STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRANSITIONAL CARE OF LAS VEGAS, LLC	5650 SOUTH RAINBOW BLVD 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to 1) ensure a Certified Nursing Assistant (CNA) performed a temperature check, answered the COVID-19 screening questionnaire and performed hand hygiene prior to entering the COVID-19 Unit and starting work per the facility's protocol, 2) ensure the staff followed the facility's policy on wearing the required Personal Protective Equipment (PPE) prior to entering rooms on transmission-based precautions, 3) ensure the paramedics wore the required PPE prior to entering a room on transmission-based precautions, 4) ensure the housekeepers discarded used PPE prior to exiting rooms on transmission-based precautions and 5) provide documented evidence of efforts to obtain N95 masks and to provide N95 fit testing for their staff. Findings include: 1) Screening On 09/15/2020 at 2:59 PM, a CNA donned PPE and entered the COVID-19 Unit, without being screened, or performing hand hygiene. On 09/15/2020 at 3:01 PM, a Licensed Practical Nurse (LPN) indicated screening before entering the COVID-19 Unit should have consisted of the staff member having their temperature taken, completing a questionnaire for signs and symptoms of COVID-19, and performing hand hygiene with soap and water at the sink located in the screening area. On 09/15/2020 at 3:11 PM, the CNA indicated all staff members working in the COVID-19 Unit should be screened before entering the unit. The CNA verbalized screening should consist of the staff member having their temperature taken, completing a questionnaire for signs and symptoms of COVID-19, and performing hand hygiene with soap and water at the sink located in the screening area. The CNA acknowledged not taking and recording their temperatures, completing the questionnaire, and performing hand hygiene with soap and water before entering the unit. On 09/15/2020 at 3:19 PM, the Infection Preventionist (IP) indicated all staff members working on the COVID Unit should have been screened at the start of their shift. The IP indicated screening should have consisted of the staff members having their temperature taken, completing a questionnaire for signs and symptoms related to COVID-19, and performing hand hygiene with soap and water. The facility policy Pandemic Infection Control Measure revised on 03/13/2020, documented to screen all employees for influenza-like illness before coming on duty and send any symptomatic employees' home. 2) Staff not wearing required PPE in a room on transmission-based precautions On 09/15/2020 at 11:28 AM, an LPN was observed exiting a resident's room who was on transmission-based precautions. The LPN was not wearing a face shield. A sign posted outside of the resident's room indicated the Personal Protective Equipment (PPE) required before entering a resident's room on transmission-based precautions should have consisted of a KN95 mask or an N95 mask, a face mask, an isolation gown and a face shield. On 09/15/2020 at 11:30 AM, the LPN indicated the appropriate PPE when entering a resident's room on transmission-based precautions should have consisted of a KN95 mask or an N95 mask, a face mask, an isolation gown, gloves, and a face shield. The LPN acknowledged a face shield should have been worn. The facility's Infection Prevention and Control Policy and Procedure (undated) documented, the facility implements infection control strategies to reduce risk of transmission of COVID-19, by implementing actions according to the Centers for Disease Control and Prevention (CDC). On 09/15/2020 at 11:24 AM, a CNA was observed coming out of a room on transmission-based precautions without a face shield or goggles. The CNA indicated working for the facility for three months. The CNA recently received training on infection control and what PPE was required to be worn inside rooms on transmission-based precautions. The CNA confirmed a face shield or goggles were not worn. The CNA explained because prescription eyeglasses were used, a face shield or goggles was not needed. On 09/15/2020 at 11:35 AM, a Wound Care Technician and a Wound Care Nurse were observed exiting a room on transmission-based precautions. The Wound Care Technician and the Wound Care Nurse did not have a face shield on. The Wound Care Nurse indicated because prescription eyeglasses were used, the face shield provided by the facility was not worn. The Wound Care Technician indicated leaving the face shield in the other wound care cart. On 09/15/2020 at 3:16 PM, the IP explained prescription eyeglasses were not considered adequate protection when entering rooms on transmission-based precautions. The IP indicated staff were expected to follow the precautions required when entering rooms on transmission-based precautions. 3)Paramedics not wearing required PPE in a room on transmission-based precautions. On 09/15/2020 in the morning, signage was observed posted outside of rooms on transmission-based precautions which explained visitors and personnel, would need to speak to a nurse before entering. An N95 mask or a KN95 mask, a surgical mask worn over the N95 mask or KN95 mask, gown and a face shield would need to be worn prior to entering the room. On 09/15/2020 at 11:32 AM, two paramedics were observed pushing a resident who was returning from [MEDICAL TREATMENT] on a stretcher into a room on transmission-based precautions. The paramedics transferred the resident from the stretcher to the bed. The paramedics were wearing a KN95 mask and gloves. The paramedics did not don a gown, wear a surgical mask over the KN95 mask and a face shield. On 09/15/2020 at 11:34 AM, a Licensed Practical Nurse (LPN) #1 indicated being an agency nurse and worked at the facility two to three times a week. LPN #1 explained staff were required to wear a KN95 mask, a surgical mask worn over the KN95 mask, a face shield or goggles, a gown and gloves prior to entering rooms on transmission-based precautions. LPN #1 indicated not being sure what the paramedics were required to wear when entering rooms on transmission-based precautions. On 09/15/2020 at 11:53 AM, LPN #2 indicated staff, providers, vendors, visitors were supposed to wear the required PPE when inside rooms on transmission based precautions, which included a gown, gloves, face shield or goggles, KN95 mask and a surgical mask worn over the KN95 mask. The facility's policy COVID-19 Testing and Response Plan (undated) - documented all visitors were informed of risk and instructed on proper PPE use prior to entering any unit. Appropriate signage would be posted. 4) Inappropriately Discarding PPE On 09/15/2020 at 10:55 AM, Housekeeper #1 was observed cleaning room [ROOM NUMBER] on transmission-based precautions. Housekeeper #1 was wearing a KN95 mask, a surgical mask over the KN95 mask, a face shield, a disposable gown and gloves. Housekeeper #1 was observed going back and forth to the cart, which was outside of the room to get the cleaning supplies. Housekeeper #1 was observed with the same gown and gloves while going back and forth to the cart. On 09/15/2020 at 11:02 AM, Housekeeper #1 exited the room, wearing the same gown and gloves and threw the used gown and gloves in the housekeeping cart. Housekeeper #1 confirmed it was a mistake to throw the used gown and gloves in the cart and should have discarded the used PPE in the garbage can inside the resident's room prior to exiting. On 09/15/2020 at 11:22 AM, Housekeeper #2 indicated PPE used inside rooms on transmission-based precautions should be discarded inside the room and not taken out of the room. The PPE should not be discarded in the Housekeeper's cart because they were considered dirty. On 09/15/2020 at 11:45 AM, Housekeeper #3 was observed going out in the hallway from inside a room on transmission-based precautions, wearing a disposable gown and gloves. Housekeeper #3 walked several steps to the housekeeping cart, which was in the middle of the hallway, while wearing the gown and gloves and proceeded to discard the gown and gloves in the cart. Housekeeper #3 confirmed the gown and gloves were soiled because it was used while cleaning the room on transmission-based precautions. Housekeeper #3 indicated the garbage can inside the resident's room was just emptied and Housekeeper #3 did not want to discard the soiled gown and gloves in the garbage can. On 09/15/2020 at 1:14 PM, the Director of Plant Operations indicated the housekeeping staff were expected to discard the soiled gown and gloves prior to leaving the resident's room on transmission-based precautions. The

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Director indicated the housekeepers should not have taken the soiled PPE out of the resident's room and should not have been discarded in the housekeeping cart. The Director indicated the housekeepers were expected to gather all needed housekeeping supplies prior to entering the resident's room and not to go back and forth to the cart and get supplies while wearing the same PPE. On 09/15/2020 at 2:15 PM, the Executive Director indicated the housekeepers should have been discarding the soiled PPE inside the resident rooms and not in their carts. On 09/15/2020 at 3:21 PM, the Infection Preventionist (IP) explained everyone who entered a room on transmission-based precautions should not be taking out the used gowns and gloves outside of the room. This applied to everyone, even to housekeepers who entered and cleaned the resident rooms. 5) N95 Masks and Fit Testing On 09/15/2020 in the morning, the Executive Director indicated the facility had no N95 masks and the staff were not fit tested for the N95 mask. The Executive Director indicated the facility provided the staff KN95 masks. On 09/15/2020 at 11:08 AM, a Respiratory Therapist (RT) indicated a KN95 mask, a surgical mask over the KN95, a gown, gloves and goggles would be worn prior to providing aerosol generating procedures to residents. The RT indicated the KN95 and mask would be discarded after each aerosol procedure was provided. The RT confirmed not being fit tested for an N95 mask. On 09/15/2020 at 11:53 AM, a Licensed Practical Nurse (LPN) was observed wearing a KN95 mask and a face shield. The LPN indicated not being fit tested for an N95 mask. On 09/15/2020 in the afternoon, staff members were observed on the COVID-19 Unit wearing a yellow jumpsuit, a KN95 mask, a face shield, and gloves. The PPE Count as of 09/14/2020 revealed the facility had 10,000 N95 masks and 785 KN95 masks. On 09/23/2020 at 2:54 PM, during a phone interview, the Executive Director confirmed the facility did not have N95 masks. The Executive Director confirmed the PPE Inventory on 09/14/2020 was not accurate. The 10,000 N95 masks listed in the inventory were KN95 masks. The Executive Director indicated it should have been corrected, to reflect the actual number of the KN95 masks they had. The Executive Director indicated the staff were provided a KN95 mask because it was difficult to obtain the N95 masks. The Executive Director indicated the facility had not done N95 fit testing for the staff since the start of March 2020, because the facility was only using KN95. On 09/23/2020 in the afternoon, the Regional Director of Operations explained the facility's policy was to use the KN95 mask because there was a shortage of the N95 masks. The Regional Director indicated working with six to seven vendors who could not get them the N95 masks. The Regional Director indicated the N95 masks were cost prohibitive. The Regional Director indicated it was their policy to use KN95 masks because they could not obtain N95 masks. The Regional Director indicated a lot of phone calls were made to obtain the N95 masks but the attempts or follow ups for the N95 masks were not documented. The facility lacked documented evidence of the facility's efforts to obtain the N95 masks and provide N95 fit testing for their staff.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on observation, interview, and document review, the facility failed to ensure staff wore the required Personal Protective Equipment (PPE) while conducting specimen collection for COVID-19 testing. Findings include: On 09/15/2020 at 1:09 PM, a Licensed Practical Nurse (LPN) conducted a specimen collection for COVID-19 testing on a staff member. The LPN was observed wearing a KN95 mask, a surgical mask, a face shield, and gloves. On 09/15/2020 at 1:15 PM, as the LPN was about to conduct specimen collection for the next staff member, the Inspector stopped the LPN, and questioned why an isolation gown was not worn. On 09/15/2020 at 1:16 PM, the Infection Preventionist (IP) and the Director of Nursing (DON), were both inside of the room while the testing was being conducted. They both verbalized being unaware of what the required PPE should have consisted of while conducting specimen collection for COVID-19 testing. On 09/15/2020 in the afternoon, the Executive Director acknowledged the required PPE while conducting a specimen collection for COVID-19 testing should have consisted of a KN95 mask or an N95 mask, a surgical mask, a face shield, an isolation gown, and gloves. The facility policy Testing for COVID-19 revised on 06/10/2020, documented PPE required for testing should consist of a gown, an N95 mask or a KN95 mask, gloves, and a face shield.