STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295072	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SILVER RIDGE HEALTHCARE CENTER	**1151 TORREY PINES DR. LAS VEGAS, NV 89146**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure (1) personal protective equipment (PPE) for care of residents on transmission-based precautions was accessible and (2) contaminated PPE was properly discarded. (1) Personal Protective Equipment (PPE): On 07/30/2020 at 9:15 AM, rooms 104, 108, 109, and 114 displayed signage which indicated transmission-based precautions were in effect. None of the rooms had a dedicated PPE caddy outside of the resident's door. rooms [ROOM NUMBERS] were on transmission-based precautions related to COVID-19 exposure and had PPE placed on a bedside table inside the resident's room. rooms [ROOM NUMBERS] were on transmission-based precautions unrelated to COVID-19. On 07/30/2020 at 9:35 AM, the Infection Preventionist (IP) revealed a PPE caddy should be outside the door of each room placed on transmission-based precautions to ensure proper donning of PPE prior to entry. On 07/30/2020 at 10:25 AM, a Registered Nurse (RN) revealed room [ROOM NUMBER] was placed on droplet precautions after the resident's roommate tested positive for COVID-19. The RN explained PPE to be used when care was provided included: an N95 mask, gown, gloves, and eye protection. The RN indicated the N95 mask and gowns were kept inside the resident's room on a bedside table. The bedside table with PPE was located past the resident's bed within the room. On 07/30/2020 at 10:28 AM, room [ROOM NUMBER] on the Presumptive Isolation Unit did not have a PPE caddy outside of the door. On 07/30/2020, five contiguous rooms (rooms 321-325) shared two PPE caddies which were placed in the hallway. A PPE caddy placed by room [ROOM NUMBER] contained no gloves or gowns. On 07/30/2020 at 10:30 AM, the IP indicated a PPE caddy should be outside each room on the Presumptive Isolation Unit. On 07/30/2020 at 10:35 AM, a Certified Nursing Assistant (CNA) outside of room [ROOM NUMBER], reported there should have been a PPE caddy by the door. The CNA revealed the caddy by room [ROOM NUMBER] was empty and needed to be restocked with PPE. The CNA reported PPE would be obtained from the nearest available place and carried back to the room when needed. On 07/30/2020 at 10:40 AM, the IP indicated it was poor practice for staff to carry needed PPE down the hall. The IP revealed availability of PPE supplies helped to ensure proper donning and use of PPE by staff members. On 07/30/2020 at 4:02 PM, the Executive Director (ED) revealed the facility had enough PPE caddies available until or if there was an increase in residents being presumptive for COVID-19. The ED revealed PPE caddies should have been available for rooms placed on transmission-based precautions. The facility policy titled COVID-19 Management Policy dated June 1, 2020 revealed procedures included to provide supplies necessary to adhere to recommended Infection Prevention and Control Practices as recommended by Centers for Medicare & Medicaid Services (CMS), CDC, and local health authorities. (2) Discarded PPE: On 07/30/2020 at 9:20 AM, signage posted outside room [ROOM NUMBER] indicated the resident was on transmission-based precautions. Inside the resident's room, multiple used isolation gowns were balled up and placed on top of a lidded receptacle. On 07/30/2020 at 9:21 AM, the Infection Preventionist (IP) verified the contaminated protective gowns were not disposed of properly. On 07/30/2020 at 9:21 AM, a CNA reported the used gowns should have been discarded inside the receptacle. On 07/30/2020 at 9:22 AM, a sign posted outside room [ROOM NUMBER] indicated the resident was on transmission-based precautions. Inside the room, used protective gowns were flowing out of a trash receptacle with no lid. On 07/30/2020 at 9:22 AM, the IP indicated the isolation gowns should have been discarded fully into a receptacle and covered with a lid. On 07/30/2020 at 9:35 AM, the IP reported the receptacle in room [ROOM NUMBER] was placed too far inside of the room to ensure proper doffing of PPE. On 07/30/2020 at 10:40 AM, the IP indicated there were opportunities for improvement in infection control practices. The IP shared had begun employment at the facility three days ago and would be ensuring infection control practice standards were followed. On 07/30/2020 at 4:52 PM, the Director of Nursing (DON) reported the facility followed the Centers for Disease Control and Prevention (CDC) guidelines regarding Transmission-Based Precautions. Per CDC guidelines: donning PPE upon room entry and properly discarding the PPE before exiting the patient room was done to contain pathogens. The CDC guidance titled Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings (undated), revealed Infection Prevention and Control (IPC) practices included ensuring necessary PPE was available immediately outside of the resident room and trash disposal bins were positioned near the exit inside of the resident room.

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