STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295021	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER HEALTH & REHABILITATION CENTER OF LV, LP	**2945 CASA VEGAS STREET LAS VEGAS, NV 89169**

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** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview and document review, the facility failed to 1) properly establish and maintain an infection prevention and control program (IPCP) that included a system of surveillance designed to screen and identify possible communicable diseases or infections before a person could enter the facility; 2) ensure resident care staff were properly fit tested and trained on the use of N95 respirator and, 3) ensure contaminated personal protective equipment was removed prior to leaving an isolation- quarantine area. Findings include: 1) On 04/08/2020 in the morning, the Administrator indicated the surveillance program required visitors entering the facility to enter through the main entrance. The person would be screened for COVID-19 by completing a questionnaire and having their temperature taken and documented. Staff members could enter through the laundry entrance and would be screened with the same process prior to entering patient care areas. Other staff members could enter through the north entrance doors which would bypass the main entrance. The staff would have to walk through the unit hallway where patients have access to and pass 5 patient rooms before arriving at the nursing station on the unit so they could be screened. On 04/08/2020 at 9:10 AM, the Charge Nurse located at the nursing station indicated prior to beginning their shift, staff members were required to complete the facility-provided COVID-19 screening form, take their own temperatures, and place the completed sheets in a basket located at the nursing station. The Charge Nurse indicated staff members were required to report any positive answers on the screening report and all temperatures above 100.4 degrees Fahrenheit (F) to the charge nurse, otherwise the screening forms were collected each shift by the Administrator or Director of Nursing (DON). On 04/08/2020 at 9:15 AM, the facility provided two thermometers for staff use at the nursing station. Both thermometers were not working. One thermometer would not display a temperature (blank display) and the second thermometer's screen read low battery. The charge nurse was unaware the thermometers were not working and should have been made aware this by the staff. There was no other thermometers available to take temperatures. On 04/08/2020 at 9:25 AM, a Licensed Practical Nurse (LPN) indicated he/she had not completed the facility-required questionnaire and did not document a temperature as required prior to starting the shift. The LPN was unable to remember the temperature and did not provide a reason to why the required screening form had not been completed. On 4/8/20 in the afternoon, the DON and Administrator indicated the LPN was not following the screening process. The LPN should have been provided the COVID-19 questionnaire, had their temperature checked and documented prior to starting work. On 04/08/2020 at 9:50 AM, the Director of Nursing was observed entering the facility through the rear entrance and was interviewed on the procedure for staff entry into the building. The DON indicated just coming in and reporting to work and would complete the required screening and temperature check at the nursing station. By the DON entering at the rear entrance, the DON contradicted the Administrators process to be screened prior to entering the patient care areas when using the rear entrance next to the laundry room. To get to the nursing station for screening, the DON entered the patient care area near the kitchen and dining, would pass 7 patient rooms and walk through the hallways where patients have access to. On 04/08/2020 at 9:58 AM, the Director of Housekeeping indicated the facility's housekeeping staff were directed to report to the laundry room to complete the COVID-19 screening questionnaire and temperature checks were done prior to the beginning of their shift. The Director of Housekeeping indicated staff were required to report all positive answers on the questionnaire and temperatures above 100 degrees Fahrenheit. A review of the screening forms and temperature log kept by the housekeeping staff revealed 12 of 15 screening forms were completed between 04/07/2020 and 04/08/2020 had documented low temperature readings (93.2 - 95.5 degrees F) and one screening form did not have a temperature documented. The Director of Housekeeping indicated the forms were collected and reviewed daily by the Administrator. The Director of Housekeeping was not knowledgeable on what temperature reading were to be reported to determine if the thermometer was working properly. The Director of Housekeeping had no concerns for a temperature readings of 93.2 - 95.5 degrees F. On 4/8/20 in the afternoon, the DON and Administrator indicated thermometer readings of 93.2 - 95.5 degrees F should have alerted staff to have the thermometer checked for a low battery or calibrated because the readings were too low to be counted as accurate. A review of visitor screening forms that were completed documented five visitors were screened to enter the facility between 04/06/2020 and 04/07/2020 did not have a temperature documented on the form. On 4/8/20 in the afternoon, the DON and Administrator indicated when visitors entered the facility the temperatures should have been documented to determine if they were taken and no temperature was present. 2) On 04/08/2020 at 8:05 AM, the Administrator indicated the facility provided two variations of the N95 respirators for the facility's care staff, but did not conduct fit testing prior to issuing the respirators to staff. The Administrator explained he was unaware of the fit testing requirements, but provided the staff with education on the use, wear, and storage of the N95 respirator. On 04/08/2020 at 9:10 AM, the unit Charge Nurse was observed wearing a surgical-style face mask. The charge nurse reported not receiving fit testing and had not been issued an N95 respirator. The charge nurse explained some staff members elected to wear their own N95 or other protective respirator. On 04/08/2020 at 9:25 AM, an LPN indicated not completing a fit testing and was not issued an N95 respirator by the facility. On 04/08/2020 at 9:30 AM, a Certified Nurse Assistant (CNA) was observed wearing an N95 respirator. The CNA indicated not being fit tested or issued a N95 respirator by the facility, but obtained one from a box in the supply area. On 04/08/2020 at 9:58 AM, the Director of Housekeeping was observed wearing an N95 respirator. The Director of Housekeeping indicated being issued a surgical respirator by the facility but purchased a respirator from a local market. The Director of Housekeeping denied receiving fit testing or training on the use, wear, and storage of the N95 respirator. The Director of Housekeeping indicated hand washing and drying the N95 respirator after each wear. On 04/08/2020 at 11:28 AM, the Director of Physical Therapy indicated the facility's Physical and Occupational therapy services were provided by contracted personnel. The Director of Physical Therapy indicated therapy staff received copies of the guidelines posted by their corporate office. However they had not been fit tested or issued N95 respirators by their corporate office or by the facility. The Director of Physical Therapy indicated therapy staff evaluated residents who were being isolated for being presumptive or were having signs and symptoms of COVID-19. On 04/08/2020 at 11:34 AM, a Physical Therapy Assistant (PTA) reported had not received a fit test and was not issued an N95 respirator. The PTA stated he/she had not received training on the use, wear, and storage of the N95 respirators. On 04/08/2020 in the afternoon, the DON and Administrator provided the manufacturer's packaging for both variations of the N95 respirators provided by the facility. The manufacturer's packaging indicated fit testing was required prior to being issued an N95 respirator. The DON indicated residents who were in isolation for COVID-19 symptoms or presumptive and awaiting for results could possibly be ordered aerosol breathing treatments. The Administrator and the DON confirmed an N95 respirator was needed when administering aerosol treatments to these residents. The DON and Administrator confirmed the need for fit testing and staff wearing an N95 respirator. On 04/17/2020 at 2:30 PM, an inspection was conducted with the Director of Nursing (DON) in the Isolation -Quarantine area (ISO-Q). An Environmental Service (EVS) worker came out from an isolation room after cleaning and was wearing full

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 -** Many	(continued... from page 1) isolation personal protective equipment (PPE). The EVS worker left the ISO-Q area with the contaminated PPE on and entered the Aseptic area with the house keeping cart. The EVS worker was not aware the PPE should had been remove prior to leaving the isolation room. The DON confirmed the observation and verbalized the contaminated PPE should had been removed prior to exit the ISO-Q area.