STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065001	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LOWRY HILLS CARE AND REHABILITATION	10201 E THIRD AVE AURORA, CO 80010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observations and interviews, the facility failed to ensure that the residents' environment remained as free of accident hazards as possible. Specifically, the facility failed to ensure security of the building. Cross-referenced to F880 (Infection Control) because the facility failed to screen visitors and staff when entering the facility. Findings include: Observations and interviews On 5/6/2020 at 3:30 a.m. the entrance to the facility was unlocked without restriction of access. Upon entering the facility an alarm sounded. Three visitors proceeded to the screening desk, however there was no one at the desk. A resident was sitting in a chair, in the main lobby, and directed them to the house supervisor who was sitting in an office on the East nurses' station. Licensed practical nurse (LPN) #1 was sitting at the nurses' station. One of the visitors asked who was going to turn off the alarm and LPN #1 said she would. The LPN said that the staff were assigned to respond to the alarm on a schedule and it was not her time to respond to the alarm. She said the residents went outside to smoke frequently throughout the night, so the nurses had a schedule of when they were assigned to respond to the alarm. She said that during the pandemic the supervisor was assigned to respond to the alarm. At 5:10 a.m. A man had approached the front doors and walked through the outside set of double doors. Then attempted to open the inside set of doors, however the door did not open and the alarm sounded off. The man was standing in between the inside and outside set of doors until the corporate officer/nursing home administrator (CO/NHA) and supervisor approached the inside set of doors, then walked out of the facility doors to outside the building. The Supervisor unlocked and opened the inside set of doors and walked to and opened the outside doors. The man approached the supervisor, and the supervisor gave his phone to the man. The CO/NHA was holding the inside set of doors open behind the supervisor. At 5:35 a.m. the supervisor was interviewed. He stated, I am at this front desk during my shift. I check with all people who are entering this building during the night shift. He said, The man that was at the front door trying to get in said, he was bleeding and was being chased. He asked to use the phone. I let him use my phone. He said that he was going to get a ride and will wait by the building until his ride gets here. Interview The director of nursing (DON) was interviewed on 5/6/2020 at 6:51 a.m. She said that the nurses were on rotation schedules to monitor the alarm to the front door. She said during the pandemic since the supervisor was usually sitting at the front desk, the supervisor was responsible for responding to the alarm. She said that the residents went out front to smoke frequently throughout the night, the front doors were usually closed and locked so when the residents went outside the alarms would sound, which prompted the staff to ensure the doors were locked after residents left and to permit the residents reentry. She said she was aware the neighborhood was in a high crime area.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) communicable diseases and infections for three out of five hallways. Specifically, the facility failed to: -Screen visitors and staff when entering the facility; -Have isolation protocols or signage in place for a new admission; -Wear the appropriate personal protective equipment (PPE) when entering a COVID positive room; -Have PPE readily available for staff, specifically surgical masks; -Implement appropriate hand hygiene with glove changes; -Ensure infection control practices when using alcohol based hand rub (ABHR); -Follow the appropriate procedure for cleaning rooms clean to dirty; -Use the appropriate surface contact time for chemical disinfectants; and, -Store and distribute linen in a sanitary manner. Cross-reference to F689 (Accident Hazards) because the facility failed to ensure safety of residents. Findings include: I. Status of COVID-19 in the facility A. Interview The corporate officer/nursing home administrator (CO/NHA), the management nursing home administrator (MNHA), and the interim nursing home administrator (INHA) were interviewed on 5/4/2020 at 10:30 a.m. The CO/NHA said the building was under temporary management. He said he would provide the information about the status of COVID-19 in the building via email, see below. He said the director of nursing (DON) worked an overnight shift and was not available. The MNHA said that he visited the building daily and was a member of the temporary management team. The INHA said she started that day and would be leaving in two weeks for a permanent position. The CO/NHA said that they were actively hiring a NHA for the building. He said that he arrived at the facility in December 2019 and the DON started in January 2020. The CO/NHA provided the COVID-19 status in the building via email. The information included the resident census of 65; six total residents tested COVID-19 positive, four of the six residents were being treated in the hospital and two of the six were being treated at the facility, one resident considered presumptive. Three staff members tested positive, two staff members were presumptive with symptoms. Two staff members had symptoms but not tested . The date of the first tested positive for COVID-19 with residents was April 5, 2020 and staff was April 6, 2020. He said that the facility was working with the [ORG] (CDPHE) and TriCounty Health Department (TCHD). He said the recommendations included treating each situation case by case. The consensus we've reached with very few cases is to not cohort symptoms but to treat in place. The management clinical consultant (MCC) was interviewed on 5/5/2020 at 9:08 a.m. She said that the facility held phone conferences with TCHD daily about the surveillance logs regarding residents and staff. She said that the facility increased disinfection, opening windows and keeping staff assigned as much as possible to the same hallways. She said that the facility struggled with some residents' willingness to wear the masks when out of their rooms. She said some residents were not able to wear the masks due to breathing difficulties so the staff were instructed to maintain distance, wear a mask and do frequent hand hygiene. The temporary management team provided support and services, shared information and policies with the facility. II. Visitor/Staff screening A. Facility policy and procedures The COVID-19 Management policy, revised [DATE]20, was provided by the corporate officer/nursing home administrator (CO/NHA) on 5/5/2020. It documented the following, in pertinent part, Our facility would use COVID-19 management practices to protect their residents, visitors, and staff from infection. All personnel in the facility were responsible for following the COVID-19 management policy. During pandemic, COVID screening for healthcare workers, visitors and vendors would be implemented prior to entry into the community to assess for symptoms consistent with COVID-19. Individuals with symptoms consistent with COVID-19 would not be allowed to enter the community. B. Observation On 5/6/2020 at 3:30 a.m. the entrance to the facility was unlocked without restriction of access. Upon entering the facility an alarm sounded. Three visitors proceeded to the screening desk, however there was no one at the desk. A resident was sitting in a chair, in the main lobby, and directed them to the house supervisor who was sitting in an office on the East nurses' station. Licensed practical nurse (LPN) #1 was sitting at the nurses' station. The supervisor said he would do the visitor screening and walked the visitors back to the lobby. He asked screening questions from a questionnaire and took each visitor' temperatures. The first visitor was asked symptomatic questions, to which she answered no. He did not ask her

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) exposure questions, he just marked them all no on the questionnaire. However, she would have answered those questions with a yes, which would have required the supervisor to follow the criteria protocol to determine if the visitor should be allowed entrance into the facility. The second visitor was asked a couple of the symptom questions, and the rest were answered no by the supervisor on the questionnaire. The supervisor did not ask the second surveyor any of the exposure questions, but answered them all no, although the exposure questions would have been answered with a yes. The third visitor was asked by the supervisor if she had any sort of illness but not the symptomatic questions on the questionnaire. He then answered all the questions no on the questionnaire, took all three visitors' temperatures and allowed them to proceed into the resident areas. He did not require hand hygiene from the visitors prior to entering the building. At 4:40 a.m. two housekeeping staff entered the building and stopped at the front desk to be screened by the supervisor. The supervisor reading from the questionnaire asked them, Are these questions all the same as yesterday? Both staff looked at the questionnaire and answered, Yes, it is the same, no changes. The supervisor took their temperatures and allowed them entrance to the resident areas. The supervisor did not require the staff to perform hand hygiene prior to entering the building. At 5:07 a.m. the CO/NHA and supervisor exited the building through the front doors when a visitor attempted to enter the building. The supervisor allowed the outside visitor use of his phone. Once the call was completed they both returned inside the building and the outside visitor remained outside. Once inside the building, the CO/NHA and supervisor failed to perform hand hygiene before entering resident areas. The supervisor did not clean his phone after the visitor used it. C. Interviews The supervisor was interviewed on 5/6/2020 at 5:03 a.m. He stated that he was responsible for screening visitors who entered the building. He said that he asked all visitors and staff questions about exposure risk and symptoms from the questionnaire. He said after the questions he took the visitors' temperatures and enforced hand hygiene prior to allowing access to resident areas. The director of nursing (DON) was interviewed on 5/6/2020 at 6:51 a.m. She said there was staff assigned to stay at the lobby desk 24 hours a day, to ensure screening took place in the lobby before entering the resident care areas. She said all questions on the questionnaire should be asked of each person during the screening process, each person should answer the questions. She said the person doing the screening should not answer for the person being screened. She said that yes responses to the questions required a call to her. She said that she was available 24 hours a day and her staff were instructed to contact her with yes responses on the questionnaire. She said she would make the determination if a person was permitted to enter the facility. She said all visitors, vendors and staff should be screened before leaving the front desk and entering the resident care areas. She said the questionnaire was developed based on the Center for Disease Control's (CDC) guidelines for screening protocol. III. Isolation protocol and access to PPE A. Facility policy and procedures The COVID-19 management policy, revised [DATE]20, was provided by the CO/NHA on 5/5/2020. It documented the following in pertinent part, New hospital admissions or returning residents will be placed in a private room and quarantined and/or isolated for 14 days or as outlined in the current guidance. Contact and droplet precautions including hand hygiene will be instituted. That includes the use of gloves, gowns. and surgical masks including eye protection for close contact with infected residents. PPE required for contact and droplet precautions will be assessed and monitored during the outbreak to determine if adequate supplies are available. B. Record review On 5/5/2020, via email, the CO/NHA provided a report on PPE availability which included the following relevant statements, All PPE is stored in the DON closet or the storage building; PPE in use and is reusable, is located either in the shower room on the 200 side for gowns and the face shields in a container labeled Dry at the nurse's station cubby; Gloves are located in resident rooms, nurse's carts, and other various areas. Isolation carts are stocked when in use. Alcohol pads are located at the nurse's carts and central supply. All surgical masks and N95 respirators are located in the DONs office closet. N95s are handed out to staff only working with COVID positive rooms. Surgical masks are given out a box at a time to the front desk to hand out to staff, residents, and other visitors. C. Observation On 5/6/2020 at 4:01 a.m. observed certified nurse aide (CNA) #3 and CNA #4 respond to the call light in room [ROOM NUMBER]. There was an isolation cart outside of the room and a sign on the door that read airborne/droplet precautions. They entered the room with a surgical mask. They did not don a gown, eye protection and gloves, and/or N95 mask (if necessary). The cart contained a box of gloves and several rolls of yellow, sugar and red bags. The CNAs said they went into the room to toilet the resident. They were aware of the isolation precautions, however they were not aware of what PPE they needed to wear. They said that they did not always have access to PPE because the isolation carts were empty. They said that they received training on precautionary measures to take during the pandemic of COVID-19 by keeping distance of greater than six feet, wearing masks at all times and doing frequent hand hygiene. At 5:06 a.m. the two CNAs enter room [ROOM NUMBER] which has an isolation cart outside the room. No signs on the door to indicate the type of isolation necessary for care of the resident. The CNAs said that they repositioned the resident. They said they were told that the person was newly admitted and he was on isolation precautions. They said that the type of PPE would be determined by the nurse but they were not given instructions on what type to wear for this resident. The isolation cart contained several rolls of bags, no gloves, gowns, and eye protection. The CNAs said that the cart at the end of the hall contained a few disposable gowns so if they needed gowns they could use those. The gloves were located inside each room. They said that they did not always have access to gloves on the outside of the rooms. The CNAs said the surgical masks were being worn for a week unless soiled then they were changed. They said if they needed another mask they would ask the nurse because the masks were locked up in the medication carts. CNA #3 said that she needed a mask when she started her shift and the nurse gave her the last one from the cart. They said they had not been issued N95 masks. They said they were instructed that if a resident was on isolation precautions that they should wear gloves, mask, and gowns. They said if they were instructed to then they would wear the N95 masks but were not sure when they needed to wear them. Licensed practical nurse (LPN) #1 said that she ran out of surgical masks earlier in the shift. She said in order to get more she would have to contact the supervisor. She said that if she needed masks immediately she would go to the other side of the unit and obtain a mask from another nurses' medication cart. At 6:51 a.m. the DON said that the residents in hallway 300 were on isolation precautions for the following reasons; - The resident in room [ROOM NUMBER] tested negative for COVID-19, however remained on precautions because of a high fever for a few days. The DON said that the resident did not understand to stay in the room so the resident wore a mask when leaving the room and was reminded to maintain six feet distance. The resident went outside to smoke frequently throughout the day. The isolation cart outside of this room contained three disposable blue gowns and several rolls of bags. The DON said the isolation carts should contain gloves and bags only since the gowns were being reused by washing and storing in the shower rooms. The CNAs have easy access to the shower rooms. - The resident in room [ROOM NUMBER] was newly admitted late the night before. The DON said that the resident was going to be placed on isolation precautions for 10 days because the hospital provided two negative COVID-19 tests, completed 24 hours prior to admission. She said this was according to CDC guidelines. She said that she had run out of signs to post on the door that identified a resident was on precautions and which PPE should be used to care for the resident. She said she would get new signs printed. She said the new admission arrived suddenly, the prior night, and staff was not prepared. - The resident in room [ROOM NUMBER] remained on isolation precautions because the roommate tested positive for COVID-19. She said that the correct PPE should be worn in all isolation rooms, especially COVID positive rooms. She said masks are always available to staff and that she was available 24 hours a day if staff ran out of masks, which were locked in her office. She said she would make sure staff was educated that day for proper isolation protocols and signage, the proper use of PPE in COVID positive and all isolation rooms, and the availability of surgical masks. She said N95 masks were given to staff members taking care of COVID positive residents. She said the N95 masks were stored in a paper bag for each staff member and locked in the central supply room when not in use. She said PPE was stocked every morning and if the staff ran out the nurses could contact her to restock. At 10:05 a.m. CNA #1 was observed entering room [ROOM NUMBER] to answer the call light. The resident in room [ROOM NUMBER] was on airborne and droplet precautions. CNA #1 entered the room and turned off the call light. The CNA did not don gloves or a gown before entering the isolation room. V. Housekeeping and hand hygiene A. Facility procedures The Housekeeping in-service, undated, was provided by the DON on 5/6/2020 at 6:31 a.m. It documented the following: Have knowledge of proper chemical kill times. As you enter the room, work clockwise around the room hitting all surfaces. Tabletops, headboards, window sills, chairs and call lights should all be cleaned. Bathroom should be cleaned last. The DON acknowledged that the facility did not have a policy for housekeeping. She said the housekeeping personnel was provided by an outside agency who provided their training. B. Professional standards According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following were the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. Disinfectant directions for use, retrieved from https://1source.diversey.com/see3/PSS064-VirexII256-LTR-env3-HRNC.pdf on 5/8/2020, revealed the product should be applied to hard, non porous, environmental surfaces. To disinfect, all surfaces must remain wet for 10 minutes. After 10 minutes, wipe surfaces, and allow to air dry. C. Observations 1. The housekeeping manager (HSKM) was observed on 5/5/2020 at 9:02 a.m. donning one glove on his right hand. He removed the broom and dustpan from the cleaning cart. He knocked on the door of room [ROOM NUMBER] and asked permission to enter. He removed a green rag from a red bucket that was soaking in a disinfecting cleaner with a contact surface time of 10 minutes per the label. He held the green rag in his right gloved hand and entered the bathroom. He used the green rag to wipe the light switches, towel bar, and the paper towel dispenser. He then wiped the sink from top to bottom. After cleaning the sink, he wiped the toilet down from top to bottom and then the inside of the toilet bowl. He then placed the dirty rag in a trash bag hanging on the side of the cart. However the bathroom should have been cleaned last. - He removed his one glove and donned a new one. He did not perform hand hygiene after removing his glove. - He removed a clean green rag from the red bucket and only wiped the over bed table and the night stand. The bed control had fallen on the floor, so he picked it up and wiped it down. He emptied the trash and removed his glove. He did not perform hand hygiene after removing his glove. - He failed to clean the dresser, closet, window sill, chairs, and call light. - He then began to sweep the room. He swept the debris to the doorway and used the dust pan to pick it up. - He removed a spray bottle of bleach from the cart and sprayed the floor in front of the toilet. He returned the spray bottle to the cart and removed a clean mop pad and placed it on the mop head. He mopped the room up to the bathroom door and then mopped the bathroom. After mopping the bathroom he removed the dirty mop pad, with his ungloved hands, and placed it in the bag hanging on the side of the cart. He placed a clean mop pad on the mop head and finished mopping the room to the door. He removed the second dirty mop pad and placed the mop handle in the cart. He then performed hand hygiene using ABHR. However, he did not perform hand hygiene after removing the first dirty mop pad and placing a clean mop pad on the mop head. - The HKSM wore only one glove when cleaning and failed to perform hand hygiene after removing the glove or after cleaning the bathroom. He failed to return to the bathroom and wipe the surfaces after ten minutes. He failed to clean all high touch areas or furniture in the residents room. 2. Housekeeper #1 was observed on 5/5/2020 at 9:44 a.m. She tied a trash bag on the side of her cleaning cart for dirty linen. She donned gloves and removed a spray bottle of disinfectant from her cart. She knocked on the door of room [ROOM NUMBER] and announced herself. She sprayed the door knobs, light switches, over the bed table, dressers, and night stand with the disinfectant spray. She entered the bathroom and sprayed the door knobs, lights switches, paper towel dispenser, towel racks, sink and the toilet. She returned the spray bottle back to the cart. - She emptied the trash in the bedroom and then the bathroom. She removed her gloves, used ABHR for three seconds, and struggled to don new gloves with her wet hands. She did not rub her hands for 20 seconds and until her hands were dry. - She removed a green rag from a red bucket of disinfectant. She wiped the door knobs, light switches, over the bed table top to bottom, top of dresser, front of dresser, side of dresser, a front wheel walker and a regular walker. - She moved the dresser, picked items up from the floor, and threw them away in her cleaning cart. She placed the dirty rag in the trash bag hanging on the side of her cart. - She grabbed a clean rag and proceeded to the second dresser. She wiped the top, front and sides of the second dresser. She then wiped the window ledge, top of the air conditioner, two chairs, front and sides of closets, the bedside table, and the call bell and cord. She walked back to the cart and placed the dirty rag in the trash bag. She removed her gloves and donned new ones. She did not perform hand hygiene after removing her gloves. - She removed the toilet bowl cleaner and the toilet brush from the cart. She walked to the bathroom and poured toilet cleaner into the toilet. She used the toilet brush to scrub the inside of the toilet. She returned the toilet cleaner and toilet brush back to her cart. However, she did not allow the appropriate surface contact time before scrubbing the toilet. - She removed a green rag from the red bucket. She walked back to the bathroom and wiped the door knobs, light switch, paper towel dispenser, towel racks, handrails, sink, the top of the toilet tank, the top of the toilet lid, under the lid, the seat, under the seat, the rim, and then the base of the toilet. After cleaning the base, she used the dirty green rag to put the seat down and then wiped the top of the seat. - She removed her gloves and donned new ones. She did not perform hand hygiene between glove changes. - She put a new trash bag in the bathroom trash can. - She removed the dusting pole from the cart and dusted the top of the closets, under the dressers, and under the night stand. She placed the dusting pole back on the cart and removed a dust mop pad. She placed the dust mop pad on the floor and placed the dust mop handle on top of it. She then began to dust mop the room. When she approached the night stand, she went down on her hands and knees, and picked items up off the floor. She threw the items away and removed her gloves. She performed hand hygiene with ABHR for five seconds. She struggled donning new gloves because her hands were still wet. She failed to rub her hands for 20 seconds and until her hands were dry. - She returned to dust mopping the room and then the bathroom. She removed the dust pad from the dust mop handle. She placed the dirty dust mop pad in the trash bag with the dirty rags. She used a broom and dustpan to pick up the debris. She removed a clean mop pad from the cart and placed it on the mop head. She finished mopping the room and placed the dirty mop pad in the trash bag. She removed a clean mop pad and mopped the bathroom. She returned the mop handle to the cart and disposed of the dirty mop pad. She removed her gloves and donned new ones. She did not perform hand hygiene between removing the dirty dust pad and placing a clean mop pad on the handle. - She removed a roll of toilet paper from the cart and placed it in the bathroom. She removed her gloves, performed hand hygiene with ABHR for five seconds, and struggled to don new gloves because her hands were still wet. She failed to rub her hands for 20 seconds and until her hands were dry. - She removed a deodorizer spray bottle from the cart and sprayed the room. She removed her gloves but did not perform hand hygiene. D. Interviews The HKSM was interviewed on 5/5/2020 at 9:02 a.m. He said isolation rooms were cleaned last. He said light switches and door knobs were cleaned first then the bathroom. He said it did not matter if the bathroom was cleaned first as long as a clean rag was used and hand hygiene was performed. He said he worked for an outside agency which trained him on cleaning procedures and the use of chemicals. He said he also attended the facility training and in-services on COVID-19 and the center for disease control (CDC) recommendations on disinfecting the facility He said with the COVID-19 virus, it was better to use a rag to wet the surfaces, that way he would not have to go back to those surfaces and re-wipe them. He acknowledged that the disinfectant directions, on the label, were correct. He said that surfaces should remain wet for 10 minutes, then wiped off before air drying. HK #1 was interviewed on 5/5/2020 at 10:12 a.m. She said she had not been trained to clean the bathroom first, but worked in a hospital prior and knew it was the correct procedure. She said she had training from her agency on the proper cleaning techniques and attended the facility training and in services with the CDC recommendations on disinfecting the facility. However, she did not know she needed to rub her hands for at least 20 seconds when using ABHR. She said she was not aware that she had to perform hand hygiene between each glove change. The DON was interviewed on 5/6/2020 at 6:51 a.m. She said the process for cleaning residents' rooms was provided by the housekeeping agency. She said the housekeeping staff was provided hand hygiene training on the correct use of ABHR and hand hygiene between glove changes. She said they follow the CDC guidelines but was not aware they needed to rub their hands for at least 20 seconds. She said she educated her staff to rub their hands until they were dry when using ABHR. She said they would update their policy and training as soon as possible. The infection control preventionist (ICP) was interviewed on 5/5/2020 at 11:19 a.m. She said she had educated the housekeeping staff on proper hand hygiene with glove changes and the proper use of ABHR. She said the facility followed the CDC guidelines for hand hygiene. V. Linen A. Professional standard According to the Centers for Disease and Prevention (CDC) infection control environmental, last up updated 11/05/15, retrieved from https://www.cdc.gov/hai/prevent/resource-limited/laundry.html included the following recommendations: Store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. B. Observations and interviews Resident #1 was observed on 5/4/2020 at 1:45 p.m. propelling himself down the hallway towards his room. He stopped at the clean linen cart and removed a sheet and two washcloths. The linen cart cover was down so he reached to the side and moved it out of his way to obtain the linens. He placed the items on his lap. He took the two washcloths from his lap and placed them back on the clean linen cart. He said he always got his own linen from the linen cart. Resident #1 was observed on 5/6/2020 at 4:30 p.m. propelling himself down the hallway towards his room. He stopped at the clean linen cart located in the hallway with the front cover lifted and exposing all the clean linens. He reached into the linen cart and

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