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	295037	A. BUILDING _____ B. WING _____	12/02/2020

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LAKE MEAD HEALTH AND REHABILITATION CENTER	**1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015**

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F 000	INITIAL COMMENTS	F 000		

This Statement of Deficiencies was generated as a result of a Focused Infection Control survey and Complaint investigations conducted in your facility on 12/02/2020, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483-Requirements for Long Term Care Facilities.

The census at the beginning of the inspection was 189.

There were four complaints investigated.

The sample size was five.

There were seven residents and nine staff members positive for COVID-19 at the time of the inspection.

There were 13 residents being monitored as Persons Under Investigation (PUI) following exposure to COVID-19 at the time of the inspection.

There were 12 newly admitted residents in the Quarantine Unit.

The investigation of regulatory compliance for Infection Control and Prevention (Tag F880) included:
- A review of the overall effectiveness of the Infection Control and Prevention Program, including policies and procedures.
- Review of Standard and Transmission-Based Precautions.
- Quality of resident care practices, including those with COVID-19 (laboratory-positive case), if applicable.

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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- The surveillance plans.
- Visitor entry and facility screening practices.
- Education, monitoring, and screening practices of staff; and
- Facility policies and procedures to address staffing issues during emergencies, such as the transmission of COVID-19.

The facility utilized the front lobby of Building B for staff members and essential visitors. A staff member reminded staff members and essential visitors to perform hand hygiene upon entry and to maintain social distancing. A temperature check and a COVID-19 signs and symptoms questionnaire were completed. The staff member provided a face mask and a face shield or goggles, which were required to be worn while in the facility.

The facility had designated the 1300 Hall as the Isolation Unit (Red Zone) for residents who tested positive for COVID-19. The staff members on this unit wore an N95 mask, a gown, gloves, and a face shield. Two nursing staff members were observed following Personal Protective Equipment (PPE) requirements in the unit.

The facility had designated the 1200 Hall the Quarantine Unit (Yellow Zone) for residents that had been exposed to COVID-19 and the 2100 Hall for newly admitted residents. The staff members on this unit wore a surgical mask, a gown, gloves, and a face shield. Three nursing staff members were observed following PPE requirements in the unit.

The 100, 200, 300, 400, 500, 1100, 2200 and 2300 Halls were COVID-free Units (Green Zone). The staff members wore a surgical mask and a

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face shield or goggles on this unit.

Staff members throughout the facility were observed using alcohol-based hand sanitizers and performing handwashing. Four Housekeeping staff members were observed cleaning high-contact surfaces with a hospital-grade disinfectant.

One Rehabilitative Aide, seven Certified Nursing Assistants, five Licensed Practical Nurses, two Registered Nurses, four Housekeepers, one Housekeeping Supervisor, the Director of Housekeeping, two Dietary Aides, the Dietary Manager, the Director of Central Supply, one Activities Assistant, one Physical Therapy Assistant, one Occupational Therapy Assistant, one Physical Therapist, one Unit Manager, and the Assistant Administrator revealed there were no concerns with the facilities PPE supply.

The facility's PPE count on 12/02/2020, documented the following: 10240 surgical mask, 5222 N95 mask, five KN95 mask, eight cases of small gloves, 41 cases of medium gloves, 28 cases of large gloves, 11 cases of extra-large gloves, 53 containers of Cavi wipes, 1378 washable gowns, 75 disposable gowns, 514 face shields, 197 goggles, and 42 bottles of hand sanitizer. The PPE count was verified by observation in the designated storage areas.

The facility provided staff education and training on the following: Infection Control, COVID-19 in Healthcare Facilities, COVID-19 Testing, Handwashing, COVID-19 Infection Control Preparedness, Tips for Social Distancing, Quarantine and Isolation During an Infectious Disease Outbreak, Disinfecting Items in Between

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Resident Usage, PPE Use, How to Manage Residents with Symptoms of COVID-19, Handwashing, Resident Handwashing Before Every Meal, Face Mask Use Guidelines, COVID-19 Steps for Success, Five Moments for Hand Hygiene, N95 Respirators, and Donning and Doffing PPE.

The following documents were reviewed during the inspection: Center Preparedness: Infection Prevention Strategies and Guidance for COVID-19, Managing COVID-19 in your Center, Emergency Staff, COVID-19 Center Reopening Guidelines and State Regulations, Emergency Plan, Comprehensive Emergency Management Plan, Long-Term Care Nursing Home Telehealth and Telemedicine Services, Returning to Work after Potential Exposure to Infectious Disease Outbreak and Infection Prevention and Control Plan, Emergency Preparedness Management Plan, Respiratory Protection Program, the Respiratory Surveillance Line List for Employees and Residents, and the Visitation Plans.
1) Complaint #NV00062637 with the following allegations could not be substantiated.

Allegation #1: The allegation the facility's staff used their own blood pressure cuffs could not be substantiated based on the following:

Two residents' blood pressure was taken by two Certified Nursing Assistants (CNAs). The CNAs used hand-held blood pressure equipment taken from the medication cart. The blood pressure equipment was stored in a plastic bag, along with a thermometer and a pulse oximeter.

The CNAs indicated the equipment was stored in the locked nurse's medication cart and CNAs

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asked the nurse to get the equipment for them. The CNAs indicated they did not use their own blood pressure equipment because the facility provided them and stored them in the medication cart. The CNAs had not observed other CNAs using their own equipment.

A licensed nurse indicated CNAs did not need to bring their own blood pressure equipment because it was provided for them by the facility. The licensed nurse had not observed any CNAs using their own equipment.

Allegation #2: The facility used different equipment throughout the day to take the resident's blood pressure could not be substantiated based on the following:

Two residents' blood pressure was taken. The CNA taking the blood pressure used hand-held blood pressure equipment taken from separate medication carts for each of the residents respectively. The blood pressure equipment was stored in a plastic bag. When taking the blood pressure, the CNA wore gloves and used bleach solution wipes for wiping down the equipment before and after use.

Two residents revealed no issues with their blood pressure being taken. The residents indicated they were aware the equipment was reused, and CNAs wiped down the equipment before and after use.

Two CNAs indicated blood pressure equipment was stored in the nurse's medication cart in a plastic bag to indicate it had been sanitized. The CNAs indicated it was possible to use different equipment to check a resident's blood pressure if

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the blood pressure equipment was taken from two separate medication carts. The CNAs indicated the process for using the blood pressure equipment was the same regardless of whether the blood pressure equipment was different. The CNAs indicated the blood pressure equipment was sanitized before and after each use and was checked for working condition by checking the line-up of the blood pressure equipment's gauge. If a resident's blood pressure did not match their baseline, they re-checked the blood pressure a second time or obtained different blood pressure equipment.

A licensed nurse indicated the resident of concern wanted to ensure an accurate blood pressure reading by having their own blood pressure equipment and did not want reused equipment. The licensed nurse indicated the facility's policy was to reuse and sanitize the blood pressure equipment before and after use and ensure the equipment was working by checking the line-up of the blood pressure equipment's gauge and re-checking the blood pressure a second time if the blood pressure was extremely high or low.

Allegation #3: Blood pressure cuffs were not professionally calibrated could not be substantiated based on the following:

Two residents' blood pressure was taken by CNAs using hand-held blood pressure equipment taken from medication carts. When taking the blood pressure, the CNAs checked the blood pressure equipment to see if it was working by checking the line-up of the blood pressure equipment's gauge. The CNAs indicated they checked the gauge to see if it was lined up in the correct position, then they took the resident's

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blood pressure. The CNAs indicated they had not calibrated blood pressure equipment because the blood pressure equipment often became worn out after three months and they disposed of it.

A licensed nurse indicated blood pressure equipment was sent to the manufacturer for calibration if it lasted that long. The licensed nurse indicated the blood pressure equipment did not last longer than three months, so the equipment was disposed of and calibration was not necessary. The licensed nurse indicated CNAs were trained to check for working condition of the equipment during each use. If equipment appeared faulty, the CNAs were to dispose of it. Manufacturer's instructions for the blood pressure equipment utilized at the facility, documented a full check of calibration was recommended every two years.

2) Complaint #NV00062603 with the following allegations could not be substantiated.

Allegation #1: A resident got COVID-19 because the facility had not isolated another resident who returned to the facility from the hospital could not be substantiated based on the following:

Two residents transferred from the hospital to the facility were observed residing on the New Admission/Readmission (Yellow) unit.

The resident of concern's legal guardian revealed the resident was admitted to the New Admission/Readmission Unit and quarantined for 14 days.

Two licensed nursing staff and the Infection Preventionist (IP) revealed residents transferring

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from the hospital were quarantined in the New Admission/Readmission unit for a period of 14 days. If the residents remained symptom free and negative for COVID-19, they were moved to the Clean (Green) unit. The Infection Preventionist revealed the resident who returned to the facility from the hospital was quarantined upon entry. The alleged resident's medical record revealed they were transferred from the hospital and placed in the new admission/readmission unit and isolated for a period of 14 days.

The facility's COVID-19 policy on new admissions/readmissions documented newly admitted residents and readmitted residents were required to quarantine in isolation on the designated New Admission/Readmission unit.

Allegation #2: The facility staff told the resident they would have to sign a discharge paper if they wanted to exercise outside the facility on the sidewalk or parking lot, because staff did not trust the resident to stay away from other people could not be substantiated based on the following:

The resident of concern was observed mobile in a wheelchair outside with a staff member.

Two residents revealed they could go outside to get fresh air when they wanted.

A licensed nurse and the Director of Rehabilitative Services indicated the resident of concern had a physician's order for physical therapy five times per week. The resident was working on upper and lower body strengthening. The licensed nurse indicated the facility used to have a sign out log for residents wishing to go out of the building, but they no longer used it because

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residents were not going out of the building during COVID-19. The licensed nurse indicated the resident of concern had not needed to sign a discharge paper because the resident went outside daily for physical therapy. The Director of Rehabilitative Services indicated 50% of the therapy was completed outside daily. The physical therapy daily treatment notes documented the resident self-propelled the wheelchair outdoors around the facility.

Allegation #3: The facility had not followed guidelines when they admitted a resident to the COVID-19 exposed Unit, gave a resident a roommate, and surrounded a resident with COVID-19 exposed residents, thus making a resident COVID-19 positive could not be substantiated based on the following:

Two residents who transferred from the hospital to the facility were observed residing on the New Admission/Readmission (Yellow) unit. The residents were in private rooms. The facility had a separate Persons Under Investigation (PUI) unit, which included residents who were potentially exposed to COVID-19. The facility followed Centers for Disease Control and Prevention (CDC) guidelines related to isolation of residents and separation of units.

The resident of concern's legal guardian revealed the resident was admitted to the New Admission/Readmission unit and the facility had a separate PUI unit. The legal guardian revealed the resident had wanted a private room upon admission to the New Admission/Readmission unit, but one was unavailable, so the resident shared a room with another newly admitted resident. The legal guardian was unaware

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whether the resident had contracted COVID-19 prior to or after admission to the facility and felt the facility followed CDC guidelines.

The IP revealed the facility's policy for admitting and readmitting was to place the resident on the New Admission/Readmission unit to quarantine for a period of 14 days. The facility attempted to place residents in a private room based on availability. If a resident needed to be cohorted, they were placed with another resident with the same or like admission date. The resident of concern was placed with a resident with a similar admission date. The resident of concern had tested positive for COVID-19 during the quarantine period on the New Admission/Readmission unit and subsequently moved to the COVID-19 Unit. The IP conducted contact tracing and root cause analysis but was unable to determine whether the resident of concern contracted COVID-19 prior to or while at the facility.

The resident of concern's medical record revealed the resident was admitted to the New Admission/Readmission unit and cohorted. The facility color coded map for the time period the resident of concern was admitted, documented the resident was admitted to the New Admission/Readmission Unit. The map documented the facility had a separate PUI unit for residents who were potentially exposed to COVID-19 at the time of the resident of concern's admission. The facility followed CDC guidelines related to admitting residents, isolating residents, separating units and cohorting residents.

Allegation #4 a newly admitted resident was in the COVID-19 exposed area, and shared the

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same staff as the COVID-19 positive residents could not be substantiated based on the following:

Two licensed nurses, two CNAs and the IP, revealed the facility had dedicated staff working the New Admission/Readmission unit, the PUI unit and the COVID-19 unit. The two licensed nurses and two CNA's revealed they did not float to other units and remained at their assigned unit. A facility COVID-19 policy and staffing schedules revealed dedicated staff were assigned to work the New Admission/Readmission and PUI units. The facility indicated they followed CDC guidelines.

3) Complaint #NV00062432 with the following allegations was substantiated without deficiencies.

Allegation #1: a resident contracted COVID-19 because the resident was transferred recklessly from a COVID-19 free facility to a facility with positive COVID-19 cases could not be substantiated based on the following:

Two residents indicated they had no issues with admission to the facility. They indicated the process went well.

The Admissions Coordinator indicated when a resident was admitted, the discharging facility's liaison was notified of the facility's COVID-19 status. The Admissions Coordinator recalled the resident of concern and indicated informing the liaison from the discharging facility and the legal guardian the facility had COVID-19 positive cases. The legal guardian indicated the resident of concern's admission to the facility was

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approved and the legal guardian knew the facility had COVID-19 positive cases. The legal guardian indicated the resident was admitted to the facility because they were better equipped to address the resident of concern's behavioral issues than the discharging facility. A History and Physical and Physician's progress note documented the resident of concern was unhappy at the discharging facility and felt psychosocial needs were not being met.

Allegation #2: A resident was not able to go off of the facility's property to go to the store because the resident was told they could potentially get COVID-19 was substantiated without deficiencies based on the following:

Two residents indicated they were able to go outside and get fresh air as needed but were not able to go off the property because outings were temporarily suspended during COVID-19 to ensure all residents' safety.

A licensed nurse, the Activities Director and the IP indicated individual and group outings were temporarily suspended during the COVID-19 pandemic to ensure all resident's safety. Residents were able to attend physician and medically necessary appointments. Residents were able to remain outdoors on the property to get fresh air but were encouraged to remain in their rooms as much as possible. The facility followed their COVID-19 Tool Kit policy which documented outings were temporarily suspended and residents were encouraged to remain in their room to the extent possible.

Allegation #3: The resident was supposed to be transferred to a smoke-free facility because the

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facility knew the resident's views on smoking could not be substantiated based on the following:

The Admissions Coordinator indicated when a resident was admitted, the discharging facility's liaison was notified the facility was a smoking facility. The Admissions Coordinator recalled the resident of concern and indicated informing the liaison from the discharging facility and the legal guardian for the resident of concern, the facility was one of a few in the city that allowed smoking. The Admissions Coordinator indicated being informed by the discharging facility's liaison the resident smoked, however, found out later the resident did not smoke. The legal guardian indicated the resident of concern's admission to the facility was approved and the legal guardian knew the facility was a smoking facility. The legal guardian indicated the resident was admitted to the facility because they were better equipped to address the resident of concern's behavioral issues than the discharging facility. Review of the resident's care plan revealed the interdisciplinary team was made aware of the resident's preference of non-smoking after the resident's admission and were in the process of researching smoke-free facilities for the resident's discharge. A Progress Note documented the facility's attempt to place the resident of concern in a room furthest from the smoking break area and the resident refused.

4) Complaint #NV00062402 with the following allegation could not be substantiated.

Allegation #1 a resident was exposed to and inhaled cigarette smoke because residents and staff smoked by windows, doors and ventilation

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systems, which caused the smoke to drift inside the facility could not be substantiated based on the following:

The Smoking break area was observed to be in an outdoor courtyard away from all resident care areas. There were five residents smoking. The five residents were gathered in the courtyard and smoking about 30 feet away from the facility's entrance/exit door, windows and vents. On another observation of the Smoking Break Area, three residents were observed smoking about 30 feet away from the facility's entrance/exit door, windows and vents. Four staff members were observed smoking outside about 15 feet away from the front entrance/exit door of the building, windows and vents.

The resident of concern's room, four hallways in the Clean Unit and one hallway in the PUI Unit were observed. There were no offensive odors identified. Three residents indicated they smoked any time of day they wanted in the Smoking break area and were required to be at least 20 feet from the entrance/exit door. A licensed nurse and a CNA indicated residents smoked any time of day they wanted and were required to be at least 20 feet away from the entrance/exit door. A Safe Smoking Policy documented smoking occurred in designated locations environmentally separate from all resident care areas.

The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295037	A. BUILDING _____ B. WING _____	12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEAD HEALTH AND REHABILITATION CENTER	**1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 14 There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.	F 000		