STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. BUILDING _____ B. WING _____	**04/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SILVER HILLS HEALTH CARE CENTER	**3450 N BUFFALO DR LAS VEGAS, NV 89129**

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, record review and document review, the facility failed to ensure an attempt to provide N95 fit testing for staff who worked with positive COVID-19 residents and failed to follow proper infection control practices while caring for a resident with COVID-19. Findings include: 1) On 04/24/2020 at 8:30 AM, the Administrator indicated the facility had a wide variety of N95 masks. The Administrator indicated staff would wear the N95 masks if they had direct interaction with the positive COVID-19 residents. On 04/24/2020 at 4:15 PM, the Administrator revealed the staff had not been fit tested for the N95 masks. The Administrator indicated they were working with a Nurse Practitioner on how to provide fit testing of the N95 masks for the staff. The Administrator could not provide written documentation of the facility's attempt to obtain the fit testing for the staff. The facility's Contingency and Crisis Plan Guidance For Critical Shortages (undated), documented fit testing would be facilitated with the support of local county health. 2) Resident #2 (R2) R2 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. Monitor the resident for fever, cough, shortness of breath, fatigued, diarrhea and or nausea. Place mask on resident, initiate droplet and contact isolation and notify the physician if symptoms were noted. On 04/24/2020 at 9:45 AM, the Administrator and the Infection Preventionist revealed it was a struggle to keep the resident isolated in the room, but they could not move R2 because they were concerned about resident rights. The resident refused to move to the Isolation Unit. The Infection Preventionist indicated the resident would refuse to keep the mask on, would attempt to go to the doorway and call staff to attend to the resident's needs and would refuse to have the door closed as the resident got anxious when the door to the room was closed. The Administrator, Assistant Director of Nursing (ADON), and Infection Preventionist felt it was better for the resident to remain isolated in the room because it would create a higher risk if the resident was transferred to the Isolation Unit and kept attempting to leave the unit to go back to the old room. The Weights and Vitals Summary from 04/19/2020 to 04/24/2020 revealed the resident's temperature readings: 04/20/2020 at 9:07 AM- 100.8 Fahrenheit 04/20/2020 at 3:30 PM- 100.1 Fahrenheit 04/20/2020 at 5:57 PM- 100.2 Fahrenheit 04/21/2020 at 4:00 AM-100.4 Fahrenheit 04/21/2020 at 2:01 PM- 101.4 Fahrenheit 04/21/2020 at 6:19 PM- 100.5 Fahrenheit 04/21/2020 at 8:17 PM-100.1 Fahrenheit 04/21/2020 at 8:20 PM- 100.1 Fahrenheit 04/22/2020 at 3:30 AM- 100.4 Fahrenheit 04/22/2020 at 4:39 AM-100.2 Fahrenheit 04/22/2020 at 4:23 PM-100.3 Fahrenheit 04/23/2020 at 5:13 AM-100.2 Fahrenheit 04/23/2020 at 7:06 AM-100.0 Fahrenheit On 04/24/2020 at 11:53 AM, the call light to the resident's room was on. The door to the room was open. A Certified Nursing Assistant (CNA) passed by the resident's room and did not answer the resident's call light. After 20 minutes, the resident was observed standing outside the room next to the isolation cabinet. The resident was not wearing any mask to cover the face. The resident attempted to call the staff to come to the room. After 12 minutes, the resident went inside the room without having any staff to answer the call light and address the resident's needs. Another CNA was observed coming from the Staff Lounge Room and was not wearing a mask. The CNA passed by the resident's room without answering the call light. The door to the room remained open. The call light remained on until 12:28 PM. Neither the CNA nor a nearby Registered Nurse attempted to remind the resident to stay within the room and wear a mask. On 04/24/2020 at 12:28 PM, a Registered Nurse (RN) was observed wearing an N95 mask and gloves and went inside the resident's room. The RN donned a clear plastic gown inside the room. Multiple used gowns (two blue plastic gowns, a hospital gown and two clear plastic gowns) were observed hanging by the wall and were piled on top of each other. The RN donned one of the clear plastic gowns. Two clear plastic bags were on the floor close to the doorway. The first plastic bag contained linen and the second plastic bag contained used personal protective equipment (blue plastic gowns and gloves). There were no dedicated trash bins for linen or trash inside the resident's room. After administering the resident's medications, the RN removed the clear plastic gown and threw it to hang on the top edge of the bathroom door. The RN removed the gloves and washed hands inside the bathroom and went outside the room. On 04/24/2020 at 12:45 PM, the RN confirmed the gowns were piled on top of each other on the wall close to the bathroom. The RN indicated the gowns were reused by staff and disposed of at the end of each shift. The RN confirmed there was no dedicated linen bin and trash bin inside the resident's room and the trash was on the floor. The RN indicated the trash bags should have been picked up by housekeeping and dedicated trash and linen bins should been placed inside the room. The RN confirmed throwing the clear plastic gown he used to hang on the top edge corner of the resident's bathroom door. On 04/24/2020 in the afternoon, the Administrator and Infection Preventionist indicated the gowns should not have been placed on top of each other while hanging on the wall and the resident should have had dedicated bins for trash and dirty linen inside the room. The Director of Nursing indicated the RN should not have thrown the used gown to hang on the bathroom door, because there was a risk of spreading droplets that could have been on the gown. On 04/24/2020 between 11:53 AM and 12:25 PM, the Registered Nurse (RN) referred to above was observed wearing gloves and interacting with a resident in room [ROOM NUMBER]B. The RN exited the room and was continuously observed walking to the nursing station down the hall, returning with a container of sanitizer while wearing the same gloves. The container was placed on the med cart. The RN went into room [ROOM NUMBER]B and performed a blood glucose check while wearing the same gloves. The RN left the room, disposed of the gloves at the med cart, returned to the room [ROOM NUMBER] and washed hands in the bathroom sink. The RN acknowledged the gloves should have been discarded and hands washed after exiting room [ROOM NUMBER]. The RN acknowledged hand sanitizing should have occurred at regular intervals.

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