STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295048	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARMON HOSPITAL - SNF	**2170 EAST 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 -** 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) Two staff members put on personal protective equipment (PPE) prior to entering a transmission-based precaution room, 2) The staff members wore a gown and gloves when providing care in the Observation Unit, and 3) Disposable gowns were available to the staff members providing care in a transmission-based precautions room. Findings include: The facility had one room with two licensed skilled nursing beds. The facility shared staff members between hospital patients and skilled nursing residents. 1) Transmission-Based Precaution: On 07/02/2020 at 9:41 AM, a transmission-based precaution room had a sign by the door with instructions to don PPE, such as gown and gloves prior to entering the room. A Lead Mental Health Technician (MHT) was observed in the transmission-based precaution room wearing a mask but no gown or gloves. The Lead MHT confirmed the room was a transmission-based precaution room. The Lead MHT conveyed PPE should have been donned prior to entering the room. On 07/02/2020 at 9:43 AM, a Certified Nursing Assistant (CNA) entered the transmission-based precaution room without PPE. The CNA confirmed the transmission-based precaution sign indicated to wear gloves and a gown prior to entering the room. The CNA conveyed PPE should have been donned prior to entering the room. On 07/20/2020 at 9:45 AM, the Administrator confirmed the observations and indicated the staff members should have donned PPE prior to entering a room on transmission-based precautions. The facility Isolation/Precautions Including Standard/Universal Precautions updated on 11/27/2017, documented gloves would be worn to provide a protective barrier and to prevent gross contamination of the hands, and gowns would reduce opportunities for transmission of microorganisms. 2) Observation Unit: On 07/02/2020 at 10:36 AM, the Administrator indicated the Observation Unit housed the new admissions who either had a negative COVID-19 test result or had not been tested for COVID-19. Regardless of whether they had a negative result, the new admissions were placed on observation for 14 days for signs and symptoms of COVID-19. On 07/02/2020 at 12:36 PM, a CNA in the Observation unit was delivering lunch trays without wearing a gown or gloves. On 07/02/2020 at 12:38 PM, a Licensed Practical Nurse (LPN) was observed entering a transmission-based precaution room without wearing a gown. On 07/02/2020 at 2:22 PM, the Clinical Service Director (CSD) indicated the staff members on the Observation Unit should have worn full PPE, which included a gown, gloves, and a mask prior to entering the transmission-based precaution rooms. 3) Personal Protective Equipment: On 07/02/2020 at 9:30 AM, a tour of the facility was conducted with the Chief Executive Officer. Rooms 106, 107, 217, 326 and 333 displayed transmission-based precaution signs posted by the door. There were over-the-door Personal Protective Equipment (PPE) set-ups that contained gloves but had no gowns. room [ROOM NUMBER] had a transmission-based precaution sign by the door but had no over-the-door PPE set-up. On 07/02/2020 at 9:42 AM, the Lead MHT indicated the gowns were kept in the medication cart. On 07/02/2020 at 9:51 AM, an LPN conveyed the gowns were kept in the medication carts. On 07/02/2020 at 10:15 AM, a House Supervisor confirmed there was no over-the-door PPE set-up for room [ROOM NUMBER]. This room had been on transmission-based precaution since 06/13/2020. The House Supervisor indicated it was the staff member's responsibility to ensure the over-the-door PPE set-ups were in place and were equipped with gloves and gowns. On 07/02/2020 at 11:00 AM, the Administrator indicated the Maintenance Director and the Central Supply Clerk were responsible for ensuring PPE was available for the staff members to use. On 07/02/2020 at 11:02 AM, the Maintenance Director indicated the medication carts were restocked with gowns daily. The Maintenance Director explained the gowns were kept in the medication carts because they disappeared faster when kept in the over-the-door PPE set-ups. The Maintenance Director conveyed the nurses were responsible for refilling the over-the-door PPE set-ups. On 07/02/2020 at 2:22 PM, the Clinical Service Director indicated the gowns should have been available in the over-the-door PPE set-up and should not have been kept in the medication carts.

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