STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295036	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH LAS VEGAS CARE CENTER	**3215 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and document review, the facility failed to: 1) distribute meal trays to prevent cross-contamination and 2) properly cover meal trays to prevent cross-contamination. Findings include: 1) Distribution of meal trays: On 07/17/2020 at 11:45 AM, a Restorative Aide (RA) and a Certified Nurse Aide (CNA) parked the meal carts for the COVID-19 unit outside the entrance in preparation for lunch to be served. The RA and CNA held out the plastic reusable serving meal trays to the nurse on the COVID-19 unit. The nurse removed the meal (served on a foam tray plate) from the plastic serving tray. Each time the foam tray was removed from the plastic serving tray, the nurse's hands touched the plastic serving tray. The RA then placed the plastic serving tray on top of the meal cart which contained the remaining unserved meals. On 07/17/2020 at 11:49 AM, the RA indicated the foam trays were flimsy, so the entire reusable plastic tray was pulled out for the nurse in the COVID-19 unit. On 07/17/2020 at 12:45 PM, the Dietary Manager (DM) verbalized the RA should have picked up the disposable foam tray from the plastic serving tray and handed it to the COVID-19 nurse to prevent cross-contamination. On 07/17/2020 at 2:10 PM, the DON indicated the nursing staff with the meal cart should have picked up the foam tray instead of the reusable plastic tray and handed it to the nurse in the COVID-19 unit to prevent cross-contamination. 2) Cover meal trays: On 07/17/2020 at 11:46 AM, the desserts on the plastic meal trays for the COVID-19 unit were uncovered and exposed to the air inside the meal cart. On 07/17/2020 at 11:50 AM, the RA acknowledged the desserts in both meal carts were uncovered. The RA verbalized all food items should have a covered lid to prevent cross-contamination when the staff walks the meal tray down the hallway to the resident room. On 07/17/2020 at 12:45 PM, the DM confirmed the desserts on the meal cart were not covered during lunch and should have been covered to prevent cross-contamination. On 07/17/2020 at 2:10 AM, the DON indicated the facility expected the kitchen staff to cover all food items in the meal cart to avoid cross-contamination and ensure safe food practices. A facility document titled, Eating and Dining COVID-19 (undated) indicated all foods and beverages should leave the kitchen covered in case of transport through hallways to provide safe food handling for the residents.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to ensure: 1) Hand hygiene was conducted before and after passing a meal tray in the COVID-19 unit and 2) Personal Protected Equipment (PPE) was worn during meal preparation and while assigned in the COVID-19 unit. Findings include: 1) Hand hygiene/Handwashing On 07/17/2020 at 11:46 AM, a Restorative Nursing (RA) removed meal trays from the meal cart with their bare hands and then handed the trays to a staff member in the COVID-19 unit. On 07/17/2020 at 11:48 AM, the RA removed sandwiches and ice cream from the desert container with their bare hands and placed the items on the meal tray. The RA did not perform hand hygiene before and after the meal distribution. The RA indicated education was provided to perform hand hygiene and to wear gloves prior to handling food. On 07/17/2020 at 12:45 PM, the Dietary Manager and Director of Nursing (DON) indicated the staff members were educated to perform hand hygiene and wear gloves prior to touching the meal trays and to perform hand hygiene after removing the gloves to avoid the potential spread of pathogens. The facility policy titled Safe Food Handling revised 10/02/17, revealed the employees were to wash their hands prior to handling food. Food was served with clean and sanitized utensils. There was no bare hand contact. 2) Inappropriate use of PPE On 07/17/20 at 11:20 AM, two kitchen staff members preparing the lunch meal wore their surgical masks below their chin exposing their nose and mouth. One staff member was wearing a black baseball cap. On 07/17/20 at 11:22 AM, a Dietary Aide indicated the surgical mask should have been worn covering the nose and mouth while preparing the food. On 07/17/20 at 11:24 AM, the Dishwasher acknowledged helping with the meal preparation and wearing the face mask below the chin. The Dishwasher acknowledged he was wearing a baseball cap. The cap was worn straight from home and brought into the kitchen. On 07/17/20 at 11:30 AM, the Dietary Manager indicated the staff members were expected to wear the mask appropriately by covering their nose and mouth. The baseball cap worn from home should have not been worn inside the kitchen or should have been changed prior to entering the kitchen. On 07/17/2020 at 12:37 PM, the cook had the face mask pulled down below her chin while assembling a boxed lunch. On 07/17/2020 at 12:39 PM, the cook was eating potato chips while making two sandwiches. On 07/17/2020 at 12:45 PM, the cook verbalized a mask should have been worn at all times to prevent the spread of infection. The cook indicated eating was not allowed in the kitchen as it was unsanitary and had the potential for cross-contamination. On 07/17/2020 in the afternoon, the Director of Nursing (DON) indicated all staff members were required to appropriately wear a mask and to hold the mask in place, the staff member should mold or pinch the stiff edge of the mask to the shape of the nose. The DON indicated the Infection Preventionist (IP) was sick and the DON had assumed the responsibility for the duration. On 07/17/2020 at 4:25 PM, two LPNs in the COVID-19 unit were wearing their N95 mask pulled below the chin exposing their mouth and nose. One LPN was passing medication. The other nurse was speaking to another nurse behind a plastic barrier. On 07/17/2020 at 4:35 PM, an LPN indicated N95 masks were to be worn in the COVID-19 unit at all times. On 07/17/2020 at 5:00 PM, the DON verbalized the staff should not have removed their N95 mask in the COVID-19 unit unless the staff were eating or drinking in the designated breakrooms. The facility policy titled, Personal Protective Equipment: Infection Prevention and Control dated 04/13/20, revealed the facility staff were to follow clinical practice standards in the use of personal equipment.

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