STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295073	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL SPRINGS HEALTHCARE AND REHAB	8501 DEL WEBB BLVD LAS VEGAS, NV 89134

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 -** Some	**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: (1) a Housekeeping staff member performed hand hygiene after handling COVID-19 linen; (2) staff dedicated to the COVID-19 unit were using a fit-tested N95 respirator mask; (3) five residents wore a mask while outside the rooms or being transported to a medical appointment, and (4) signage was posted at the COVID-19 unit entrance to identify the isolation unit and the personal protective equipment (PPE) required before entry. Findings include: 1) Housekeeping Staff: On 07/23/2020 from 1:20 PM to 1:34 PM in the laundry room, a housekeeper tore open the plastic bags containing linen from the COVID-19 unit. The laundry touched the housekeeper's forearm and upper arm. The housekeeper did not perform hand hygiene after removing their gloves. Two laundry staff members confirmed the observation and revealed the plastic bags should not have been torn open. On 07/23/2020 at 2:05 PM, the Director of Staff Development (DSD) and the Infection Preventionist (IP) indicated the Housekeeping staff should not have torn open the laundry bags. The DSD and IP indicated the Housekeeper should have performed hand hygiene after handling contaminated laundry. On 07/23/2020 at 2:58 PM, the Director of Housekeeping Services (DHS) indicated the actions of the Housekeeping staff were unacceptable considering training had been repeatedly provided on hand hygiene and PPE use. The DHS explained the linen bags used for the COVID-19 unit disintegrated in the washer and should not have been torn open. 2) N95 Mask: On 07/23/2020 at 8:38 AM, the Assistant Director of Nursing (ADON) reported the COVID-19 unit was an isolation unit placed on droplet precautions. The ADON revealed a KN95 mask was required to be worn on the COVID-19 unit. On 07/23/2020 at 8:45 AM, the ADON reported facility staff members had not been fit tested for the N95 respirator masks. There were 60 N95 respirator masks on hand but had not been successful in obtaining fit tests for staff assigned to the COVID-19 unit. On 07/24/2020 at 9:57 AM, the DON, ADON, IP, and DSD indicated N95 respirator fit testing needed to be completed for safe use of N95 respirator masks. The DON, ADON, IP, and DSD revealed fit testing would be prioritized for staff dedicated to COVID-19 unit. On 07/24/2020 at 11:45 AM, a Registered Nurse (RN) assigned to the COVID-19 unit wore an N95 respirator. The RN reported the N95 respirator was purchased personally and had not been fit tested . The RN expressed a greater level of safety was felt wearing the N95 respirator rather than the KN95 mask provided by the facility. 3) Resident Face Masks: On 07/23/2020 at 8:05 AM, a Certified Nursing Assistant (CNA) transported a resident in a wheelchair from the 200 Hall to the front lobby without a facemask on the resident. The CNA revealed having forgotten to put a face mask on the resident. On 07/23/2020 at 8:23 AM, the Infection Preventionist (IP) reported face masks were required to be worn by residents when outside of their rooms. On 07/23/2020 at 12:00 PM, a resident was walking down the 300 Hall without a face mask. The resident walked past two CNAs and a nurse at the 300 nurse's station. On 07/23/2020 at 12:01 PM, a CNA indicated residents should wear a face mask and placed a face mask on the resident. On 07/23/2020 at 12:05 PM, a CNA transported a resident from the activity lounge to the resident's room. The resident's face mask was pulled underneath their chin, exposing their mouth and nose during transport. The Director of Food Services acknowledged the resident's face mask was pulled under their chin and reported residents should wear a face mask when outside of their rooms. On 07/23/2020 at 1:32 PM, a resident was walking through the hallway near the laundry room without wearing a face mask. A Registered Nurse (RN) acknowledged the resident was not wearing a face mask and indicated the resident should have been wearing a face mask while in the hallway. On 07/24/2020 at 8:54 AM, a resident was sitting in a wheelchair near room [ROOM NUMBER] and was not wearing a face mask. A Unit Manager confirmed the resident was not wearing a face mask and indicated residents were expected to wear face masks when outside of their rooms. On 07/24/2020 at 9:50 AM, a resident was sitting in a wheelchair in the 100 Hall Activity Lounge and was not wearing a face mask. The resident did not have a face mask to wear and indicated staff did not provide one to wear. A transportation staff member arrived to transport the resident to [MEDICAL TREATMENT]. The transportation staff member did not offer a face mask to the resident. A Unit Manager reported the resident should have been wearing a face mask when outside of their room. A review of the facility policy titled, Testing Policy for COVID-19 (undated), revealed residents who must regularly leave the facility for medically necessary purposes must wear a facemask whenever they leave their room. (4) COVID-19 Unit Signage: On 07/24/2020 at 9:56 AM, the ADON revealed the COVID-19 Unit had dedicated staff. The ADON expressed staff providing essential services such as wound care also entered the unit. On 07/24/2020 at 11:40 AM, the entrance to the COVID-19 unit did not have signage to identify the unit as an isolation unit. The double doors were not locked to prevent entry. A plastic bin containing gowns, gloves, and eye protection was placed outside the double doors. There was no signage to indicate the appropriate PPE required prior to entry. On 07/24/2020 at 11:42 AM, a Licensed Practical Nurse (LPN) and Registered Nurse (RN) verified there was no signage which identified the COVID-19 unit, or the PPE required to enter the unit. On 07/24/2020 at 11:50 AM, an RN assigned to the COVID-19 unit acknowledged there was no signage outside the entrance to the unit. The RN reported there had never been a sign at the unit entrance, but it was known by staff that it was the COVID-19 unit. On 07/24/2020 at 11:55 AM, the Assistant Director of Nursing (ADON) and Staff Development Coordinator acknowledged there should have been signage posted at the entrance of the isolation unit which indicated PPE was required before entry into the unit.

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