STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295089	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARQUIS CARE AT CENTENNIAL HILLS	**6351 N FORT APACHE RD LAS VEGAS, NV 89149**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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, record review and document review, the facility failed 1) to place a newly admitted resident in a private room while under observation for signs and symptoms of COVID-19 for 1 of 6 sampled residents (Resident #3), 2) to communicate with a [MEDICAL TREATMENT] center a resident had pending test results for COVID-19 for 1 of 6 sampled residents (Resident #1), 3) to house residents with COVID-19 like symptoms on transmission-based precautions for 3 of 6 sampled residents (Residents #1, #2, and #5), and 4) to ensure staff used the proper personal protective equipment (PPE) prior to entering a transmission-based precaution room. Findings include: 1) New Admission: The facility's New Admissions COVID-19 Protocol revised on 06/07/2020, documented the following: - A single negative test upon admission does not mean the resident was not exposed or will not become infected in the future. - A newly admitted or readmitted resident would be monitored for signs and symptoms of COVID-19 for 14 days, which started on the date of the negative COVID-19 test result from the previous facility. - A new admission would be placed in a private or non-shared room, when possible. - Contact/Droplet/Eye protection Precautions would be implemented for 14 days, or from 14 days of a negative COVID-19 test result. Resident #3 (R3) R3 was admitted on [DATE], with [DIAGNOSES REDACTED]. R3 had a negative COVID-19 test result from the hospital on [DATE]. R3 was housed in a shared room on C hall upon admission, with another long-term care resident. The facility's designated area for newly admitted residents and re-admissions to the facility was on the Observation unit which was located on the first floor in A hall. On 07/29/2020 in the afternoon, the Infection Prevention (IP) Nurse indicated newly admitted residents would be under observation for signs and symptoms of COVID-19 for 14 days, starting on the date of the negative COVID-19 test result. Vital signs would be obtained daily, a private room was not required, and the resident must wear a mask prior to leaving the room. The IP Nurse explained newly admitted residents with a negative COVID-19 test result from the hospital would not be placed on transmission-based precautions. The new residents could be roomed with a COVID-free resident, since all the residents in the facility were being monitored for signs and symptoms of COVID-19. The facility's New Admission COVID-19 Protocol revised on 06/07/2020 was reviewed with the IP Nurse. The IP Nurse acknowledged R3 should have been placed in a private room upon admission and should have been placed on transmission-based precaution until 08/06/2020. The IP Nurse could not provide a reason why R3 had not been placed in the facility's designated area (A hall) for newly admitted residents or why the resident was not placed in a private room. On 07/30/2020 at 8:50 AM, the Administrator explained the New Admission COVID-19 Protocol had not been followed and had been misinterpreted by the facility. The Administrator indicated it would have been possible to place R3 in a private room at the time of the resident's admission. R3 should have been placed on transmission-based precautions. 2) [MEDICAL TREATMENT] Communication: Resident #1 (R1) R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. R1 had been scheduled for outpatient [MEDICAL TREATMENT] on Tuesdays, Thursdays, and Saturdays. An Interdisciplinary Team Progress note dated 07/27/2020, revealed R1 had complained of chest congestion, a productive cough with a milky colored sputum, and a headache. On 07/27/2020, R1 had been tested for COVID-19 and a chest x-ray had been completed. The chest x-ray showed slight venous congestion. The COVID-19 test results were pending at the time of survey. The [MEDICAL TREATMENT] Resident Communication Report dated 07/28/2020 and 07/30/2020, lacked documented evidence the [MEDICAL TREATMENT] center had been informed of R1's COVID-19 like symptoms on 07/27/2020 and the pending COVID-19 test results. A physician's progress note dated 07/29/2020 documented R1 had been seen by the resident's attending physician. The progress note documented R1 had a slight cough with shortness of breath, and a sore throat. The documentation indicated the results of the chest x-ray had been discussed with the Nephrologist at the [MEDICAL TREATMENT] center. On 07/29/2020 in the morning, the Infection Prevention Nurse (IP) verbalized the facility's van driver had transported R1 to the [MEDICAL TREATMENT] center for outpatient [MEDICAL TREATMENT] treatments on Tuesdays, Thursdays, and Saturdays. On 07/30/2020 at 7:21 AM, the facility van driver confirmed R1 was scheduled for [MEDICAL TREATMENT] today and would leave the facility around 8:30 AM. On 07/30/2020 at 7:38 AM, the Charge Nurse confirmed R1 had been tested for COVID-19 on 07/27/2020. The Charge Nurse explained R1 had gone out for [MEDICAL TREATMENT] treatment on 07/28/2020, and the [MEDICAL TREATMENT] center had been notified of the chest x-ray results. The [MEDICAL TREATMENT] center had not been informed R1 had been tested for COVID-19 and the results were pending. The Charge Nurse explained he/she was not aware R1 had been tested for COVID-19 until yesterday (07/29/2020). The Charge Nurse indicated the facility's process was to inform the [MEDICAL TREATMENT] center of any changes in the resident's condition through the [MEDICAL TREATMENT] communication notes or through a telephone call. The Charge Nurse revealed it was important for the [MEDICAL TREATMENT] center to be informed of a change in a resident's condition. This was important so proper precautions could be implemented to keep everyone safe and to prevent the spread of [MEDICAL CONDITION]. On 07/30/2020 at around 8:15 AM, the facility van driver transported R1 to the [MEDICAL TREATMENT] center. The Charge Nurse verbalized he/she had failed to inform the [MEDICAL TREATMENT] center of R1's change in condition prior to R1 leaving the facility for [MEDICAL TREATMENT] treatment. An Interdisciplinary Team Progress note dated 07/30/2020 at 8:35 AM, documented the Charge Nurse called the [MEDICAL TREATMENT] center and informed the center R1 had been tested for COVID-19 and the results were pending. On 07/30/2020 in the afternoon, the Administrator of the [MEDICAL TREATMENT] center where R1 received [MEDICAL TREATMENT] treatment indicated the facility had called on 7/30/2020. The facility informed the center R1 had presented with COVID 19-like symptoms and the COVID-19 test result were pending. The Administrator indicated when R1 arrived at the [MEDICAL TREATMENT] center R1 was asked to return to the facility. The Administrator of the [MEDICAL TREATMENT] center was not aware R1 had been tested for COVID-19 on 07/27/2020. The Administrator's expectation was for the facility to communicate this kind of information to the [MEDICAL TREATMENT] center, so the [MEDICAL TREATMENT] treatment could be scheduled in a manner to prevent cross contamination. 3) Transmission-based Precautions: Resident #1 (R1) Resident #1 was admitted on [DATE], with [DIAGNOSES REDACTED]. The resident received [MEDICAL TREATMENT] treatment in an outpatient [MEDICAL TREATMENT] facility on Tuesdays, Thursdays and Saturdays. R1's medical record revealed on 07/27/2020, the resident complained of chest congestion, productive cough with milky colored sputum, and a headache. A test for COVID-19 was performed. A nursing progress note dated 07/29/2020, revealed the physician had seen the resident and ordered a throat [MEDICATION NAME] for sore throat. A physician's orders [REDACTED]. On 07/29/2020 in the afternoon, the IP Nurse explained R1 was regularly transported to the [MEDICAL TREATMENT] center by facility transportation. The IP Nurse confirmed R1 has had a roommate since admission and had not been placed on transmission-based precautions for signs and symptoms of COVID-19 after each [MEDICAL TREATMENT] treatment. The IP Nurse confirmed R1 was tested for having COVID-19 like symptoms on 07/27/2020. The IP Nurse indicated the facility would not isolate a resident who exhibits one of the symptoms. The facility would complete tests such as laboratory and chest x-ray. On 07/30/2020 at 9:44 AM, the Attending Physician explained R1 was a long-time patient under their care. The Physician indicated R1 had complained of chest congestion and cough several times in the past and has had to be seen in the emergency room due to low oxygen saturation. The Physician stated R1's respiratory problem was related to fluid overload since the

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) patient had end stage [MEDICAL CONDITIONS]. The Physician indicated communication with the attending Nephrologist was established to request the removal of extra fluids during the [MEDICAL TREATMENT] treatment. The Physician was not thinking about COVID-19 symptoms when R1 was assessed on 07/29/2020 and was not aware a COVID-19 test had been performed due to the respiratory symptoms. The Physician agreed with the COVID-19 test and verbalized it would be a good idea to place the resident in a private room since R1 went out of the facility three times weekly for [MEDICAL TREATMENT] treatment. Resident #2 (R2) R2 was admitted on [DATE], with [DIAGNOSES REDACTED]. A cough [MEDICATION NAME] was administered for the cough, a nebulizor treatment was administered for the dyspnea, and [MEDICATION NAME] were given for the sore throat. The nursing progress note indicated the Charge Nurse was made aware of R2's respiratory condition and a chest x-ray was ordered. The radiology report for a chest x-ray dated 07/25/2020, reported R1 had left lower lobe pneumonia. A nursing progress note dated 07/25/2020, documented the attending physician and the Infectious Diseases Physician Assistant were notified. Intravenous antibiotics [MEDICATION NAME] and [MEDICATION NAME] were ordered. Documentation titled Follow Up Questions Report from 07/01/2020 through 07/29/2020, documented the following question: COVID-19: Does resident have new or worsening cough. The report revealed the question was answered affirmatively with a yes on 07/25/2020, 07/26/2020, and 07/27/2020. A nursing progress note dated 07/29/2020, revealed R2 continued with a moist cough, shortness of breath (observed), and slight wheezing noted in the lower lobe of the left lung. R2's medical record lacked documented evidence R2 had been placed on transmission-based precautions for having COVID-19 like symptoms on 07/25/2020. On 07/29/2020 at 8:30 AM, observations were conducted with a Resident Care Manager (RCM) on the unit where R1 and R2 resided. There was no evidence transmission-based precautions had been implemented, including signage or an isolation cart containing personal protective equipment such as gowns, gloves, goggles, face masks or face shields. On 07/30/2020 at 8:50 AM, the Administrator confirmed R1 and R2, and two other residents in the facility were tested for COVID-19 on 07/27/2020. The specimens were collected by the IP Nurse and were sent to the Southern Nevada Health District. All four residents had pending COVID-19 test results. On 07/29/2020 at 4:45 PM, the CNA assigned to care for R1 and R2 was not aware the residents had been tested for COVID-19 and had used surgical mask and gloves while providing care. On 07/30/2020 at 7:38 AM, the Charge Nurse was not aware R1 and R2 had been tested for COVID-19 until 07/29/2020. The Charge Nurse indicated staff members should be informed whenever there was an infection, so they could keep everyone safe by using proper precautions to prevent the spread of the infection such as the use of PPE. Resident #5 (R5) Resident #5 was admitted on [DATE] and re-admitted on [DATE], with [DIAGNOSES REDACTED]. An Interdisciplinary Team (IDT) note dated 07/26/2020, documented R5 did not leave the room for restorative care because R5 complained of nasal congestion and a cough. The IDT note dated 07/26/2020, revealed R5 was coughing with phlegm and green sputum. The Charge Nurse was made aware, the attending physician was notified, and new orders were obtained which included [MEDICATION NAME] (a cough medication) 600 milligrams, [MEDICATION NAME]/[MEDICATION NAME] inhaler for shortness of breath and a chest x-ray. A radiology report for a chest x-ray dated 07/26/2020, documented R5 had pneumonia. A physician's orders [REDACTED]. An Infection Control note dated 07/28/2020, indicated R5 was on antibiotics for pneumonia and oxygen was administered as needed, due to the resident's oxygen saturation level decreasing to 87%. An infection control note dated 07/28/2020, documented R5 complained of cough, shortness of breath and had distant lung sounds. A nebulizer treatment and cough syrup were administered. R5's medical record lacked documented evidence R5 had been placed on transmission-based precautions for having COVID-19 like symptoms on 07/26/2020. On 07/29/2020 at 8:10 AM, during the entrance conference, the Infection Preventionist (IP) Nurse verbalized the facility did not have COVID-19 positive cases. The IP indicated the facility did not have residents in transmission-based precautions for COVID-19 like symptoms. The IP Nurse provided the Infection Control Line List (a table that summarizes information about persons who may be associated with an outbreak). Review of the Infection Control Line List revealed the last entry for symptomatic residents was documented on 07/06/2020. There was no documented evidence the facility had positive COVID-19 cases or suspected cases at the time of the entrance conference. On 07/29/2020 at 8:45 AM, observations were conducted with the RCM on the unit where R5 resided. The resident had a productive cough. The RCM confirmed the observation. R5 had a roommate (Resident #7). There was no evidence transmission-based precautions had been implemented, including signage or an isolation cart containing personal protective equipment such as gowns, gloves, face masks, goggles and face shields. On 07/29/2020 in the afternoon, the Charge Nurse explained in the event a resident developed COVID-19 like symptoms, the attending physician, the Director of Nursing (DON) and the Infection Preventionist should be notified. The Charge Nurse indicated a COVID-19 test, a chest X-ray and other diagnostic laboratory tests would be performed. The Charge Nurse indicated the DON and the IP would determine if the resident required transmission-based precaution. On 07/29/2020 in the afternoon, the DON indicated the signs and symptoms of COVID-19 were cough, runny nose, fever, congestion, sore throat, nausea, and vomiting. If the resident had COVID-19 like symptoms, the resident would probably be placed on transmission-based precautions. On 07/29/2020 at 4:43 PM, the Administrator explained if a resident had COVID-19 like symptoms and a test to rule out the infection was performed, the resident should have been placed on transmission-based precautions. 4) Personal Protective Equipment: The facility policy titled Management of Respiratory Illness 2020 dated 05/20/2020, documented residents having respiratory illness symptoms including cough, shortness of breath and sore throat, would remain in their rooms. The policy documented standard, contact and droplet precautions plus eye protection would be applied to the residents with the above-mentioned symptoms. The policy listed a gown, gloves, a face shield or goggles and an N-95 respirator as the personal protective equipment required to enter the isolation rooms. On 07/29/2020 in the afternoon, the DON indicated if a resident had COVID-19 like symptoms, the resident would probably be placed on transmission-based precautions and staff members would wear proper personal protective equipment such as goggles/face shield, N95 masks, gloves and gown. On 07/30/2020 at 8:00 AM, two signs were observed at the entrance of room [ROOM NUMBER], located in the B Hall. One of the signs displayed Contact Precautions and required hand hygiene and the use of a gown and gloves. The other sign indicated Droplet Precautions and required the use of gloves, gown, and a face mask to enter the room. The signs did not mention the use of face or eye protective devices, or an N-95 mask. On 07/30/2020 at 7:35 AM, a Certified Nursing Assistant (CNA) assigned to care for R1 and R2 did not know why the residents were placed on transmission-based precaution. On 07/30/2020 at 7:48 AM, the Charge Nurse was observed donning a gown, gloves and a face mask prior to entering a droplet/contact precaution room (room [ROOM NUMBER]). The Charge Nurse did not wear a face shield or goggles. The Charge Nurse was asked why a face shield wasn't worn. The Charge Nurse indicated eyeglasses were on and those should work as eye protection. On 07/30/2020 at 8:20 AM, a CNA delivered a meal tray to R2 in a droplet/contact precaution room (room [ROOM NUMBER]). The CNA wore a face mask, a gown and gloves. The CNA did not wear a face or eye protective device, or an N-95 mask. On 07/30/2020 at 9:02 AM, the CNA explained the box of face shields located at the entrance of the isolation room appeared to be empty, because the face shields were transparent. This was why the face protection was not used. The CNA confirmed the box contained face shields. The CNA verbalized it was the first day of her/his orientation at the facility as a new employee and was not aware why the residents in room [ROOM NUMBER] were on transmission-based precautions. On 07/30/2020 at 9:15 AM, the Charge Nurse confirmed the sign placed at the entrance of room [ROOM NUMBER] had not been updated. The information regarding eye protection, such as the required use of a face shield or goggles had been missed.