STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SOUTH LAS VEGAS	2325 E. HARMON AVE. LAS VEGAS, NV 89119

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** - Some	**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: 1) Ensure transmission-based precaution signs were posted outside the room for 8 of 25 newly admitted residents (Rooms 317, 322, 320, 204, 121, 117, 110, and 319), and; 2) Ensure Personal Protective Equipment (PPE) was available when entering resident rooms on transmission-based precautions for 1 of 3 staff members observed donning PPE, and; 3) Follow their policy to transfer residents who were COVID-19 negative, free of symptoms and had completed 14 days of monitoring for signs and symptoms of COVID-19 out of the observation area and into an appropriate designated area. Findings include: 1) No transmission-based isolation precaution signs posted outside of new admission rooms: On 09/15/2020 in the morning, the facility map revealed the 100 Unit, 200 Unit, and Rooms 302 through 322 were identified by the facility to be the Yellow Unit. This area was for new admissions, residents being monitored for signs and symptoms of COVID-19 for 14 days, and residents suspected of COVID-19. Fifty-three residents resided in this area. The Director of Nursing (DON) indicated the PPE required while in the hallway of the Yellow Unit was an N95 mask and face shield or goggles. A gown and gloves were required if entering a transmission-based precaution room. On 09/15/2020, at approximately 9:45 AM, a tour of the Yellow Unit revealed 8 of 25 rooms lacked signage indicating transmission-based precautions were in place for rooms 317, 322, 320, 204, 121, 117, 110, and 319. The Infection Preventionist (IP) was present during the tour and confirmed the observations. On 09/15/2020, at approximately 10:00 AM, a Certified Nursing Assistant (CNA) was in the Yellow Unit hallway wearing an N95 mask and a face shield. The CNA entered room [ROOM NUMBER], occupied by two newly admitted residents, and did not put on a gown or gloves prior to entering the room. There was no signage posted outside the room indicating transmission-based isolation precautions were required. The IP indicated there should have been a transmission-based precaution sign outside the door of room [ROOM NUMBER]. The CNA reported not being aware the residents were new admissions and did not know the room was a transmission-based precaution room. The CNA had been trained in isolation precautions and indicated new admissions should be on transmission-based precautions. During the morning shift change, the CNA was not informed room [ROOM NUMBER] was a transmission-based isolation precaution room. On 09/15/2020 at approximately 10:15 AM, a Licensed Practical Nurse (LPN) indicated the residents in room [ROOM NUMBER] had been admitted the day before and were supposed to have been on transmission-based precautions. The LPN confirmed there should have been a sign posted outside the resident's door indicating the resident was on transmission-based precautions. The LPN indicated the nurse who admitted the residents was responsible for setting up the isolation signs. On 09/15/2020 at approximately 11:15 PM, the DON indicated she had asked the admission nurse to place transmission-based precaution signs in the past, but it was not the responsibility of the admitting nurse to set up transmission-based precaution signs. The DON indicated the Nursing Supervisor was responsible for setting up the transmission-based precaution signs for new admissions after hours and weekends. The IP was responsible during the weekdays. The IP confirmed being responsible for ensuring transmission-based precaution signage was set up during the week. At night and on weekends, the Nursing Supervisor was responsible. The facility policy titled Coronavirus (COVID-19) Standard and Transmission-Based Precautions, revised 06/17/2020 documented, the facility would place all admitted and readmitted residents under droplet and contact precautions for 14 days of observation for signs and symptoms of COVID-19. All recommended COVID-19 PPE should be worn during the care of residents under observation, included an N-95 mask, eye protection, gown, and gloves. The facility policy titled Transmission-based Precautions and Isolation Procedures, revised 07/25/2019, documented when a resident is placed on transmission-based precautions, the staff should implement the following: - Clearly identify the type of precautions and the appropriate PPE to be used. - Place signage in a conspicuous place outside the resident's room. - Make PPE readily available near the entrance to the resident's room. - Don appropriate PPE upon entry into the room. 2) Ensure PPE was available: On 09/15/2020, at approximately 10:00 AM, a Certified Nursing Assistant (CNA) entered room [ROOM NUMBER] wearing an N95 mask and a face shield. There were no PPE supplies set up near the room. The Infection Preventionist (IP) confirmed the observation. The facility policy titled Transmission-based Precautions and Isolation Procedures, revised 07/25/2019, documented when a resident is placed on transmission-based precautions, the staff should implement the following: - Clearly identify the type of precautions and the appropriate PPE to be used. - Place signage in a conspicuous place outside the resident's room. - Make PPE readily available near the entrance to the resident's room. - Don appropriate PPE upon entry into the room. 3) Transfer of COVID-19 free residents to appropriate areas: On 09/15/2020 in the morning, the facility map revealed the 100 Unit, 200 Unit, and rooms 302 through 322 were identified by the facility to be the Yellow Unit. This area was used for newly admitted residents who were being monitored for signs and symptoms of COVID-19 for a 14-day observation period, and for residents suspected of COVID-19. Fifty-three residents were housed in the Yellow Unit. Rooms 401 A through 411 B housed the COVID-19 free residents and was designated the Green Unit. Thirteen of the residents in the Yellow Unit met the criteria to be housed in the Green Unit. These residents met the criteria to be moved to the Green Unit, as the residents did not have any signs or symptoms of COVID-19, were negative for COVID-19 and had been monitored for greater than 14 days. On 09/15/2020 at approximately 12:15 PM, the Director of Nursing (DON) indicated the facility had made changes to their plans for housing residents in the dedicated Yellow area in order to maximize the availability of rooms for new admissions. The DON indicated she did not want to move the residents who were COVID-19 free to the Green Unit because she believed there was not a real COVID free area. In addition, she wanted to keep beds open for new admissions. The facility mainly housed short-term stay residents, and the COVID-19 free residents in the Yellow area were ready to go home, so it was not necessary to move them. On 09/05/2020 in the afternoon, the Administrator indicated the decision to make changes and go against the facility's original plan for housing specific residents in dedicated areas was a group decision between him the Administrator and the DON. The facility policy titled Coronavirus (COVID-19) Standard and Transmission-Based Precautions, revised 06/17/2020 documented, the facility should place residents in dedicated areas of the facility depending on COVID-19 status. Colors (Red, Yellow, Green) can be used on facility maps to help visualize testing results to facilitate the moving of residents. The Yellow unit was indicated for residents with unknown COVID-19 status. All residents in the Yellow Unit warranted transmission-based precautions. After the test result was back, the resident should be moved to the appropriate area of the facility. Residents in the Yellow unit can be transferred to the COVID-19 negative areas of the facility if they remain free of fever and without symptoms for 14 days.
F 0885 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	Based on interview and document review, the facility failed to update residents, their representatives, or families of confirmed COVID-19 cases in the facility by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. Findings include: The facility policy titled Coronavirus (COVID-19) Policy revised 06/17/2020, documented the facility must inform residents, their representatives, or families by 5:00 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection and with each subsequent COVID-19 infection of

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 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 1) residents or staff members. The facility must provide cumulative weekly updates to residents and their representatives or families regarding the status of the outbreak, which included cumulative totals of COVID-19 cases and clusters, and mitigation strategies to prevent or reduce the risk of transmission. The facility's Long-Term Care (LTC) Respiratory Surveillance Line List dated 09/15/2020, documented the facility had confirmed COVID-19 cases on the following dates: On 08/26/2020, there were six positive resident cases of COVID-19. On 08/28/2020, there was one positive staff case of COVID-19. On 09/09/2020, there was one positive resident case of COVID-19. On 09/15/2020 in the afternoon, the Infection Preventionist (IP) confirmed the data on the LTC Respiratory Surveillance Line List. The IP indicated the Liaison was assigned to call the resident representatives or family members for weekly updates regarding the facility's COVID-19 status, but was not sure where it was documented. The Liaison was not available for an interview at the time of the survey. On 09/15/2020 at 3:19 PM, the Director of Admissions indicated the Liaison made phone calls to the resident representatives and family members to give updates regarding the facility's COVID-19 status. The Director of Admissions indicated the Liaison would log the information on a Call Log and send a copy to the Administrator. On 09/15/2020 at 3:42 PM, the Administrator confirmed the Liaison called the resident representatives or family members to give updates regarding the facility's COVID-19 status monthly and not weekly.