STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY HEIGHTS REHAB AND CARE COMMUNITY	656 DILLON WY AURORA, CO 80011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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 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. Specifically, the facility failed to ensure: -Isolation precautions were implemented for Resident #1 upon admission to meet the 14 day quarantine recommendation; -Medical supplies and personal protective equipment (PPE) were properly stored; -Proper housekeeping procedures were followed for resident rooms and develop a process to sanitize bathroom keys for the front men/women bathrooms; -Hand hygiene options were available to residents in their rooms or offered to residents prior to dining; and, -Social distancing of residents within the community and outside in the patio/smoking area. Findings include: I. Failure to ensure isolation precautions were implemented for Resident #1 upon admission. A. Professional reference CMS Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes revised 3/9/2020 read in pertinent part, Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room). B. Facility policies and procedures The Infectious Disease Threat, policy dated 4/19, was provided via e-mail by the nursing home administrator (NHA) on 4/7/2020 at 2:07 p.m. The policy read, An infectious disease threat is defined as a rapidly spreading (highly contagious), virulent illness that threatens the health and safety of residents, staff and visitors. A communicable disease outbreak is not considered a disaster unless the disease results in loss of life or severe illness and has the potential to spread easily from person to person. Emerging (newly identified) infectious pathogens and diseases are identified by public health agencies (for example, local health departments, the Centers for Disease Control and Prevention and the World Health Organization). The policy revealed the infection preventionist was responsible for establishing relationships and managing information from public health agencies regarding existing or emerging infectious disease events. An Infectious Disease Threat Plan is initiated when the spread of a serious pathogen is sustaining human-to-human transmission in the United States, and the Infection Prevention and Control team determines that residents, staff and visitors face imminent threat of infection. The Equipment and Supplies Used During Isolation policy, revised 10/18, was provided via fax by the nursing home administrator (NHA) on 4/7/2020 at 2:07 p.m. The policy read in pertinent part, Appropriate infection prevention and control equipment and supplies are obtained, stored and used in accordance with current guidelines and manufacturer instructions. The policy revealed, Personal protective equipment (PPE) (i.e., gloves, gowns, etc.) were worn when handling or transporting resident care equipment and supplies that were visibly soiled or had been in contact with blood or body fluids. The Transmission-Based Precautions (TBP) (i.e., Contact Precautions, Droplet Precautions and Airborne Isolation Precautions) to be followed to prevent spread of infections; which included selection and use of PPE (e.g., indications, donning/doffing procedures) and the specific clinical conditions for which specific PPE should be used was requested from the facility on 4/6/2020. The policies provided by the facility on 4/7/2020 did not include the above requested information. C. Resident #1 1.Resident status Resident # 1, age 87, was admitted on [DATE]. The 2020 computerized physician orders [REDACTED]. The resident was discharged from the hospital and admitted directly to the facility. A minimum data set (MDS) assessment was not completed. A brief interview for mental status (BIMS) score was not assessed. The resident had not been in the facility for more than one day. 2. Observation The outside of Resident #1 ' s room was observed on 4/6/2020 at 10:38 a.m. A box of vinyl gloves were on the hand rail to the left of the resident ' s room. A closed cardboard box approximately 12 inches by 12 inches was on the floor outside the resident room to the left of the doorway. A new yellow gown in an unopened clear plastic package was placed on top of the cardboard box. The door did not have a sign which indicated the room was under isolation precautions and the type of precaution. Proper personal protective equipment (PPE) and medical supplies were not available for staff use upon entering the room. At 12:20 p.m. the gloves, cardboard box and packaged yellow gown were no longer outside of Resident #1 ' s room. At 12:30 p.m. an unknown CNA wearing a surgical mask delivered lunch plates to resident ' s rooms on the south unit. The CNA entered Resident #1 ' s room with a lunch plate. Proper PPE was not available for staff to put on before entering the room. The door did not have a sign which indicated the resident was under isolation precautions or the type of precaution. 3. Record review A care plan had not yet been developed for the resident as he had not been at the facility for more than one day. Hospital records dated 4/2/2020 read in pertinent part, the resident was brought to the emergency department (ED) after being found down with [MEDICAL CONDITION] and hypoxemia [MEDICAL CONDITION]. The resident was diagnosed with [REDACTED]. The physician documented, After discussion with ID (infectious disease) the plan is to treat with [MEDICATION NAME] for 4 weeks with plans for repeat CT (CAT scan). The hospital admitting [DIAGNOSES REDACTED]. The resident was tested for [DIAGNOSES REDACTED] COV2- PCR (Covid-19) upon his admission to the hospital on [DATE]. -Although the test was negative it was completed eight days before the resident was admitted to the facility. A second test was not completed at the facility upon admission, and was not isolated and monitored for 14 days considering the residents symptoms. The 4/2020 CPO showed an order dated 4/6/2020 for [MEDICATION NAME] Tablet 875-125 MG ([MEDICATION NAME]-pot Clavulanate), one tablet by mouth two times a day for pneumonia/probable aspiration until 4/26/2020. Progress notes from 4/5/2020 through 4/7/2020 showed staff documented the resident was on isolation precautions for pneumonia for seven days, was on abx (antibiotic) therapy for pna (pneumonia), had inadequate intake for nutrition and hydration, had a productive cough, diminished lung sounds in right (R) middle and lower lobes, dyspnea and used supplemental oxygen via nasal cannula. On 4/6/2020 at 10:50 a.m. while RN #1 was reviewing Resident #1 record for isolation, a handwritten nursing note was on top of the medication cart, and was read by RN #1. The RN stated the note read, Resident #1 was on precautions for pneumonia for 7 days. A nursing data collection note dated 4/5/2020 at 2:55 p.m. showed Resident #1 ' s admission information. The note documented the resident was alert, hand grasps were equal, he was disorientated and did not respond appropriately when questioned, he had dyspnea and used supplemental oxygen via nasal cannula. A nursing note dated 4/5/2020 at 8:28 p.m. revealed the resident arrived at the facility at 2:55 p.m. via ambulance and stretcher. The resident was alert and oriented (A/O) times one to two. He verbalized his needs with some difficulty and was on isolation precautions for 7 days. The nurse ' s assessment showed his lungs were CTA (clear to auscultation), his skin had multiple alterated (sic) areas, currently covered with dry dressing. The nurse documented a wound care consult was required. On assessment his vital signs showed his blood pressure (BP) was 128/80, pulse 78, oxygen level was 91% on room air (RA), temperature was 98.9, and respirations were 16 breaths per minute. The note revealed the resident required total assistance with transfers and activities of daily living (ADL). He was incontinent of his bowel and bladder and tolerated medications by mouth (PO) one at a time in applesauce. A nursing note dated 4/5/2020 revealed the on call physician was notified of the resident ' s admission and the resident ' s medications were reconciled. A nursing note dated 4/6/2020 at 1:40 p.m. documented Resident #1 was on abx (antibiotic) therapy for pna (pneumonia). He had inadequate

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) intake for nutrition and hydration. He had a productive cough. His lung sounds clear in top lobes and diminished in right (R) middle and lower lobes. A nursing note dated 4/7/2020 at 1:35 a.m. documented the resident was on oxygen 1.5 liters (L) via nasal cannula (NC). A nursing note dated 4/7/2020 at 11:49 a.m., written by the DON, documented rounds were completed with the physician assistant (PA). The resident was not on any ISO precautions. His lung sounds were diminished in lower lobes, otherwise unremarkable. He denied having shortness of breath (SOB). The resident ' s temperature summary from his admission on 4/5/2020 to 4/7/2020 revealed his temperature was 98.9 F on 4/5/2020, 96.6 F on 4/6/2020 at 12:35 p.m., 98.3 F on 4/6/2020 at 8:02 p.m. and 101.6 F on 4/7/2020 at 1:10 p.m. The documented temperatures from 4/5 and 4/6 revealed a decrease of 2.3 degrees. The resident ' s temperature was taken again the evening of 4/6/2020 which showed an increase of 2.3 degrees. At 12:35 p.m. on 4/7/2020 the resident ' s temperature rose another 3.3 degrees to 101.6 degrees. The above progress note on 4/7/2020 was written two hours and 20 minutes before the resident ' s temperature increase showed isolation precautions were not needed. The note did not include the reason it was not needed. D. Staff interviews An unidentified staff person was interviewed on 4/6/2020 at 10:36 a.m. The staff said she did not know if or why the resident was on isolation precautions. She said the nurse would have to be asked. Registered nurse (RN #1) was interviewed on 4/6/2020 at 10:38 a.m. The RN stated the resident came from the hospital the night before and was on isolation precautions but he did not know why. The RN stated he was going to follow up with the hospital to find out. A follow up interview at 10:50 a.m. revealed RN #1 was not able to obtain any information from the hospital. The RN stated the resident was on seven day precautions for pneumonia. He stated there was not much information in his (Resident #1 ' s) record. The RN stated, if the resident was on isolation there should be PPE available outside the door. He said he did not know why there wasn ' t a PPE cart or a sign on the door. The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 4/6/2020 at 1:15 p.m. The NHA stated he had removed the gloves, box and the packaged gown from the floor. He said staff placed the gown on top of an empty box so it wouldn ' t be on the floor. He said there were enough PPE cabinets and staff should have used one for the PPE storage instead of putting the gown on a cardboard box. The DON stated the gloves, gown and box were removed because the resident did not need isolation. She said his pneumonia sputum culture was negative. The infection preventionist specialist (IPS) was interviewed on 4/7/2020 at 5:30 p.m. The IPS stated Resident #1 was admitted from the hospital with the order for isolation. She said the facility ' s isolation process was different than the hospital ' s process, but at that time, the isolation precautions and PPE should have been in place. She said, it was her responsibility to put out the PPE cart and the sign on the resident ' s door if she was in the building. If she was not in the building, she trusted the nurses to set up and put out the isolation cart and a sign on the door. The IPS stated she was not in the building on 4/5/2020 when the resident was admitted or on 4/6/2020. She said the facility ' s process was to isolate residents if there were signs and symptoms of a new or worsening illness and laboratory (lab) work, or chest x-ray which indicated the resident was contagious and needed isolation. Infections that required isolation precautions were [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) depending on location of wounds, a positive urine lab, any positive culture, or a positive sputum culture. She said the facility did not use isolation precautions without an identified organism and cultures were done only if ordered by the doctor. The IPS stated the facility did not separate residents who lived in the same room (roommates), even if we wanted to; the facility is at capacity. The IPS confirmed Resident #1 had a temperature of 101.6 degrees F on 4/7/2020. She said the resident was not going to be placed on isolation precautions because he was tested for everything and it all came back negative at the hospital. -However the resident remained in the hospital for approximately eight more days after he tested negative, which in this time would be sufficient time for the resident to possibly come in contact with the COVID-19 disease. The facility failed to isolate, contain the resident upon admission for the recommended time according to the CDC guidelines regardless of any preexisting additional diseases that could be contagious. Furthermore, Resident #1 ' s medical condition put him at a greater risk of contracting COVID-19. II. Failure to ensure medical supplies and personal protective equipment (PPE) for isolation precautions were properly stored. A. Observation Resident #1 ' s room was observed on 4/6/2020 at 10:38 a.m. A box of vinyl gloves were on the hand rail to the left of the resident ' s room. A closed cardboard box approximately 12 inches by 12 inches was on the floor outside the resident room to the left of his doorway. A yellow gown in a clear plastic package was on top of the cardboard box. The door did not have a sign which indicated the room was under isolation precautions. B.Staff interviews The NHA was interviewed on 4/6/2020 at 1:15 p.m. The NHA stated he had removed the gloves, the packaged gown and the box from the floor. He said the staff placed the gown on top of an empty box so it wouldn ' t be on the floor. He said there were enough PPE cabinets and staff should have used one for the PPE storage. The infection preventionist specialist (IPS) was interviewed on 4/7/2020 at 5:30 p.m. The IPS stated an isolation cart (PPE cabinet) should contain gloves, booties, hair caps, gowns, biohazard bags, red sugar bags for contaminated laundry and, prior to quarantine, masks. She said during resident care, staff were already using standard precautions by wearing masks and gloves due to Covid-19. III. Failure to ensure proper housekeeping procedures were followed for resident rooms A. Resident rooms 1. Professional reference Environmental Cleaning and Disinfection Validate environmental services staff members processes: (1) Follow label instructions on the hospital grade disinfectant; (2) Validate disinfection policies and procedures (e.g., cleaning from clean to dirty, changing gloves and performing hand hygiene between rooms and between resident surfaces within the same room). 2. Observation Housekeeper (HSK #3) cleaned room [ROOM NUMBER] on 4/6/2020 at 11:01 a.m. HSK #3 sanitized her hands with alcohol based hand rub (ABHR), donned gloves, removed the broom from her cart and swept the floor. She returned to her cart and removed a rag and spic and span spray and returned to the room. She removed a Bible, four silverware packets and three ketchup packets from the tray table. She sprayed spic and span on the tray table and wiped it with the rag, replaced the items she removed, and returned the spic and span to the cart. She removed the trash bag from the receptacle and brought it to her cart. She removed the Comet spray from the cart, sprayed the door handle and wiped it. She sprayed Comet in the sink and with the same rag she wiped it immediately. She went to the bathroom, sprayed the toilet with Comet, wiped inside the toilet bowl, seat, and then the outside of the toilet, tank, sides and bottom of the toilet. She sprayed the commode/over the seat toilet chair and wiped it down. With the same rag, she wiped the grab bars. She returned the Comet to the cart and took the Mr. Clean Max floor cleaner and the mop. She sprayed the floor with the floor cleaner and mopped the floor. She sprayed Febreeze in the air, returned it to her cart, removed her gloves and sanitized her hands with ABHR. HSK #3 was unable to be interviewed due to difficult communication as English was not her first language. -HSK #3 ' s housekeeping process revealed several gaps in infection control. Lack of glove changes and hand hygiene during the room cleaning, chemical dwell times not followed for proper disinfection, use of the same rag throughout the room and bathroom (i.e., cleaning inside the toilet bowl then the seat, outside, and tank with the same rag) the cleaning from dirtier to cleaner surfaces using the same rag (i.e., toilet, commode then the grab bars). 3. Staff interviews Housekeeper (HSK #1) was interviewed on 4/6/2020 at 11:29 a.m. HSK #1 stated Spic and span, general disinfectant with a dwell time of 10 minutes, was used on hard porous surfaces, tray tables, bed rails, mirrors and glass. He said it was used on everything except where Comet goes. Comet had 10 minute dwell time and was used on wet surfaces such as the sink, toilet, and toilet lid or anywhere water can stand for a period of time. Febreeze was sprayed on cloth surfaces, not in the air. One rag was used for cleaning; It was folded into eights. The rag was folded in half, then folded in half again so there were eight clean sides to use. He said gloves were changed for every room. The HSK said he did hands on training with HSK #3. The housekeeping supervisor (HS) was interviewed on 4/6/2020 at 11:53 a.m. The HS stated she trained housekeepers on the chemical and safety data sheet. She said staff received weekly training regarding Covid-19 infection control. The training went over, how to clean and how to dispose of PPE. Spic and span had 10 minute dwell. She said it was used on the mirror and wiped right away. Comet was used for the sink and toilet and had a 10 minute dwell time. Spray toilet bowl with comet wait for dwell time clean inside bowl with a toilet brush and rag for sides and back tank. She said a rag was used on the bathroom, sink, and nightstands. The same rag should not be used for grab bars and the toilet. Staff go through seven rags cleaning a room. Staff changed gloves for every room. She said HSK #3 was a new staff, hired a couple of weeks ago. Communication was difficult as she did not speak much English. She was trained, but I do not have documentation of training on paper for HSK #3. Had her do the initial training. Typically a five day training. She stated monitoring for proper housekeeping procedures was not done. She said she will monitor now HSK #2 was interviewed on 4/7/2020 at 11:59 a.m. HSK #2 stated she trained HSK #3 only one day. HSK #1 trained HSK #3 the other four days. She said the Comet spray had a 10 minute dwell time and was used for the sink and the bathroom. A scrub brush was used for the inside of the toilet and a clean rag for the seat and rim. She stated, during training, Communication was a snag. I showed her what she needed to do then followed behind and showed what she missed. IV. Failure to ensure hand hygiene options were available to residents in their rooms or offered to residents prior to dining. A. Professional references

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care, retrieved 4/8/2020. The Center for Disease Control (CDC) guidance Supplies for Recommended Infection Prevention and Control Practices directed facilities to ensure hand hygiene supplies were available for use by residents. The guidance read in pertinent part, Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). The Centers for Medicare and Medicaid Services (CMS) Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes, revised 3/9/2020 Ref: QSO-20-14-NH read in pertinent part, Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), reinforce strong hand-hygiene practices, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc. Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms. B. Facility policy The Hand Hygiene policy for staff and resident hand hygiene, specifically before meals was requested from the facility via email on 4/6/2020. The Handwashing policy was provided via fax by the NHA on 4/7/2020 at 2:07 p.m. The policy read in pertinent part, Handwashing is the single most important step we can take to prevent the transfer of infection. The policy documented, Always wash your hands before eating. Alcohol-based hand sanitizers which do not require water are an excellent alternative to handwashing, particularly when soap and water aren't available. They're actually more effective than soap and water in killing bacteria [MEDICAL CONDITION] that cause disease. Not all hand sanitizers are created equal, though. Some 'waterless' hand sanitizers don't contain alcohol. Use only the alcohol-based products. The policy did not include how resident hand hygiene was provided prior to meals. 1. South Hall a. Observations On 4/6/2020 at 12:30 p.m. staff were observed delivering meals to residents in their rooms. Staff did not offer hand hygiene to residents before eating their lunch or provide hand sanitizer to capable residents in their rooms. At 12:30 p.m. an unknown CNA delivered lunch to Resident #1 ' s room. Although the CNA wore a surgical mask, proper PPE was not available outside of the room for staff to put on to deliver the lunch. The door did not have a sign which indicated the resident was under isolation precautions. The CNA did not offer hand hygiene to either resident in the room. At 12:36 p.m. room [ROOM NUMBER] was observed at lunchtime. The observation revealed there was no hand sanitizer or hand wipes available for the residents to use prior to eating lunch. At 12:38 p.m. RN #1 delivered lunch to room [ROOM NUMBER]. The resident was seated in front of his tray table. The RN placed the plate and silverware in front of the resident. The RN did not offer the resident hand hygiene prior to eating his lunch. 2. North Hall b. Observation and interviews On 4/6/2020 beginning at 12:11 p.m. certified nurse aides (CNAs) #1 and #2 were observed to quickly pass out room trays to seven residents. There was no evidence of hand sanitizer solution or wipes seen stored on the tray cart. CNA #1 and #2 did not offer to assist any of the seven residents to wash their hands or offer them any hand sanitizer gel or wipes. Some of the residents were observed lying in bed and others were observed ambulating in their wheelchairs by using their hands to propel the wheels themselves to position themselves up to the bedside table where their trays were sat down. Residents began to eat their meals as soon as it was placed in front of them. Resident #5 was interviewed on 4/6/2020 at 12:30 p.m. The resident stated she was unable to wash her own hands because she could not reach the sink in her wheelchair. She said staff did not provide hand hygiene before meals. She also stated she was not provided education for hand hygiene or social distancing. She said all they told her was to not go out anywhere. Resident #3 was interviewed on 4/6/2020 at 12:36 p.m. She stated staff did not offer hand hygiene before or after eating. She said she could not get to her sink due to her inability to get up on her own. She stated hand sanitizer or hand wipes were the only things she really needed. She said she was not provided education for hand hygiene or Covid-19. CNA #1 was interviewed on 4/6/2020 at 12:42 p.m. She said that she had been trained and reeducated regarding proper hand washing techniques for staff and for residents. She said staff should be asking or helping residents to wash their hands before and after they eat their meals to minimize spread of infection. She said she usually carried a small bottle of hand sanitizer with her in her pocket but had run out. She acknowledged that she did not offer residents to clean their hands when she passed them their trays. Resident #9 was interviewed on 4/6/2020 at 12:44 p.m. He said he had to eat in his room all the time now with the illness restrictions. He said the aides did not say anything to him about cleaning his hands or offer to wipe his hands when they brought his food. Resident #7 and #8 were interviewed on 4/6/2020 at 12:55 p.m. They both said that staff do not always offer or ask them to wash their hands when their meals are brought to them. V. Failure to ensure social distancing of residents within the community and outside in the smoking area. A.Observations The smoking patio outside of the south unit was observed on 4/6/2020 at 10:45 a.m. The observation showed residents seated at round patio tables with an approximate diameter of four feet. Three residents at the table to the left were within approximately four feet of each other. Two residents at a patio table to the right moved closer to each other and looked at a cell phone together. A manicure activity located in the common area between the north and south units was observed on 4/6/2020 at 10:23 a.m. One staff person was sitting next to the manicure cart and four residents were sitting in a semi-circle in front of the staff person with an approximate distance of two to three feet in between each resident. The NHA and DON walked by and told the staff and resident ' s the need to social distance and asked them to spread out to six feet between each person. On 4/6/2020 at 12:16 p.m., seven residents were observed outside in the south smoking patio. They were sitting next to each other around two patio tables and not six feet apart. There was one female staff member sitting at one of the tables with the face mask ear loops over her ears but the front of the mask was pulled down under her chin and not covering her nose or mouth. She was observed to hand one of the residents a lighter. She was sitting across the patio table from the resident. Resident #10 was going out the south door in his wheelchair at the time of this observation. He was going out to smoke. He was asked if the facility staff had educated him regarding social distancing. He said yes and that the residents tried but it did not always happen because they just wanted to go out and smoke. B. Resident interviews Resident #5 was interviewed on 4/6/2020 at 12:30 p.m. The resident stated she was not provided education on social distancing. She said all they told her was to not go out anywhere. Resident #3 was interviewed on 4/6/2020 at 12:36 p.m. The resident stated she was not provided education on social distancing. VI. Failure to develop a process to sanitize bathroom keys for the front men/women public bathrooms. A. observation and interview On 4/6/2020 at 10:30 a.m. two keys, attached to plastic PVC ([MEDICATION NAME] chloride) pipe, were hanging outside the men and women's public bathroom on the wall and accessible to everyone. The storage of the keys created a potential for cross-contamination. Staff were observed using the keys to gain access to both bathrooms. The housekeeping supervisor (HS) was interviewed on 4/6/2020 at 1:00 p.m. She said the keys at the front of the building had been there for over a month. She said she was not sure why they were put there. She acknowledged that the keys presented a sanitation concern. She said wiping the keys down was not part of the housekeeping department's responsibility. Housekeeper (HSK) #4 was interviewed on 4/6/2020 at 1:05 p.m. He said he had not cleaned the keys but he was responsible for cleaning the two bathrooms. He said if he saw the keys soiled he would wipe them down. VII. Improper storage of medical supplies On 4/6/2020 at 10:46 a.m. a brown box was observed directly on the floor in front of the linen closet on the northwest hallway of the facility. The top of the box was opened and inside were boxes of gloves. The nursing home administrator (NHA) was shown the boxes on the floor and interviewed on 4/6/2020 at 10:55 a.m. He said he did not know what they were doing there and said they should not be stored there. He then picked up the box and took them to an appropriate storage area. E. Additional staff interviews The infection prevention specialist (IPS) was interviewed on 4/7/2020 at 12:39 p.m. She said that staff and residents had been educated on the importance of proper hand washing and hand hygiene. She said some residents were independent and could wash their hands in their sink. She said the facility had some hand sanitizer dispensers throughout the building in the hallways. She said residents should have their hands cleaned before and after they eat and for the residents who smoke, they should be cleaning their hands after they come back from smoking. She said she expected the staff to be offering hand hygiene to the residents prior to them eating. She said that residents had been told about the importance of social distancing and to stay six feet away from each other. She said this was especially difficult with the residents who smoked on the south side of the building because they were a close knit group. She said that staff try to reeducate and monitor the residents. She said it was their right to choose to go out and smoke. She said they did not have a current system in place to document resident refusals.