STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observations, staff interviews and the facility's policy, entitled, Coronovirus Guidance, the facility failed to screen accordingly for one (1) of three (3) COVID-19 screenings. This failure occurred during a COVID-19 pandemic. The findings include: During an observation on 05/05/2020 at 1:00 p.m., the receptionist as part of COVID-19 screening asked, Have you been around anyone with COVID-19? No other screening questions were asked of the visitor. During an interview on 05/05/2020 at 1:33 p.m., the Director of Nursing stated, she expected all COVID-19 questions to be asked, during screenings. During an interview on 05/05/2020 at 2:10 p.m., the receptionist acknowledged that she was aware of the COVID-19 pandemic. She stated, her normal practice was to ask staff, etc., as aforementioned related to COVID-19. She stated that she was aware of the questions that were posted on the wall to be asked, as part of the screening process; however, had not been asking the questions verbatim, during screenings. Review of the facility's policy, dated March 2020, screening questions to be asked related to Coronovirsus, revealed, .Fever greater than 100.0 F (Fahrenheit) .cough .shortness of breath .repeated shaking with chills .headache .new loss of taste or smell .diarrhea .chills .muscle pain .sore throat .vomiting .

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.