STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295090	A. BUILDING _____ B. WING _____	**04/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH CARE OF LAS VEGAS	**5840 W SUNSET RD LAS VEGAS, NV 89118**

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.** Based on interview and document review, the facility failed to ensure resident care staff were fit tested for N-95 masks. Findings include: On 4/9/2020 at 9:15 AM, Administrator indicated facility was under the impression fit tests for N-95 masks were not required per guidance from Centers for Medicare and Medicaid Services (CMS). Administrator indicated no fit tests had been conducted for staff at time of survey. The facility had 35 N-95 mask available for staff if an out break of COVID-19 occurred. On 04/09/2020 at 9:20 AM, the Administrator produced an email that stated the annual fit testing was not required. The true intent of the letter was explained to the Administrator about the requirement of initial fit testing. The Administrator acknowledged the no annual fit testing requirement was misinterpreted as no fit testing was required. The Administrator, Director of Nursing and Assistant Director of Nursing confirmed fit testing had not been conducted for staff for the N-95 mask. On 4/9/2020 at 9:35 AM, a Licensed Practical Nurse reported not being fit tested for N-95 masks. On 4/9/2020 at 9:42 AM, a Certified Nursing Assistant reported not being fit tested for an N-95 mask. On 4/9/2020 at 9:50 AM, a Registered Nurse reported not being fit tested for an N-95 mask.

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.