STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHERIDEN WOODS	**321 STONECREST DRIVE BRISTOL, CT 06010**

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 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on observation, interviews, and review of facility documentation, the facility failed to ensure that facility staff had been tested for COVID 19. The finding includes: Review of staff schedules and facility testing documentation from 6/26/20 through 8/20/20 and interview with the Administrator on 8/21/20, identified 5 staff members had not been tested for COVID-19 and worked at least once during that period. Further review with the Administrator on 8/21/20 of staff schedules and facility testing documentation, for all staff members that worked at least once between 7/16/20 through 8/20/20, an additional 11 staff members had not been tested for COVID-19 and 14 staff members had been tested on ly once. Review of the facility memo dated 7/20/20 identified COVID-19 testing was offered only on Mondays and Thursdays from 6:00 AM to 4:00 PM. The memo further identified that all staff members needed to come in for testing weekly during that time (unless previously tested positive). Additionally, the memo identified that if not tested , the staff member would be removed from the schedule and it was the staff members responsibility to get tested weekly. Interview with the Administrator on 8/21/20 at 5:40 PM identified although COVID-19 testing was offered to all staff members starting 6/26/20, some staff members had not been tested as required and the facility must improve on monitoring and reinforcing testing. The Administrator further identified that the most recent COVID-19 positive result was on 7/16/20 and although the facility questioned the accuracy of the results, all facility staff members and residents should still have been tested weekly for at least 14 days after to detect possible transmission.

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.