STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295081	A. BUILDING _____ B. WING _____	**04/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEVADA STATE VETERANS HOME - BOULDER CITY	**100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005**

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 and interview, the facility failed to ensure staff were appropriately using personal protective equipment (PPE) and residents were [MEDICATION NAME] social distancing. Findings include: On 04/28/20 at 10:20 AM, a Certified Nursing Assistant (CNA) exited a resident's room identified as on contact precautions not wearing a face mask. The CNA verbalized removing the mask after taking the residents vitals. The CNA acknowledged the face mask should have been worn at all times. On 04/28/20 at 10:25 AM, 15 residents were observed in the common area located in the facility's mariner/cove unit not [MEDICATION NAME] social distancing. A Registered Nurse verbalized staff should have been redirecting and reminding residents on the importance of [MEDICATION NAME] social distancing. On 04/28/20 at 11:31 AM, the Infection Control Nurse indicated staff should have been wearing a face mask at all times while inside of the facility and residents should have been maintaining social distance at all times. On 04/28/20 at 12:01 PM, the Administrator confirmed the CNA should have been wearing a face mask at all times while on the unit. The Administrator explained all staff were required to wear a face mask at all times while in the facility. The Administrator explained all residents should have been [MEDICATION NAME] social distancing, and staff should have been redirecting residents reminding them the importance of [MEDICATION NAME] social distancing.

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.