STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065146	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY CREEK NURSING CENTER	14699 E HAMPDEN AVE AURORA, CO 80014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure infection control practices were followed to prevent the spread of COVID-19 infection. Specifically, the facility failed to ensure: -Staff performed appropriate hand hygiene during in-room meal service delivery for three of six hallways; -Environmental services employees performed hand hygiene appropriately; -Residents' rooms/bathrooms were properly cleaned/disinfected and specific manufacturer's disinfectant wet/contact/dwell time; -Nursing staff used the appropriate disinfectant and adhered to the specified manufacture's dwell time for the disinfectant product for two of two individual resident glucometers; -Nursing staff performed appropriate sanitary techniques during medication administration; and -Nursing staff labeled disinfectant containers, had knowledge of the disinfectant in the container and adhered to the specified manufacturer's dwell time for the disinfectant product for two of two Hoyer lift observations; Findings include: I. Improper hand hygiene A. Professional standards 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. The following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before 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. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Facility policy and procedure The Handwashing Procedure For Dining Services policy, undated, was provided by the facility on 6/9/20. The policy read in pertinent part: Gloves are not meant to be used in place of proper handwashing. They are only effective if proper handwashing is completed. Employees must wash their hands immediately after removing gloves or other personal protective equipment (PPE). Hand hygiene continues to be the primary means of preventing the transmission of infection Before and after handling food Before and after assisting residents with meals After handling soiled equipment Between glove changes Between tasks. The Handwashing/Hand Hygiene Residents policy, dated 3/1/20, was provided by the nursing home administrator on 6/9/20 at 4:00 p.m. The policy read in pertinent part: The facility considers hand hygiene the primary means to prevent spread of infections Hand hygiene products and supplies shall be readily accessible and convenient for resident use to encourage compliance with hand hygiene policies. For residents who are unable to complete handwashing or require reminders, facility staff will provide assistance and encouragement as needed. C. Manufacturer guidance The Treehouse antiseptic 80% Topical Solution Safety Data Sheet, implemented 4/2/20, was provided by central supply on 6/8/20 at 6:55 p.m. According to the safety data sheet, staff was to use enough antiseptic to thoroughly cover their hands by rubbing them briskly together until completely dry. 1. Resident hand hygiene during meals A. Observations Observations were conducted on 6/8/20 at between 4:30 p.m. and 5:25 p.m. during in room tray delivery of dinner on the Eldorado unit. Certified nurse aide (CNA) #1 and restorative aide (RA) served meals to residents in the 100 hall. RA offered and encouraged resident hand hygiene as he delivered the dinner meal to each resident. CNA #1 did not offer or encourage hand hygiene when he delivered the dinner meal. Three residents in the 100 hall did not receive hand hygiene before they ate their meal. Observations were conducted on 6/9/20 between 11:20 a.m. and 11:50 a.m. during in room tray delivery of lunch on the Eldorado unit. The dietitian (DT) was observed delivering in room meal trays to residents in the 200 and 300 halls. The DT did not offer resident hand hygiene as she delivered the in room meal trays. Hand hygiene was not offered during the drink cart delivery that followed the meals trays. RN #3 was observed to offered hand hygiene to a resident on the 200 hall in room [ROOM NUMBER], as she served an in room meal tray. Hand hygiene was not provided to residents in room numbers #201, #202, #207, #301, #302, #304 and #307. B. Staff interviews CNA #1 was interviewed on 6/8/20 at 5:20 p.m. He said he was trained to offer hand hygiene to residents as he delivered their meal trays. The clerical/staffing coordinator (RT) #2 was interviewed on 6/8/20 at 6:50 p.m. She said she was able to provide resident hand hygiene on the 200 and 300 hall as dinner in room meal trays were delivered. She said she entered the meal service late and believed the other halls already received hand hygiene during the meal delivery. The RT #2 said resident hand hygiene should be conducted at the time of meal delivery to ensure the residents' hands remained clean as they prepared to eat their meal. The DT was interviewed on 6/9/20 at 12:01 p.m. She reviewed the required preparation steps of meal delivery. According to the DT staff must knock on doors, announce themselves, encourage the resident to wear a face mask when staff was present, and ensure the meal card matched the meal and name of the resident delivered. The DT did not include resident hand hygiene when reviewing the meal delivery steps. When the DT was asked when the residents should have received hand hygiene, she responded at time of meal delivery. She said residents should have been offered hand hygiene at meal delivery to ensure that their hands were clean and free of contaminants when they ate their meal. Registered nurse (RN) #3, who was identified as the Eldorado unit manager, was interviewed on 6/9/20 at 12:08 p.m. RN #3 said she was responsible for the Eldorado unit and Rapid Recovery unit which included halls 100 though 600. She identified herself as the CNA and nurse supervisor for her unit. RN #3 was informed of the limited hand hygiene on her unit during meal services. She said resident hand hygiene should have been performed on all residents during meal tray delivery. The RN said she would provide increased training on all CNAs and inform the supervisor of the DT of the observed concern. The director of nursing (DON) was interviewed on 6/9/20 at 1:40 p.m. She said hand hygiene must be conducted before resident meals. She said staff had all been trained to offer hand hygiene and time of meal delivery to ensure residents ate their meal with clean hands to decrease the risk of transmission [MEDICAL CONDITION] or infections. She said she would provide increased training to the identified staff. C. Record review The DON provided follow up one on one education with the DT on 6/9/20. According to the education, the DT was re-trained to offer hand hygiene to the resident at meals. 2. Staff hand hygiene while cleaning resident rooms A. Observations HK #3 was observed on 6/9/20 between 10:17 a.m. and 10:40 a.m., as he deep cleaned room [ROOM NUMBER]. HK #3 performed hand hygiene with alcohol based hand rub (ABHR) before and after donning gloves. HK #3 doffed his gloves after each change of task. The HK did not cover all surfaces of his hands with the ABHR or allow the ABHR to completely dry on his hands before donning a new pair of gloves. HK #3 doffed and donned gloves after he dropped and picked up a cap off the floor. He applied ABHR, and rubbed

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** - Some	(continued... from page 1) hands together for four seconds. The glove adhered to his left back side hand from moisture. He doffed and donned gloves after collecting the linen off the bed and spraying the overlay mattress. He applied ABHR, rubbed his palms together for three seconds. HK #3 did not apply ABHR to the back side of his hands and fingers. HK #3 doffed and donned gloves after wiping down the primary mattress. He applied ABHR, and rubbed his hands together for five seconds. ABHR dripped off his hand as he donned a new pair of gloves. HK #1 was observed on 6/9/20 between 10:45 a.m. and 11:02 a.m., cleaning room [ROOM NUMBER]. HK #1 doffed gloves after she wiped down high touched surfaces. She applied ABHR on her hands for 12 seconds before donning gloves. HK #1 doffed her gloves after sweeping the floor. She applied ABHR on her hands for 10 seconds before donning gloves. She doffed her last pair of gloves after mopping the floor. She applied ABHR on her hands for seven seconds. The environmental service manager (ESM) observed the practice and reminded her to perform hand hygiene with ABHR for 20 seconds. The HK complied and rubbed her hands together with ABHR for 30 seconds. B. Staff interviews The environmental district manager (EDM), was interviewed with the ESM, on 6/9/20 at 10:42 a.m. The EDM said the facility used Treehouse Alcohol Antiseptic that contained 80% alcohol. He said staff should rub together hands with the ABHR until the hands were thoroughly dry. The ESM said hand hygiene with the ABHR should have been performed for a total of 20 seconds for proper use. II. Unsanitary medication administration A. Facility policy The Administering Oral Medication policy, revised October 2010, was provided by the facility on 6/11/20. The policy read in pertinent part: The purpose of this procedure is to provide safe administration of oral medications Wash hands For tablets or capsules from bottles, pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication with your hands For dose unit tablets or capsules, place packaged medication directly into the medication cup B. Observations RN #1 was observed on 6/8/20 at 6:00 p.m. as she prepared medication for Resident #2. The RN opened the medication cart drawers, retrieved a blood sugar lance, a blood glucose monitor, a bottle of tablets, and a pill card. She did not perform hand hygiene after touching the handles of the medication cart drawers. RN #1 placed the pill card over her left and popped out two pills into the left hand. She placed the pills into a medication cup. The collected the prepared medication and enter the room of Resident #2. C. Staff interviews RN #1 was interviewed on 6/8/20 at 6:47 p.m. She said medication from pill cards should have been placed directly into the medication cup and never placed into bare hands to limit the risk of cross-contamination to the medication. RN #3 was interviewed on 6/8/20 at 6:59 p.m. She said bare hands should not come in contact with resident medication. She said medication from a pill card should be directly popped in a medication cup. The DON was interviewed on 6/9/20 at 1:40 p.m. She said medication placed into the nurse ' s hand was an inappropriate administration technique. She said she would provide re-education to the RN on sanitary practices. III. Improper cleaning of medical equipment A. Professional reference The Centers for Disease and Prevention (CDC) Injection Safety, Infection Prevention during Blood Glucose Monitoring and Insulin Administration, last up updated May 2, 2011 retrieved from https://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.htm, provided recommendations from the Food and Drug Administration (FDA) retrieved from https://www.fda.gov/medical-devices/vitro-diagnostics/letter-manufacturers-blood-glucose-monitoring-systems-listed-fda. The guidance read in pertinent part: The disinfection solvent you choose should be effective [MEDICAL CONDITION].[MEDICAL CONDITION], and [MEDICAL CONDITION] virus. Outbreak episodes have been largely due to transmission of [MEDICAL CONDITION] and [MEDICAL CONDITION]. However, of the two, [MEDICAL CONDITION] virus is the most difficult to kill. Please note that 70% [MEDICATION NAME] solutions are not effective against [MEDICAL CONDITION] bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device B. Facility policy The Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised October 2018, was provided by the nursing home administrator on 6/9/20 at 4:00 p.m. The policy read in pertinent part: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers of Disease Control), recommendations for disinfectants and the OSHA Blood borne Pathogens Standard C. Manufacturer guidance The Treehouse antiseptic 80% Topical Solution Safety Data Sheet, implemented 4/2/20, was provided by central supply on 6/8/20 at 6:55 p.m. According to the safety data sheet, the intended use of the antiseptic hand sanitizer was to reduce agents on the skin that could cause disease. D. Observations Licensed practical nurse (LPN) # 1 was observed on 6/8/2020 at 4:40 p.m., to check the blood glucose level of Resident #4. LPN #1 prepared the supplies at the medication cart. He obtained a blood glucose meter with the residents name on it, test strips, alcohol wipes and a disposable lancet. He went to the residents room, performed hand hygiene, applied gloves, cleaned the residents index finger on her left hand, obtained blood with the lancet and applied it to the test strip in the blood glucose meter. He returned to his medication cart and placed the contaminated meter on top of the cart. He said the blood glucose meter needed to be sanitized after every use. He was observed to wipe the front and back of the meter with a Micro Kill wipe. The meter dried in less than one minute. He was asked what the dwell time (time the equipment must remain wet with the product to be effective) was for the Micro Kill wipe. He said he did not know what that meant. After an explanation he said three minutes. He said he had not ensured the blood glucose meter was wet for three minutes. The Micro Kill container was reviewed with LPN #1. The container documented a two minute dwell time. LPN #1 said there was no way to keep it wet for two minutes, I can let it air dry for two minutes. RN #1 was observed on 6/8/20 at 6:10 p.m. exiting the room of Resident #2 with a blood glucose monitor in her hand. She pulled a clean glove out the glove box and set the glove on her medication cart. RN #1 placed the blood glucose monitor on top of the glove. She removed a spray bottle labeled hand sanitizer out her pocket. She proceeded to spray down the blood glucose monitor with the hand sanitizer before placing inside her medicine cart. E. Staff interviews LPN #3 was interviewed on 6/8/2020 at 4:53 p.m. He said he did not have blood glucose checks this evening, but could explain how to disinfect a blood glucose meter. He said after the blood glucose was completed, the meter was cleaned with a Micro Kill wipe. He said it took about 20 seconds for the meter to dry and then it was put back in the case. The dwell time on the Micro kill wipes container was reviewed with LPN #3. He said I never leave it on for two minutes. RN #1 was interviewed on 6/8/20 at 6:35 p.m. She said the blood glucose monitor was only used on Resident #2 so she could clean the resident ' s equipment with either the hand sanitizer that contained alcohol or the wipes in the purple lid bottle. RN #1 could not produce the purple lid bottle and did not know what disinfectant was in the purple bottle. She said the hand sanitizer killed germs on the hands so it should have been appropriate to use on the resident ' s blood glucose monitor. The RN did not know the alcohol content of the sanitizer but assumed it was 70%. She did not know the appropriate dwell time a chemical should be left on the blood glucose monitor. RN #2 was interviewed on 6/8/20 at 6:39 p.m. She said resident equipment could be cleaned with the red lid micro kill wipes with a two minute dwell time or the micro kill with blue lid wipes that contained bleach with a three minute dwell time. RN #2 said she would not clean resident equipment with hand sanitizer. RN #3 was interviewed on 6/8/20 at 6:59 p.m. She said the Micro Kill with the red lid would have been appropriate to clean the blood glucose monitor. She said RN #1 should not have used hand sanitizer to clean the blood glucose monitor. The unit manager (UM) was interviewed on 6/9/2020 at 12:05 p.m. The UM said the glucometers were cleaned with Micro Kill wipes and had a two minute dwell time. She said she wiped them down and let them dry for two minutes. She said she was not aware that the meter needed to remain wet with the product for two minutes to be effective. The facility failed to ensure individual resident blood glucose meters were disinfected after use, to prevent contamination of other surfaces. The director of nursing (DON) was interviewed on 6/9/20. She said RN #1 should not have cleaned the resident ' s blood glucose monitor with hand sanitizer. She said the hand sanitizer was an antiseptic and the resident equipment required a disinfectant after use. The DON said she would re-educate nursing staff on appropriate cleaning of the blood glucose monitor. IV. Insufficient disinfectant dwell time A. Facility policy and procedure The 5-Step Daily Patient Room Cleaning procedure, undated, was provided by the nursing home administrator (NHA) on 6/9/20 at 4:00 p.m. The policy read in pertinent part: Review chemical kill times on the chemical efficacy data sheet Follow the efficacy data sheet for the specific germicide you are using to know the specific amount of time the chemical must stay wet on the surface to kill certain bacteria The Cleaning and Disinfection of Environmental surfaces policy, revised August 2019, was provided by NHA on 6/9/20 at 4:00 p.m. The policy read in pertinent part: Non-critical environmental surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and directions for use B. Manufacturer guidance The Virex Plus reference sheet and safety data sheet, 2/20/15, was provided by the facility on 6/9/20. According to the reference sheet, severe acute respiratory syndrome ([DIAGNOSES REDACTED]), associated coronavirus required a 10 minute contact time. C. Observations Housekeeper (HSK) #3 was observed on 6/9/20 between 10:17 a.m. and 10:40 a.m., as he deep cleaned room [ROOM NUMBER]. Observations were conducted with the environmental district manager (EDM). -At 10:38 a.m., HSK #3 sprayed the back side of the resident ' s mattress with Virox Plus disinfectant. He immediately proceeded to wipe off the disinfectant not allowing dwell (contact) time to occur. The EDM observed the action and reminded HSK that he had to allow five minutes to pass before he could wipe the product off the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) mattress. HSK #1 was observed on 6/9/20 at 10:45 a.m. cleaning room [ROOM NUMBER]. She performed hand hygiene, donned gloves, and entered the room. She sprayed Virox Plus disinfectant on the high touch surfaces on the resident's bedside table, dressers and sink. She wiped down surfaces within two minutes of spraying the disinfectant. HSK #2 was observed on the summit park hallway on 6/9/2020 at 9:16 a.m. as she cleaned room [ROOM NUMBER]. --At 9:16 a.m., HSK #2 failed to perform hand hygiene prior to donning gloves. She started the cleaning by spraying a liquid from a spray bottle unto the table tops, the washing hand basin and the toilet seat in the aforementioned room. The HSK #2 immediately wiped off the liquid that was sprayed on the surfaces mentioned above. While she bent to clean the surrounding of the toilet seat, HSK #2 ' s gown was rubbing against the toilet seat. When she was done wiping the surrounding area of the toilet seat, HSK #2 then retrieved a dust mop from the cleaning cart in the hallway. When she returned to the room, HSK #2 moped the bathroom floor and later came out to clean the bedroom floor with the same mop head she had used to clean the toilet. After partly cleaning some portion of the room with the mop head she had used to clean the toilet floor as discussed above, HSK #2 was called out of the room by her supervisor who provided on the spot education. HSK #2 then retrieved a wet mop with a replaceable cleaning cover from the cart and mopped the rest of the residents' bedroom floor without recleaning the areas of the floor she had contaminated with the mop from the toilet. She repeatedly removed the cover from the mop head that she had just used to mop the toilet floor and also the bedroom floor, touching the soiled surface with her gloved hands. She returned the mop cover to her cart, got a cleaning cloth from a bucket of cleaning solution, and wiped down the bedside table that belonged to the resident in the room. As she wiped down the table, she picked up and replaced the resident's personal items which included a glass casing, water pitcher, a glass of apple juice, a bible and a small carton of supplement with a straw inside. She also touched the door knobs on the main room and the toilet door without disinfecting them. After cleaning and mopping the rest of the residents' room, the housekeeper returned to the cleaning cart in the hallway, disposed of her gloves and retrieved a new pair of gloves. The housekeeper immediately donned the new gloves, and moved toward another resident's room without performing hand hygiene. HSK #2 then proceeded to room # 2311. In addition to the failures discussed above, HSK #2 failed to replace her gown which had rubbed against the toilet seat in room # 2104. D. Staff interviews HSK #1 was interviewed on 6/9/20 at 11:03 a.m. She said she should allow a five minute dwell time before wiping the surfaces down after spraying. The environmental service manager (ESM) was interviewed on 6/9/20 at 11:05 a.m. He said the Virox plus disinfectant had a five minute dwell time and should have been left on the surfaces for the duration of the five minutes. The ESM was interviewed a second time on 6/9/2020 at 12:53 p.m. The ESM stated housekeepers should clean from the clean areas to dirty areas and use different rags to clean the different living areas of residents and the entire room. He said, Not following the proper cleaning procedures, touching residents personal effects with used gloves and not using the cleaning products correctly can affect their disinfecting properties and thus increase the spread of infections. The ESM stated the housekeeper should perform hand hygiene before donning and after doffing gloves. He said in the case of the gown rubbing against the toilet seat, that the safe practice was for another housekeeping staff to have helped HSK #2 grab a new gown and not to wear the gown out of the room needless to say into another resident's room. The director of nursing (DON) and the NHA were interviewed at 4:30 p.m. According to the management staff, proper housekeeping procedures in execution of recommended disinfectant dwell time, were an ongoing concern. The NHA said housekeeping staff were in the process of observation audits with on-the-spot and emergency training based on past concerns. The NHA said an action plan had been put into place. E. Record review The quality assurance improvement plan for housekeeping and disinfection, dated 6/8/20, was provided by NHA on 6/9/20 at 4:15 p.m. According to the plan, housekeepers did not follow the 5-step order when cleaning. The plan indicated the expected date of completion was 6/8/20. An inservice was conducted on 6/8/20 with the housekeeping/environmental services staff record and attendance sheet was provided by NHA on 6/9/20 at 4:15 p.m. According to the inservice, cleaning product dwell times were reviewed. The attendance sheet indicated HSK #1 and HSK #3 attended the inservice. V. Disinfection and labeling of chemicals for mechanical lifts A. Facility policy and procedure The policy titled, Cleaning and Disinfection of Resident-Care items and Equipment, revised October 2018, was received on 6/9/ at 4:00 p.m. The policy documented in pertinent part, Durable Medical Equipment (DME) must be cleaned and disinfected before use by another resident. Reusable resident care equipment will be decontaminated between residents according to manufacturer's instructions. B. Observations and interviews On 6/8/2020 at 6:25 p.m., two mechanical lifts (lifts used to transfer residents) were observed in an activity room across from and next resident rooms. The lifts each had a green bottle hanging from them. The green bottle read sanitizer. There was no other information on the bottles. LPN #2 was present. He said the lifts were used to transfer many residents. He did not know how many. He said the green bottles with liquid in them were used to clean the lifts. He did not know what the product in the bottles was or the dwell time for the product to be effective. He said the bottles should have been labeled because what if it caused a burn. He said the bottles should be labeled so we know how to use the chemical and how it works. He left the room with the bottles hanging on the lifts to find a certified nurse aide (CNA) who might know what was in the green bottles. CNA #2 was interviewed on 6/8/2020 at 6:34 p.m. She looked at the green bottles hanging on the two lifts. She said she sprayed the lifts with the chemical and wiped them dry between each resident. She did not know what the chemical was, or the dwell time for the chemical. She said she would ask the unit manager (UM). The UM was interviewed on 6/8/2020 at 6:37 p.m. She said she did not know what chemical was in the green bottles, but she would check the safety data sheet in her book. She went to the desk and began looking through safety data sheets in a binder. She said she was unable to find the sheet because she did not know the name of the product she was looking for. She said she thought it was a new product they had been inserviced on last week. She could not recall the name. The UM said it had a 10 to 15 minute dwell time.She said the product should be labeled with the name and directions. She said it could be dangerous if it had gotten in someone's face. She said she would contact the central supply clerk (CSC) to see what the product was. The environmental services manager (ESM) was interviewed on 6/8/2020 at 6:45 p.m. He said the green bottles did not come from the housekeeping department and he did not know what was in them. He said maybe they came from central supply. The ESM said the bottles had to be labeled with the name and directions because they could be harmful or poisonous to the staff or residents. He said the staff need to know how to use the chemicals. He opened one of the bottles and smelled the contents. He said it smelled like chemicals, but he did not know which one. The CSC was interviewed on 6/8/2020 at 6:51 p.m. with the nursing home administrator (NHA), in the room with the lifts. The CSC and NHA said they did not know what was in the bottles. The CSC said she had not seen them before. The NHA said she would check the rest of the facility for similar bottles to ensure they were removed. The facility failed to ensure potentially hazardous chemicals were labeled and the staff were aware of the proper use.