. Upon completion of direct resident care gloves are removed and hand hygiene is completed. PPE for staff members assigned to Covid unit is located directly outside of temporary barrier located closet to front lobby. Upon arrival for work staff members assigned to the Covid unit will use the temporary barrier / entrance located closest to the front lobby to enter the Covid unit for work. If an employee or visitor enters the facility without a mask, they will be supplied a mask by the designated screening employee. Asymptomatic Covid positive employees will only be allowed to work on the Covid Unit per CDC guidance for Mitigating Healthcare Personnel Staffing Shortages memo received from the Durham County Health Department. All employees are screened at the screening station in main lobby. In-services began 5/2/20 by the Director of Nursing for all staff related to screening process, location of screening, utilization of time clock and application of PPE. All staff will be in-serviced prior to reporting for their next shift. Signage was placed on all doors