STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295006	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAS VEGAS POST ACUTE & REHABILITATION	2832 S. MARYLAND PARKWAY LAS VEGAS, NV 89109

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to label, and secure disinfectant and cleaning products stored on housekeeping carts. Findings include: On 09/17/2020 at 8:50 AM, a housekeeping cart was observed on the 300 Hall. There were three unsecured bottles of liquid on the cart. One bottle contained a blue-colored liquid, and the other bottle had a clear liquid. Housekeeper #1 reported the bottle with the blue-colored liquid was a glass cleaner, and the bottle with the clear liquid was a disinfectant. Two of the bottles had no label. The cart did not have a locked cabinet to secure the disinfectant and cleaning products. Housekeeper #1 could not explain why the bottles did not have labels. Housekeeper #1 explained when away from the cart, the bottles were covered with towels so the residents could not grab the chemicals. On 09/17/2020 at 8:53 AM, Housekeeper #2 and the Maintenance Director conveyed it was not safe to keep unsecured chemical bottles on the housekeeping carts because the residents could grab and drink the chemicals. On 09/17/2020 at 9:00 AM, a housekeeping cart was observed on the 100 Hall with an unsecured bottle of floor cleaner stored on the bottom shelf. The housekeeping cart had a cabinet that was not locked. The cabinet contained two bottles of cleaning products; one bottle was a blue-colored liquid without a label. Housekeeper #3 indicated the bottle with the blue-colored liquid was glass cleaner. Housekeeper #3 was not sure why the bottle did not have a label. Housekeeper #3 conveyed it was not safe to keep unlabeled bottles on the cart because they could be mistaken for something else. Housekeeper #3 reported the cart was not locked because the key was nowhere to be found. On 09/17/2020 at 9:00 AM, Housekeeper #3 indicated the disinfectant and cleaning products should have been secured because the residents could poison themselves by grabbing the chemicals and drinking the contents. On 09/17/2020 at 9:06 AM, a second housekeeping cart was observed on the 300 Hall by room [ROOM NUMBER]. The cart had a cabinet, but the lock was missing. The cabinet contained cleaning products. The Maintenance Director confirmed the lock of the cabinet was missing but could not verbalize why. On 09/17/2020 at 11:20 AM, the Infection Preventionist (IP) conveyed the chemicals on housekeeping carts should have been secured. The IP indicated some residents wandered around and could grab the chemical bottles and drink the contents. The IP indicated the issues with the housekeeping carts not having a locked or a working cabinet was discussed in last month's Quality Assurance Performance Improvement (QAPI) meeting. The IP reported the facility was supposed to order housekeeping carts with locked cabinets. On 09/17/2020 at 11:35 AM, the Assistant Administrator confirmed the issue with the housekeeping carts was recognized in the last QAPI meeting. The Assistant Administrator indicated the facility had planned to not use the housekeeping carts while waiting for the new housekeeping carts with the locked cabinets. The Assistant Administrator conveyed the housekeeping carts had not been ordered. The facility's Labeling of Chemicals Policy (undated) documented all products containing a hazardous chemical would be properly labeled prior to the use of the chemical.
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 observation, interview, and document review, the facility failed to ensure a housekeeper donned (put on) Personal Protective Equipment (PPE) prior to entering a transmission-based precaution room, and the doors to rooms on transmission-based precautions were closed for nine resident rooms (Rooms 302, 303, 304, 305, 306, 307, 308, 309, 310). Findings include: Personal Protective Equipment (PPE) not worn: On 09/17/2020 in the morning, resident rooms 302 to 310 had transmission-based precaution signs posted outside of the resident's door during the facility tour. The sign indicated the doors should be kept closed. On 09/17/2020 at 9:10 AM, a Certified Nursing Assistant (CNA) conveyed the residents in rooms 302 to 310 were on transmission-based precautions. The CNA confirmed the doors for rooms 302 to 310 were open, and the transmission-based precaution signs indicated the doors should be kept closed. On 09/17/2020 at 10:00 AM, the IP confirmed resident's rooms on transmission-based precautions were open and should have been kept closed. The IP conveyed the air from the resident rooms on transmission-based precautions could get out and potentially spread the infection. Doors Not Closed to Rooms on Transmission-based Precautions: On 09/17/2020 at 10:00 AM, a housekeeper was observed in a resident's room on transmission-based precaution without PPE. A transmission-based precaution sign posted on the wall outside of a resident's room indicated staff members and essential visitors must wear a gown, a face mask, eye protection, and gloves prior to entering the resident's room. On 09/17/2020 in the morning, the housekeeper acknowledged the transmission-based precaution sign indicated PPE should have been donned prior to entering the resident's room. On 09/17/2020 in the morning, the IP confirmed the observation and indicated the housekeeper should have donned the required PPE prior to entering a room on transmission-based precautions.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on interview and document review, the facility failed to ensure the Infection Preventionist completed the training required for infection prevention and control. Findings include: On 09/17/2020 in the morning, training certifications completed by the Infection Preventionist (IP) were provided by the facility. The IP completed 11 of 15 modules of the Center for Disease Control (CDC) Nursing Home Infection Preventionist Training Course. On 09/17/2020 in the afternoon, the IP confirmed the CDC Nursing Home Infection Preventionist Training Course was started in December 2019, but had not had the time to complete all 15 modules. The IP indicated no other staff members in the facility were trained or certified in infection prevention and control. The facility's Coronavirus Disease 2019 (COVID-19) Mitigation Plan (undated) revealed the facility would ensure the health care providers received infection prevention and control training.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure: 1) Manufacturer's guidelines for the Becton, Dickinson and Company (BD) Veritor point-of-care instrument and the facility's policy was followed for the use of a molecular assay test to confirm and rule out a negative result of COVID-19 for 6 of 16 sampled residents (Resident #1, #3, #4, #5, #7, #9) and before allowing staff members to return to work for 4 of 5 staff members (Staff Member #1, #2, #3, and #4) and 2) A State Laboratory Waiver was in place prior to using the BD Veritor. Findings include: 1) COVID-19 status: The Manufacturer's Guidelines for the BD Veritor dated 08/2020 documented the BD Veritor was used for the rapid detection of [DIAGNOSES REDACTED]-CoV-2 for individuals suspected of COVID-19. Negative results should be treated as presumptive, does not rule out [DIAGNOSES REDACTED]-COV-2 infection, and should not be used as the sole basis for treatment or resident management decisions, including infection control decisions. Negative results should be considered in the context of a resident's recent exposures, history, and the presence of clinical signs and symptoms consistent with COVID-19. A negative result should be confirmed with a molecular assay, if necessary, for resident management. The facility's Discontinuation of Transmission-Based Precautions on Residents with COVID-19 Infection Policy (undated) revealed the following: The criteria for the test-based strategy for residents who were symptomatic included: -resolution of fever without the use 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295006	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAS VEGAS POST ACUTE & REHABILITATION	2832 S. MARYLAND PARKWAY LAS VEGAS, NV 89109

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 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) fever-reducing medications, and -improvement in symptoms, and -negative results from two consecutive respiratory specimens collected more than 24 hours apart using a Food and Drug Administration (FDA) authorized molecular [MEDICAL CONDITION] assay to detect [DIAGNOSES REDACTED]-CoV-2 Ribonucleic Acid (RNA). The criteria for the test-based strategy for residents who were asymptomatic included: -negative results from two consecutive respiratory specimens collected more than 24 hours apart using a Food and Drug Administration (FDA) authorized molecular [MEDICAL CONDITION] assay to detect [DIAGNOSES REDACTED]-CoV-2 Ribonucleic Acid (RNA). On 09/17/2020 at 10:25 AM, the Infection Preventionist (IP) conveyed the BD Veritor was an [MEDICATION NAME]-based test and not a molecular assay test. Resident #1 (R1) R1 was re-admitted on [DATE], with [DIAGNOSES REDACTED]. R1's medical record documented on 08/15/2020, R1 was tested and an outside laboratory reported a negative result of COVID-19. On 08/17/2020, a negative result of COVID-19 was reported using the BD Veritor. The medical record revealed R1 had a negative molecular assay test followed by a negative [MEDICATION NAME] test. The medical record lacked documented evidence R1 had negative results from two consecutive molecular assays to rule-out COVID-19. Resident #3 (R3) R3 was re-admitted on [DATE], with [DIAGNOSES REDACTED]. R3's medical record documented on 08/18/2020 and 08/23/2020, R3 was tested and an outside laboratory reported a positive result of COVID-19. On 08/24/2020, a negative result of COVID-19 was reported using the BD Veritor. On 09/09/2020, R3 was tested and an outside laboratory reported a negative result of COVID-19. The medical record revealed R3 had a negative molecular assay test followed by a negative [MEDICATION NAME] test. The medical record lacked documented evidence R3 had negative results from two consecutive molecular assays to rule-out COVID-19. Resident #4 (R4) R4 was admitted on [DATE], with [DIAGNOSES REDACTED]. A Situation, Background, Assessment and Recommendation (SBAR)/Change of Condition (COC) Assessment Form dated 08/07/2020, documented R4 was confirmed positive for COVID-19 and was placed on transmission-based precautions. The medical record documented on 08/03/2020, R4 was tested and an outside laboratory reported a positive result of COVID-19. On 08/17/2020 and 08/18/2020, a negative result of COVID-19 was reported using the BD Veritor. On 08/20/2020, R4 was tested and an outside laboratory reported a negative result of COVID-19. The medical record revealed R4 had a negative molecular assay test followed by two negative [MEDICATION NAME] tests. The medical record lacked documented evidence R4 had negative results from two consecutive molecular assays to rule-out COVID-19. Resident #5 (R5) R5 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 09/07/2020, the BD Veritor reported a negative result of COVID-19. On 09/11/2020, R5 was tested and an outside laboratory reported a negative result of COVID-19. The medical record revealed R5 had one negative molecular assay test and one negative [MEDICATION NAME] test. The medical record lacked documented evidence R5 had negative results from two consecutive molecular assays prior to rule-out COVID-19. Resident #7 (R7) R7 was admitted on [DATE], with [DIAGNOSES REDACTED]. On 08/18/2020, a negative result of COVID-19 was reported using the BD Veritor. On 08/31/2020, R7 was tested , and an outside laboratory reported a negative result of COVID-19. The medical record revealed R7 had one negative molecular assay test and one negative [MEDICATION NAME] test. The medical record lacked documented evidence R7 had negative results from two consecutive molecular assays to rule-out COVID-19. Resident #9 (R9) R9 was readmitted on [DATE], with [DIAGNOSES REDACTED]. R9's medical record revealed on 08/18/2020, a negative result of COVID-19 was reported using the BD Veritor. On 08/20/2020, R9 was tested and an outside laboratory reported a negative result of COVID-19. The medical record revealed R9 had one negative molecular assay test and one negative [MEDICATION NAME] test. The medical record lacked documented evidence R9 had negative results from two consecutive molecular assays to rule-out COVID-19. The facility's Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 Policy (undated) revealed the following: The criteria for the test-based strategy for staff members who were symptomatic included -resolution of fever without the use of fever-reducing medications, and -improvement in symptoms, and -negative results from two consecutive respiratory specimens collected more than 24 hours apart using a Food and Drug Administration (FDA) authorized molecular [MEDICAL CONDITION] assay to detect [DIAGNOSES REDACTED]-CoV-2 Ribonucleic Acid (RNA). The criteria for the test-based strategy for staff members who were asymptomatic included: -negative results from two consecutive respiratory specimens collected more than 24 hours apart using a Food and Drug Administration (FDA) authorized molecular [MEDICAL CONDITION] assay to detect [DIAGNOSES REDACTED]-CoV-2 Ribonucleic Acid (RNA). Staff Member #1 On 09/17/2020 in the afternoon, the IP reported Staff Member #1 tested positive for COVID-19 on 08/11/2020. On 08/12/2020, Staff Member #1 was tested , and an outside laboratory reported a positive result of COVID-19. On 09/18/2020 at 11:25 AM, the IP conveyed on 08/31/2020 and 09/01/2020, Staff Member #1 was tested , and negative results of COVID-19 were reported using the BD Veritor machine. The IP confirmed Staff Member #1 had two negative [MEDICATION NAME] tests. Staff Member #2 On 09/17/2020 in the afternoon, the IP reported Staff Member #2 complained of cough and body ache on 08/11/2020 and tested positive for COVID-19. The IP conveyed on 08/31/2020 and 09/04/2020, a negative result of COVID-19 was reported using the BD Veritor. The IP confirmed Staff Member #2 had two negative [MEDICATION NAME] tests. Staff Member #3 On 09/17/2020 in the afternoon, the IP reported Staff Member #3 tested positive for COVID-19 on 09/01/2020. The IP conveyed Staff Member #3 was tested on [DATE]. An outside laboratory reported a negative result of COVID-19. On 09/14/2020, a negative result of COVID-19 was reported using the BD Veritor machine. The IP confirmed Staff Member #3 had one negative molecular assay test and one negative [MEDICATION NAME] test. Staff Member #4 On 09/17/2020 in the afternoon, the IP reported Staff Member #4 tested positive for COVID-19 on 08/22/2020. On 09/02/2020 and 09/03/2020, a negative result of COVID-19 was reported using the BD Veritor. The IP confirmed Staff Member #4 had two negative [MEDICATION NAME] tests. The facility lacked documented evidence the staff members had received negative results from two consecutive molecular assays prior to returning to work. 2) State Laboratory License On 09/17/2020 at 10:25 AM, the IP conveyed the facility received the BD Veritor machine in August 2020 and started to use the BD Veritor machine on the second day of receipt. The IP confirmed the BD Veritor machine was used to rule out COVID-19 for residents and to clear staff members to return to work. The IP was not aware if the facility had obtained a CLIA Certificate of Waiver and a State Laboratory License for the use of the BD Veritor machine. On 09/17/2020 at 12:20 PM, the Assistant Administrator provided the Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver, but not the State Laboratory License. On 09/17/2020 at 2:45 PM, the Administrator confirmed the facility had applied for the State Laboratory License but had not received it.