STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MEAD HEALTH AND REHABILITATION CENTER	**1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015**

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 document review and interview, the facility failed to ensure resident care staff were properly fit tested for the use of N95 respirators. Findings include: On 04/08/2020 at 1:20 PM, the Infection Control (IC) Nurse explained the facility's staff were divided into three teams to care for residents with presumptive or known COVID-19 infection. The IC nurse explained 17 staff members initially assigned to Care Team A, received fit testing and were issued N95 respirators. The IC nurse indicated the facility was in the process of screening more staff members for assignment to Care Team B and Care Team C. A review of the facility's N95 fit testing documentation revealed the facility contracted with a vendor designated to perform the medical screenings and fit testing online. The documentation included medical screenings signed by the contracted vendor's doctor but did not indicate fit testing was performed. The IC Nurse and Administrator explained the N95 respirators issued by the facility were form fitted and adjustable and did not require fit testing. On 04/08/2020 at approximately 3:45 PM, the Administrator provided the manufacturer's N95 respirator packaging indicating fit testing was required prior to use.

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