STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	**1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as the result of a State Licensure COVID-19 Focused Infection Control Survey conducted in your facility on 01/20/21. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for 56 Residential Facility for Group beds for elderly and disabled persons, and/or Assisted Living, Category II residents, and 16 Alzheimer's Disease, Category II residents. The census at the time of the survey was 37. Six resident records and two staff records were reviewed. There were six COVID-19 (COVID) positive residents in the facility at the time of the survey. Four residents were located in the Memory Care Unit and two residents were located in the Assisted Living Unit. There were two COVID positive staff members at the time of the survey. Both staff members tested positive on 01/15/21 and one staff member was allowed to continue worked in the facility. The facility was not following the Centers for Disease Control and Prevention (CDC) symptom-based or test-based strategy to determine when a staff member was able to return to work. The investigation of regulatory compliance for Infection Control and Prevention included: Observations: - The front desk receptionist measured the temperature of the health facilities inspectors prior to entry into the facility. The receptionist screened the health facilities inspectors with a questionnaire regarding COVID symptoms and travel history. - The front desk receptionist wore a KN95 mask. - Posting signage related to wearing a mask and social distancing were posted on the front door of the facility. - Alcohol Based Hand Rub (ABHB) dispensers were located at the front entrance of the facility, at the front counter, and throughout the facility. - The facility stored their personal protective equipment (PPE) in an unused resident room, a storage room, and in the Administrator Designee's office. The facility had a stock of	0000		

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	(1,500) gowns, (135,000) pairs of gloves, (770) KN95 masks, (10,250) surgical masks, (90) face shields, (10) goggles, (56) gallons of ABHB, (36) containers of disinfecting wipes, (60) 3M 8210 N95 masks, and (248) of the Dasheng, DTC3X Niosh N95 masks. - PPE stations were located outside each COVID positive resident's room and inside the main entrance door of the Memory Care unit. - Posting signage related to donning PPE before entering the COVID positive resident rooms was posted on each of the resident's room doors and at the entrance of the Memory Care unit. - All staff in the Assisted Living unit were donning a face covering and a face shield. - All staff in the Memory Care unit were donning a gown, gloves, a Dasheng, DTC3X Niosh N95 mask and a face shield. - All residents in the Memory Care unit were social distancing. Resident's in the Assisted Living unit were not observed outside of their rooms. Interviews: The Administrator Designee verbalized the following: - A resident had been sent out to the hospital due to gastrointestinal symptoms and a low-grade temperature on 12/09/20 and tested positive at the hospital on 12/10/20. The resident had been seen by an outside wound care nurse. - All residents were tested on 12/14/20. All residents were already in private rooms. - All residents family and guardians were notified of the positive case on 12/11/20 by mail. - The facility had designated care staff for the six positive residents. - All Caregiver staff were completing all of the housekeeping duties in the COVID positive resident rooms. - The facility was requiring all staff to wear a face shield at all times. - The facility was only allowing individual activities. - All residents were required to maintain at least six feet of distance between each other when they were in the common areas (living room, dining room) to adhere to social distancing guidelines. - All visitors, employees and essential healthcare workers were required to have their temperatures taken and screened with a questionnaire about COVID symptoms and travel history before entry into the facility. All visitors were required to practice hand hygiene, social distancing, and wear			

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	appropriate PPE. - Infection control training to include hand hygiene and donning and doffing of PPE was last provided to staff on 11/25/20. The Vice President of Operations verbalized the following: - Meals were provided to residents in their private rooms in the Assisted Living unit and at least six feet apart or at separate dinning tables in the Memory Care unit. Disposable dishware was being used. - All residents returning from a hospital stay or after receiving outside treatment were required to isolate in the resident's room for 14 days. - Temperature checks for residents would be conducted at least once a day for non-positive residents and at least once a shift (3 times a day) for COVID positive residents. - Remind all staff at the beginning of each shift to don the appropriate PPE throughout their shift. - High touch surfaces would be disinfected using disinfecting wipes, a disinfectant-deodorizer-cleaner (Buckeye E22), and a fogger disinfectant (VITROTAB). - The facility had a process in place to contact the State Office of Public Health Investigations and Epidemiology (OPHIE) of a suspect or positive case of COVID. - There were no employees medically cleared and fitted for the use of a N95 mask. Record Review: - A facility infection control policy comprised of recommendations from the CDC and local health authorities regarding isolation, quarantine, and aseptic areas in the scenario of a resident being identified as positive for COVID. The policy included a component to cohort residents and assign dedicated staff members to residents who were tested and may have been identified as positive for COVID. - Facility policies and procedures to address standard and transmission-based precautions for COVID. - Facility policies and procedures to address visitor entry and facility screening practices including screening questions, hand sanitization and temperature checks. - Facility policies and procedures to address infection control, dining, and social distancing practices and examples. - Facility policies and procedures to address resident laundry process. - Education, monitoring and screening practices of staff including temperature checks, hand washing and			

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	disinfecting and sanitizing practices. - Facility policies and procedures to address staffing issues during emergencies, such as the transmission of COVID. - Facility's Respiratory Protection Program. - Facility in-service education and employee sign-in sheets for training on procedures related to appropriate donning and doffing of PPE. The findings and conclusions of any investigation by the Health Division 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. The following deficiency was identified:			
0593 SS= F	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on interview and document review, the facility failed to provide a safe environment for residents (and staff) by not 1) failing to have staff fit tested for N95 respirator masks (N95s), 2) provide staff education on the appropriate procedure for doffing of Personal Protective Equipment (PPE) for 3 of 3 employees, and 3) follow the Centers for Disease Control and Prevention (CDC) symptom-based or test-based strategy to determine when a staff member was able to return to work. Findings include: Fit Testing of N95 Masks On 01/20/21 at 11:28 AM, the Vice President of Operations verbalized approximately 50% of the facility staff had failed a N95 mask Fit Test due to improper size of the N95 mask. The facility had purchased Dasheng, DTC3X Niosh N95 masks and the staff dedicated to care for COVID-19 (COVID) positive residents were instructed to don the masks after the first resident tested positive on 12/10/20. The Vice President of Operations verbalized the Dasheng, DTC3X Niosh N95 masks did not require a Fit Test to be completed to be donned. On 01/20/21 at 12:11 PM, an	0593	Tag 0000 Comments: We sincerely appreciate the thorough review by the Inspectorsfor our Infection Control Survey conducted on 01/21/21 and the Observationsshared in this report. In the Observations comments, we further appreciated theacknowledgement that from the point of entry through the observationsthroughout the community, appropriate screening of visitors and personnel,masking, face shield use, signage, social distancing, hand sanitizing was occurring,and proper placement of PPE was observed as well as supplies being plentifulwas noted. The comprehensive notesprovided in the Inspectors Comments portion of this report served to encourageand validate the ongoing effort by all team members in the community. We want to note that on January 26th, 2021 100%of the team members and residents tested COVID negative., Testing of teammembers has occurred every 10 days and recently was adjusted to every 14 daysper policy even though all willing residents and team members have beenvaccinated and vaccination scheduling continues to be offered. Tag 0593	04/02/2021

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	opened box of Dasheng, DTC3X Niosh N95 masks was located in the staff break room in the Memory Care unit. The box had a yellow sticky note on the side of the box. The sticky note was undated and documented, "All COVID/Isolation. Please wear one and replace blue medical mask after done with each resident." The Dasheng, DTC3X Niosh N95 mask box documented approved respirators shall be selected, fitted, used and maintained in accordance with the Occupational Safety and Health Administration (OSHA) and other applicable regulations. The Use Instructions, on the box, documented before the use of the respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 Code of Federal Regulations 1910.134 such as training and fit testing. On 01/20/21 at 12:17 PM, in the Memory Care unit, the Resident Assistant confirmed the Resident Assistant donned a Dasheng, DTC3X Niosh N95 mask. The Resident Assistant verbalized not having been Fit Tested for the mask and confirmed the Resident Assistant should not be providing care to COVID positive residents. On 01/20/21 at 1:55 PM, the Vice President of Operations confirmed the staff providing care to COVID positive residents had not been Fit Tested for the Dasheng, DTC3X Niosh N95 mask. The Vice President of Operations confirmed the facility had not followed the facility's Respiratory Protection Program. The facility policy titled, "COVID-19 Respiratory Protection Program," dated 11/13/20, documented prior to a designated staff member providing care to residents positive for COVID, the staff member would be Fit Tested for a N95 mask. Doffing of PPE On 01/20/21 at 12:14 PM, in the Memory Care unit, the Resident Assistant verbalized doffing of PPE as removing the gown first, then the facemask, then the gloves. The Resident Assistant verbalized the Resident Assistant's hire date with the facility was 12/18/20, and had been shown by demonstration by another staff member how to don/doff PPE. The Resident Assistant verbalized the Resident Assistant did not sign any In-Service training nor did		1) Fit testing kits are on site in Fernley Estatesand fit testing will be conducted by the leadership team for the team members priorto being assigned to provide dedicated care for any resident testing positive. Ateam member who fails the fit test will not be assigned. 2) Training on proper use of PPE (donning and doffing)was conducted in an all staff training on February 17, 2021. PPE training continuessince that February date and will be provided by the community leadership team.Pages 28, 30 & 31 of the COVID Guidance Manual demonstrate the step-by-stepprocess of CDC for donning and doffing and will continue to be part of all PPEtraining. Training sign in documents will be maintained in employee files. 3) The COVID Guideline Manual has been updated as of2/6/21 with reference to Team Member Illness Symptoms and Notification ofIllness and COVID Positive Team Member Communication Form and clearance for returnto work. CDC guidance will be followed. Additional COVID policies have beenupdated with input from the DPBH Infection Control Consultant and new CDCguidance with the newest policies activated on 4/1/21 and will be on site forreview as advised by the Deputy Administrator of the Division of Public andBehavioral Health.	

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	the facility provide any videos or documentation on the appropriate way to don/doff PPE. On 01/20/21 at 12:21 PM, the Administrator Designee verbalized all staff were trained by demonstration on the proper use of donning/doffing of PPE, using the CDC guidelines, on 11/25/20. On 01/20/21 at 12:23 PM, the Administrator Designee verbalized doffing of PPE as removing the gown first, then the facemask, then the gloves. On 01/20/21 at 2:41 PM, the Wellness Director verbalized doffing of PPE as removing the gown first, then the gloves, then the facemask. On 01/20/21 at 2:44 PM, the Administrator Designee confirmed the Administrator Designee, Resident Assistant and the Wellness Director had not followed the training provided on 11/25/20 or the facility policy on donning/doffing of PPE. An All Team Meeting dated 11/25/20, documented an In-Service training was provided to all staff members regarding the appropriate donning/doffing of PPE, with printouts from the CDC demonstrating the order in which PPE was to be donned and doffed. The facility policy titled, "COVID-19 Guideline Manual," dated 03/18/20, documented before caring for residents with confirmed or suspected COVID-19, staff members must be trained on how to put on and take off PPE. The policy referenced the CDC guidelines on donning/doffing PPE and outlined the proper removal of PPE was to remove gloves first, then remove gown, perform hand hygiene, remove face shields or goggles, remove respirator or facemask, then perform hand hygiene for a final time. Staff Returning to Work On 01/20/21 at 10:34 AM, the Administrator Designee verbalized the Maintenance Director was 1 of 2 staff members having tested positive on 01/15/21, and had continued to be allowed to work in the Memory Care unit as the Maintenance Director was not showing any signs or symptoms of COVID. On 01/20/21 at 10:39 AM, the Vice President of Operations verbalized the Maintenance Director had set up an office in the Memory Care unit and had not been allowed in the Assisted Living unit since the Maintenance Director's positive COVID test result. The Maintenance Director's record lacked			

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	documented evidence the Maintenance Director had been cleared to return to work. On 01/20/21 at 2:29 PM, the Vice President of Operations confirmed the facility did not follow their policy and procedure checklist regarding clearing a COVID positive staff member before allowing the Maintenance Director to return to work. The Vice President of Operations verbalized the Vice President of Operations could not answer if the facility was following the CDC strategies to determine when a staff member was able to return to work after a positive COVID test result. The Vice President of Operations stated, "At this time, I feel like I cannot give you any answer." On 01/20/21 at 2:38 PM, the Maintenance Director verbalized the Maintenance Director was called by the Administrator Designee on 01/17/20 and informed of the positive COVID test result. The Maintenance Director verbalized the Administrator Designee did not instruct the Maintenance Director to stay home or to monitor for symptoms. The Maintenance Director verbalized the Maintenance Director was informed by a personal physician to self-isolate. The facility policy titled, "COVID-19 Guideline Manual," dated 03/18/20, documented a procedure checklist was to be completed prior to a staff member returning to work after a positive COVID test result. The steps of the checklist included the staff member would be sent home and the facility would check in daily with the staff member to record details of symptoms, doctor's appointments and updates. The facility policy lacked language to include a symptom-based or test-based strategy for determining when a staff member could return to work, and to have the staff member self-isolate. The CDC COVID-19 Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance), updated 08/10/20, documented healthcare personnel who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test. Severity: 2 Scope: 3			