| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **295088** | A. BUILDING _____ B. WING _____ | **09/15/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WINGFIELD HILLS HEALTH & WELLNESS** | **2350 WINGFIELD HILLS DR SPARKS, NV 89436** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review the facility failed to appropriately quarantine a resident with know exposure to COVID-19, ensure only designated staff were entering the quarantine unit, staff providing care to residents in the quarantine unit were using the appropriate personal protective equipment (PPE), and ensure staff had been fit tested for N-95 respirators. Findings include: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].#1 after the resident had transferred to the hospital. The positive resident was roommates with Resident #2 and Resident #2 had not been tested and had not been placed in quarantine. Resident #2 had been isolated to the resident's room, but the resident did not have dedicated staff and staff did not don N-95 respirators, face shields, or gowns when providing the resident care. On 09/15/20 at 9:15 AM, a Licensed Practical Nurse (LPN) verbalized Resident #2 had never had designated staff assigned and staff never donned additional PPE to care for the resident when the resident was in isolation. On 09/15/20 at 11:46 AM, the Director of Nursing confirmed the entire facility had potentially been exposed to COVID-19 when Resident #2 was not isolated and cared for by designated staff after known exposure. On 09/15/20 at 9:07 AM, the doors to the quarantine unit were closed and had a sign posted on both doors documenting all personnel who entered would don a KN95 face mask, face shield, and gown. On 09/15/20 at 9:07 AM, a Certified Nurses Assistant (CNA) entered the quarantine unit wearing a surgical mask. The CNA entered the clean utility room inside of the quarantine unit and exited the unit holding a package of briefs. On 09/15/20 at 9:09 AM, the CNA verbalized the CNA entered the quarantine unit to retrieve supplies from the clean utility room an average of nine times per shift. The CNA verbalized the clean utility in the quarantine unit was the storage location for toiletry supplies and briefs for residents. The CNA verbalized the CNA never donned additional PPE when entering the quarantine unit and only wore a surgical mask. On 09/15/20 at 9:07 AM, the staff working in the quarantine unit were wearing KN95 masks to care for presumptive positive residents. ON 09/15/20 at 9:12 AM, a housekeeping aide verbalized the quarantine unit was cleaned daily and the housekeeping staff wore a KN95 mask, faceshield and gloves when cleaning the residents' rooms. The PPE stock documentation provided by the facility documented the supply of N-95 respirators in stock on 09/01/20 was 150 and the facility had 144 N-95 respirators in stock on 09/14/20. On 09/15/20 at 10:38 AM, the Mobile Administrator verbalized the facility had not completed fit testing for any of the staff because the facility did not have access to the necessary supplies to perform a fit test. The Mobile Administrator verbalized the facility had not sent staff designated to care for residents in the quarantine or isolation unit to an occupational health office or physicians office to complete fit testing. |
| F 0886<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review the facility failed to perform COVID-19 testing in a timely manner for a resident with known exposure to COVID-19 for 1 of 86 residents (Resident #2). Findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2 was the roommate of the positive resident and Resident #2 had not been placed in quarantine and had not yet been tested for COVID-19. The DON verbalized Resident #2 had not been out of the resident's room since the facility was notified of the roommates positive test result. Resident #2 had not been assigned designated staff and staff were not donning additional Personal Protective Equipment (PPE) when care was provided to the resident. COVID-19 testing had not yet been completed for any residents in the facility in the 18 days since the facility had been notified of the resident's positive test result. On 09/15/20 at 9:15 AM, a Licensed Practical Nurse (LPN) verbalized Resident #2 had not had designated staff assigned and staff had not donned additional PPE to care for the resident after the facility was notified of the positive test result for Resident #2's roommate. The LPN verbalized Resident #2 had not been tested for COVID-19. On 09/15/20 at 10:38 AM, the Mobile Administrator verbalized facility wide testing of residents had last been completed on 05/26/20. On 09/15/20 at 11:46 AM, the DON confirmed the entire facility had potentially been exposed to COVID-19 when Resident #2 was not isolated and cared for by designated staff after known exposure. The DON verbalized the facility had waited to test the resident in case the resident's roommate had a false positive test result from the hospital. The facility had been notified of five test results from the positive resident since the initial notification on 08/28/20 and all five test results were positive. |

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.