STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN HEIGHTS HEALTH CARE CENTER	**3131 S FEDERAL BLVD DENVER, CO 80236**

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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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#8) of three out of 10 sampled residents were kept free from abuse. Specifically, the facility failed to ensure Resident #8 was kept free from physical abuse from Resident #1. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised November 2019, was provided by the nursing home administrator (NHA) on 5/5/2020 at 5:33 p.m. It revealed, in pertinent part, Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment and willful neglect of the resident ' s basic needs. II. Resident status A. Resident #1 Resident #1, age 65, was admitted on [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 5/1/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required limited assistance of one person with bed mobility, transfers, and personal hygiene. He required supervision with locomotion off the unit. It indicated the resident had verbal behavioral symptoms directed toward others such as threatening others, screaming at others and cursing at others one to three days and rejected care daily during the assessment period. 1. Record review The behavior care plan, revised on 4/10/2020, revealed the resident had behaviors of resistive to care, yelling at staff and cursing. It indicated the resident had a history of [REDACTED]. The interventions included: encourage the resident to utilize strategies from a self-directed behavior plan that he established with assistance from staff, monitor behavior episodes and determine the underlying cause and remove the resident from the area when verbal aggression was occurring. The 4/13/2020 nursing progress note revealed on 4/5/2020 a certified nurse aide (CNA) reported to the nurse the resident was aggressive, verbally abusive and came at the CNA with full force in his electric wheelchair. It indicated the resident attempted to hit the CNA with his electric wheelchair and had to use a room tray cart to protect herself from the resident. B. Resident #8 Resident #8, younger than 65, was admitted on [DATE]. According to the May 2020 CPO, the [DIAGNOSES REDACTED]. The 2/24/2020 MDS assessment revealed the resident had mild cognitive impairment with a brief interview for mental status score of 12 out of 15. He was independent with all activities of daily living. III. Incident on 4/12/2020 between Resident #1 and Resident #8 A. Record review The 4/12/2020 nursing progress note for Resident #8 revealed the resident was observed seated upright on the floor next to the outside door with his legs folded yoga style. He said another resident had struck him with an electric wheelchair while entering the facility from the outside smoking area. The resident was assessed by the registered nurse (RN) with no injury noted. The resident was assisted to a standing position and able to ambulate without pain. The 4/13/2020 incident report revealed Resident #1 was in the area before the designated smoking area and was blocking the door. Resident #8 reported it to the CNA. Resident #1 opened the door and rammed into Resident #8. Resident #8 lost his balance and fell . The summary of the investigation indicated the physical abuse was substantiated due to the video footage showing Resident #1 intentionally hit Resident #8 with his power wheelchair. The 4/13/2020 progress note for Resident #1 revealed the NHA, social worker and director of nursing (DON) met with the resident to inform him the power chair would be removed for 30 days due to the resident intentionally running into another resident resulting in the resident falling to the ground. The resident agreed to use a manual wheelchair IV. Staff interviews The NHA and the social services director (SSD) were interviewed on 5/5/2020 at 4:30 p.m. The NHA said it was reported Resident #1 ran into Resident #8 with his electric wheelchair on 4/12/2020. She said Resident #1 was in his electric wheelchair outside blocking the door to get to the smoking area. She said Resident #8 attempted to open the door and was unable due to Resident #1 blocking the door. She said Resident #1 got upset, opened the door and hit Resident #8 with his electric wheelchair. She said Resident #1 denied hitting Resident #8, however the video surveillance footage showed Resident #1 intentionally hit Resident #8 with the electric wheelchair. She said Resident #8 had decided to press assault charges against Resident #1. She said Resident #1 had a hearing scheduled for 5/13/2020. The NHA said Resident #1 had a history of [REDACTED]. She said by hitting the resident with his electric wheelchair, he violated the agreement with the facility. She said she informed the resident he would not be allowed to use the electric wheelchair for 30 days. She said the facility provided the resident with a manual wheelchair. She said Resident #1 was angry at first, but had calmed down and was agreeable with the use of the manual wheelchair.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#2) of three out of 10 sampled residents was not transferred or discharged from the facility while a discharge appeal was pending. Specifically, the facility failed to ensure Resident #2 was not discharged from the facility while a formal appeal was pending for a 30 day discharge notice. Cross reference F624: the facility failed to ensure a safe discharge for Resident #2. Findings include: I. Resident #2 status Resident #2, age 64, was admitted on [DATE] and readmitted on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 2/13/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required supervision with bed mobility and toileting. He was independent with transfers, dressing, eating and personal hygiene. It documented the resident had an active discharge plan to return to the community. A. Record review The 3/31/2020 resident education revealed the facility provided education to the resident in relation to the State of Colorado Governor stay at home order related to the COVID-19 pandemic. It indicated the facility was temporarily suspending all pass privileges. It documented if you choose to leave the facility against our recommendation and put others at risk, the following will occur: - You will be screened upon return. This means you must fill out the respiratory screen questionnaire and have your temperature taken. - Your room assignment may be reconsidered to ensure the safety of your roommate and other residents. - You will be asked to wear a mask to wear while in the facility. - If you have symptoms, you will be placed in isolation. It documented the resident refused to sign the education. It did not document if the resident chose to leave the facility, he would be issued a discharge against medical

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) advice (AMA). The 4/2/2020 involuntary transfer or discharge notice revealed the resident was provided an involuntary discharge notice due to the resident ' s health had improved sufficiently so the resident no longer needed the services provided at the facility. It indicated the effective day of discharge was 5/2/2020. The 4/2/2020 progress notes revealed the nursing home administrator (NHA), director of nursing (DON) and social worker (SW) met with the resident and issued him a 30 day involuntary discharge notice. It documented the resident's health had improved, independent and would leave the facility multiple times per day, driving in his car. It documented the case manager with the transitional housing program (THP) was notified of the discharge notice to assist the resident in obtaining housing. The resident stated he did not want to sign the discharge notice until he spoke with an elder attorney. The 4/16/2020 email sent to Colorado Department of Public Health and Environment (CDPHE) by a resident advocate sent on behalf of Resident #2 revealed a formal request to appeal the 30 day involuntary discharge notice to CDPHE. An acknowledgement of the resident ' s request for an appeal was sent back on the same day. The 4/21/2020 progress note revealed the NHA and the nurse educated the resident regarding the stay at home order. It indicated the resident continued to leave the facility for extended periods of time and if he continued to leave the facility, he would be discharged AMA. The 4/26/2020 nursing progress note revealed the nurse saw the resident leave the facility in his vehicle. It indicated the resident had signed an agreement he was not allowed to leave the facility related to the COVID-19 virus. The resident's medical record did not reveal documentation of such agreement. It indicated upon his return, the staff had packed up his belongings and placed them outside the facility. The resident refused to sign a document which indicated he was leaving the facility against medical advice. B. Resident advocate interview The resident advocate was interviewed on 5/5/2020 at 12:45 p.m. She said the resident was issued a 30 day involuntary discharge notice on 4/2/2020. She said the facility had determined Resident #2 no longer required long term care assistance. She said the resident had contacted her and wished to appeal the involuntary discharge notice. She said she assisted the resident with the appeal process. She said the resident went through the two forms of appeal at the facility, which were each denied. She said she sent a message to CDPHE on behalf of the resident, upon his request, to formally appeal the discharge notice to CDPHE on 4/16/2020. She said the facility management was aware of the resident ' s request for a formal appeal to CDPHE. She said while the resident was waiting for the discharge appeal, the facility had discharged the resident AMA. She said the resident was leaving the facility in his vehicle to do some work as a mechanic. She said the resident was working to save money for housing. She said the resident had informed her when he left the facility he always wore a mask and did not understand why the facility would threaten him with an AMA discharge. She said the facility violated the resident ' s discharge rights when they discharged him AMA while he was waiting for the appeal determination. C. Staff interviews The NHA, DON and SW #1 were interviewed on 5/5/2020 at 1:20 p.m. The NHA said Resident #2 was leaving the facility for extended periods of time, working as a mechanic. She said the interdisciplinary team had determined the resident ' s condition had improved and he no longer required long term care. She said the resident was presented with a 30 day discharge notice on 4/2/2020. She said the resident requested both appeal processes at the facility. She said the facility denied both appeal requests because his level of care he required had decreased. She said she was aware the resident had requested an appeal through CDPHE. She said she could not remember what date she was informed of the resident ' s appeal request. She said she had met with the resident, with the DON and SW#1 regarding the stay at home order. She said they requested the resident not leave the facility to ensure he did not put himself at risk for contracting COVID-19. She confirmed the education provided to the resident on 3/31/2020 did not indicate the resident would be discharged AMA if he continued to leave the facility. She said the resident would not participate in the screening process when he would return to the facility. She said that was why he was issued an AMA discharge. She confirmed the nursing staff packed his belongings when he left the facility and left them outside for the resident. She confirmed the facility did not have documentation the resident refused to follow the screening process upon his returns to the facility. She said she did not know if the resident used a mask when he was outside of the facility. She confirmed the federal regulations stipulated a resident should not be discharged from the facility while a 30 day involuntary discharge appeal was pending.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a safe discharge from the facility for one (#2) of three out of 10 sampled residents. Specifically, the facility failed to ensure a safe discharge for Resident #2. Cross reference: F622: the facility failed to ensure a resident was not discharged from the facility while a 30 day discharge appeal was pending. Findings include: I. Resident #2 status Resident #2, age 64, was admitted on [DATE] and readmitted on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 2/13/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required supervision with bed mobility and toileting. He was independent with transfers, dressing, eating and personal hygiene. The MDS documented the resident had an active discharge plan to return to the community. A. Record review The discharge care plan, initiated 1/11/19, revealed the resident was admitted to the facility for 24 hour care related to [MEDICAL CONDITIONS]. It documented the resident was hoping to be stable enough to discharge to the community. The 3/31/2020 resident education revealed the facility provided education to the resident in relation to the State of Colorado Governor stay at home order related to the COVID-19 pandemic. It documented the facility was temporarily suspending all pass privileges. It documented if you choose to leave the facility against our recommendation and put others at risk, the following will occur: - You will be screened upon return. This means you must fill out the respiratory screen questionnaire and have your temperature taken. - Your room assignment may be reconsidered to ensure the safety of your roommate and other residents. - You will be asked to wear a mask to wear while in the facility. - If you have symptoms, you will be placed in isolation. It documented the resident refused to sign the education. It did not document if the resident chose to leave the facility, he would be issued a discharge against medical advice (AMA). The 3/27/2020 psychosocial progress note revealed the social worker (SW) received an email from the transitioning housing program (THP) case manager regarding a town home that was available for the resident and his sister. It indicated the resident did not want to move to the townhome due to the area in which the town home was located. The 4/1/2020 psychosocial progress note revealed the resident was witnessed leaving the facility grounds in his vehicle. It documented the resident continued to leave the facility even though he had been educated and pass privileges had been temporarily suspended. The 4/1/2020 psychosocial progress note revealed the SW informed the THP case manager the resident was receiving a discharge notice for lack of medical necessity and not following the pass privileges due to COVID-19. The 4/2/2020 involuntary transfer or discharge notice revealed the resident was provided an involuntary discharge notice due to the resident's health having improved sufficiently so the resident no longer needed the services provided at the facility. It documented the effective day of discharge was 5/2/2020. The 4/2/2020 progress notes revealed the nursing home administrator (NHA), director of nursing (DON) and SW met with the resident and issued him a 30 day involuntary discharge notice. It documented, the resident's health had improved, and was independent with activities of daily living and would leave the facility multiple times per day, driving in his car. It indicated the case manager with the THP program was notified of the discharge notice to assist the resident in obtaining housing. The resident stated he did not want to sign the discharge notice until he spoke with an elder attorney. The 4/2/2020 psychosocial progress note revealed the resident was witnessed leaving the facility in his vehicle. It documented the resident returned to the facility at 7:15 p.m., left the facility at 8:40 p.m. and returned at 11:50 p.m. The 4/3/2020 psychosocial progress note revealed the resident was seen driving his vehicle down the road at 10:45 a.m. with another resident as a passenger. Both residents returned at 11:15 a.m. Resident #2 left the facility again at 11:20 a.m. The 4/4/2020 nursing progress note revealed the resident was found sleeping in his car with the chair reclined. He said he slept better in his car than in the facility. He said he used to be a truck driver and was comfortable sleeping in his vehicle. The 4/5/2020 nursing progress note revealed the resident did not return to the facility during the evening or night shift. The 4/9/2020, 4/11/2020, 4/14/2020, 4/15/2020, 4/19/2020, and 4/20/2020 nursing progress notes revealed the resident left the facility in his vehicle. The 4/16/2020 email sent to Colorado Department of Public Health and Environment (CDPHE) by a resident advocate sent on behalf of Resident #2 revealed a formal request to appeal the 30 day involuntary discharge notice to CDPHE. An acknowledgement of the resident's request for an appeal was sent back on the same day. The 4/17/2020 nursing progress note revealed the resident was getting ready to leave the facility. The nurse instructed the resident to use his scarf, observe social distancing, and wash his hands frequently. The 4/21/2020 psychosocial progress note revealed the NHA and a licensed practical nurse (LPN) educated the resident on the stay at home order. It indicated they told the resident if he continued to leave the facility he would be discharged AMA. The 4/22/2020 nursing progress

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F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) note revealed the resident had left the facility. When he returned the resident was educated to shelter in place. The resident agreed to have his temperature taken, received a face mask and filled out the respiratory form. The 4/22/2020 medical director progress note indicated the resident spent most of the day outside of the facility and used the facility as room and board. After review of the resident's medication and chart, the medical director indicated the resident did not require long-term care and agreed with the 30 day discharge notice. He indicated the resident put residents at risk for COVID-19 because he went out into the community. The 4/23/2020 psychosocial progress note revealed the SW provided the resident with information on an apartment with the THP program with pictures. SW said he would follow up with THP for the resident's decision. The resident's plan of care was reviewed on 5/5/2020 at 1:34 p.m. It failed to document the resident refused to comply with wearing a facial covering when returning to the facility from being out in the community. It did not document the resident refused the facilities screening process upon returning to the facility from the community. According to the nursing progress note on 4/22/2020 the resident did comply with the facilities screening process and was given a mask upon returning to the facility. The 4/26/2020 nursing progress note revealed the nurse saw the resident leave the facility in his vehicle. It documented the resident had signed an agreement he was not allowed to leave the facility related to the COVID-19 virus. The resident's medical record did not reveal documentation of such agreement. It documented upon his return, the staff had packed up his belongings and placed them outside the facility. The resident refused to sign a document that he was leaving the facility against medical advice. B. Resident advocate interview The resident advocate was interviewed on 5/5/2020 at 12:45 p.m. She said the resident was issued a 30 day involuntary discharge notice on 4/2/2020. She said the facility had determined Resident #2 no longer required long term care assistance. She said the resident had contacted her and wished to appeal the involuntary discharge notice. She said while the resident was waiting for the discharge appeal, the facility had discharged the resident AMA. She said the resident was leaving the facility in his vehicle to do some work as a mechanic. She said the resident was working to save money for housing. She said the resident had informed her when he left the facility he always wore a mask and did not understand why the facility would threaten him with an AMA discharge. She said he had been offered housing once and it was a townhome in a high crime area. She said the resident turned down the housing option because he was not comfortable with his sister being home alone while he worked in that area. She said his sister and him were on the THP list together for housing. She said because the facility had discharged the resident AMA they had effectively removed the resident from the THP housing list and he had lost his housing benefits. She said the resident was currently living at a hotel and did not have the financial means to continue to stay at the hotel. She said the resident would be out on the street in the next few days and did not have a safe place to live. C. Staff interviews The NHA, DON and SW #1 were interviewed on 5/5/2020 at 1:20 p.m. The NHA said Resident #2 was leaving the facility for extended periods of time, working as a mechanic. She said the interdisciplinary team had determined the resident's condition had improved and he no longer required long term care. She said the resident was presented with a 30 day discharge notice on 4/2/2020. She said she had met with the resident, with the DON and SW#1 regarding the stay at home order. She said they requested the resident not leave the facility to ensure he did not put himself at risk for contracting COVID-19. She confirmed the education provided to the resident on 3/31/2020 did not show evidence that the resident would be discharged AMA if he continued to leave the facility. She said the resident would not participate in the screening process when he would return to the facility. She said that was why he was issued an AMA discharge. However, the NHA said the facility did not have documentation the resident refused to follow the screening process upon his return to the facility. She said she did not know if the resident used a mask when he was outside of the facility. She confirmed the nursing staff packed his belongings when he left the facility and left them outside for the resident. She confirmed the federal regulations stipulated a resident should not be discharged from the facility while a 30 day involuntary discharge appeal was pending. SW#1 said he did not arrange the resident's discharge from the facility. He said he did not know where the resident discharged .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observations, interviews and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as Coronavirus disease (COVID-19). Specifically, the facility failed to: -Ensure residents and staff followed guidelines for facial coverings to prevent the spread of infections; -Ensure residents practiced social distancing; and -Ensure housekeeping staff practiced hand hygiene in between glove changes. Findings include: I. Professional references According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 4/29/2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter their room. Health care professionals (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE (personal protective equipment), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHR (alcohol based hand rub) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. According to the Colorado Department of Public Health and Environment, COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities, Restrict all residents to their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health. If residents must leave their room, they should perform hand hygiene, limit their movement within the facility, wear a cloth face covering, and perform social distancing (stay at least six feet from others). II. Ensure residents followed guidelines for facial coverings to prevent the spread of infections A. Observations During a continuous observation conducted throughout the facility on 5/5/2020 beginning at 10:40 a.m., the following was observed: - Two residents were observed sitting in the common area near the front door. Both residents were not wearing a facial covering. - Two residents were observed wheeling down the hallway. Both residents were not wearing a facial covering. - A resident was observed talking to a social worker. The resident was not wearing a facial covering. The social worker did not offer or remind the resident to wear a facial covering. - A resident was observed walking down the hallway. He did not wear a facial covering. - A resident was observed sitting in his wheelchair in the hallway. He was not wearing a facial covering. - Two male residents came into the facility from the smoking area. They were not wearing a facial covering. Three staff members passed by the residents. The staff did not offer or remind the residents to wear a facial covering. - A resident was observed approaching another resident ' s room. The two residents came in direct contact with one another. Neither resident was wearing a mask. - A resident was observed talking with the social services director (SSD). She came within one foot of the resident. The resident did not wear a facial covering. She did not remind or offer the resident a facial covering. - Two residents were observed standing at the medication cart with a nurse. Neither resident was wearing a facial covering. The nurse did not offer or remind the residents to wear a facial covering. B. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/5/2020 at 2:32 p.m. She said she was not sure if residents were supposed to wear a facial covering when outside of their room. She said she had never been instructed by the facility management to ensure residents wore a facial covering. Licensed practical nurse (LPN) #1 was interviewed on 5/5/2020 at 2:40 p.m. She said residents were provided a mask or facial covering when they left the facility to go to an outside appointment. She said residents were not required to wear masks while at the facility. The director of nursing (DON) and assistant director of nursing (ADON) were interviewed on 5/5/2020 at 4:09 p.m. The ADON said she was the infection preventionist at the facility. She said residents were not required to wear a facial covering while they were in the facility. She said staff should encourage each resident to wear a facial covering, but were not required. III. Ensure residents practiced social distancing A. Observations During a continuous observation conducted throughout the facility on 5/5/2020 beginning at 10:40 a.m., the following was observed: - Two residents were observed sitting in the common area at the entrance of the facility. The residents were not sitting six to eight feet apart to observe social distancing guidelines. - A resident was observed approaching another resident ' s room. The two residents came in direct contact with one another. The residents were not six to eight feet apart to observe social distancing guidelines. Neither resident wore a facial covering. - Two residents were observed sitting outside a nursing station. The chairs were positioned two feet from each other. Multiple staff members were observed inside the nursing station. The resident ' s did not observe social distancing guidelines. B. Staff interviews CNA #1 was interviewed on 5/5/2020 at 2:32 p.m. She said each resident should be observing social distancing guidelines. She said social distancing guidelines indicated each person should be at least six feet apart. LPN #1 was interviewed on 5/5/2020 at 2:40 p.m. She said all staff and residents should practice social

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) distancing guidelines. She said social distancing guidelines required people to be at least six feet apart. She confirmed the chairs outside the nursing station were not placed six feet apart to enforce social distancing guidelines. The DON and ADON were interviewed on 5/5/2020 at 4:09 p.m. The ADON said the residents and staff should observe social distancing guidelines of being six feet apart from one another. The DON said they had been moving the chairs throughout the facility to ensure social distancing guidelines, however they had not done it in a while. She confirmed the chairs outside the nursing station were not placed to observe social distancing guidelines. She confirmed the common areas seating were not placed to ensure social distancing guidelines. IV. Ensure housekeeping staff practiced hand hygiene in between glove changes A. Observations During a continuous observation conducted throughout the facility on 5/5/2020 beginning at 10:40 a.m., the following was observed: - At 10:53 a.m. a housekeeper was observed cleaning a resident room. She was observed, with gloved hands, cleaning the sink and obtaining debris from the clogged drain. - She exited the room, doffed the gloves and then donned new gloves. She did not use hand hygiene prior to donning new gloves. - She grabbed the mopped and entered the room. After mopping the room, the housekeeper doffed her gloves. She did not perform hand hygiene. She pushed the housekeeping cart down the hallway to clean another resident ' s room. B. Staff interviews The NHA and DON were interviewed on 5/5/2020 at 6:00 p.m. The DON said hand hygiene should be performed in between glove changes. She said it was important to use hand hygiene after doffing gloves to ensure any infectious pathogens were removed.