STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265736	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
U-CITY FOREST MANOR	1301 PARTRIDGE AVENUE SAINT LOUIS, MO 63130

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** - Immediate jeopardy **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 properly contain COVID-19 by not developing policies and procedures and not following current standards of practice regarding the control of infection transmission. When staff first identified residents as having COVID-19, the facility had no dedicated area for the treatment of [REDACTED]. Three residents who tested positive for COVID-19 and resided on the memory care unit had roommates who were either negative for COVID-19 or had an unknown COVID-19 status (Residents #5, #6, #9, #10, #7 and #8). Staff placed the positive residents on transmission based precautions, but left them in the same room with their roommate, putting the roommates at risk from [MEDICAL CONDITION], from 8/4/20 when the first positive test results came back until after informed by the state survey team on 8/5/20 of the failure. The facility failed to have a current, trained staff member designated as their infection preventionist. A resident known by staff to be positive for COVID-19 (Resident #5) was observed to sit in the television area with an unmasked resident negative for COVID-19 (Resident #13), and staff failed to immediately redirect the positive resident to his/her room. Staff failed to appropriately mark a positive resident's room (Resident #11) to identify the resident's COVID status. Staff failed to wear proper personal protective equipment (PPE) and failed to properly dispose of used PPE when caring for residents positive for COVID-19. Furthermore, staff failed to properly wear facemasks while preparing food, have sufficient biohazard waste containers available for staff and to properly store them (Residents #1, #2, #3, #4 and #12). The resident sample size was 13. The census was 90. The administrator was notified on 8/7/20 at 2:20 P.M., of an Immediate Jeopardy (IJ) which began on 8/4/20. The IJ was removed on 8/7/20, as confirmed by surveyor onsite verification. Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID 19 in Nursing Homes guidelines, updated 6/25/20, showed the following: -Given their congregate nature and resident population served (older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19. As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and health care personnel (HCP); -Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19; -Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use; -Have a plan for how residents in the facility who develop COVID-19 will be handled: -Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated; -The facility is to provide supplies necessary to adhere to recommended infection prevention and control practices. The facility should position a trash can near the exit, inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room; -Environmental Cleaning and Disinfection: Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas. -If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohort in the same area of the facility and these residents are not known to have any co-infections; -Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities; -HCP should wear a facemask at all times while they are in the facility; -Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room. Review of the facility's hand hygiene policy, dated August 2020, included the following information: -This facility considers hand hygiene the primary means to prevent the spread of infections; -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -After removing gloves; -Before and after entering isolation precaution settings; -Hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 1. Review of the facility's list of COVID-19 positive residents, dated 8/5/20, showed the following: -Total of ten residents tested positive for COVID-19 as of 8/5/20; -Residents #1, #2, #3, #4, #5 #7, #10, #11 and #12 were included on the list of residents who tested positive for COVID-19. Upon entrance to the facility on [DATE] at 7:15 A.M., the business office manager (BOM) said there were positive residents on the 400 hall and also on the secured unit, which included the 300 and 500 halls. The residents on the secured unit would not be moved due to risk of elopement. At 7:48 A.M., the BOM said the red tape at the resident's room door meant the room had a positive resident. Yellow tape meant the resident had been exposed or was under quarantine. Observations of the secured unit on 8/5/20 at 7:45 A.M., 8:50 A.M., and 10:10 A.M., showed the facility failed to post signs at the entrance to the 300 hall or 500 hall to inform staff or visitors they were entering a COVID-19 positive area or to don the appropriate PPE. Observation of rooms, showed two rooms with red tape and one room with yellow tape on the 300 hall and one room with red tape on the 500 hall. Observations of the 400 hall on 8/5/20 at 8:00 A.M. and 10:20 A.M., showed the facility failed to designate an area for COVID-19 positive residents. The facility identified 6 residents who tested positive on the 400 hall and 10 negative residents remained on the 400 hall. The facility failed to post signs to inform staff or visitors they were entering a COVID-19 positive area or to don the appropriate PPE. Review of Resident #5's medical record, showed the following: -Admission face sheet, showed an admission date of [DATE] and a readmission date of [DATE]; -[DIAGNOSES REDACTED]. Review of Resident #6's medical record, showed the following: -Admission face sheet, showed an admission date of [DATE] and a readmission date of [DATE]; -[DIAGNOSES REDACTED]. Observations on 8/5/20 at 8:47 A.M. and 10:20 A.M., showed resident #5 and #6 resided in the same room. Staff placed red tape around the exterior of the doorframe to indicate a positive resident. Staff failed to separate the positive resident from the negative/unknown status resident. During an interview on 8/6/20 at 12:30 P.M., the administrator verified Resident #5 tested positive for COVID-19 and the facility received the resident's test result late on 8/3/20. The administrator received the notification regarding the test results between 10:00 A.M. and 11:00 A.M. on 8/4/20. She notified the Assistant Director of Nursing (ADON) on 8/4/20 about Resident #5's positive test result and informed the ADON that Resident #5 needed be transferred to a room with another positive COVID-19 resident. The administrator said Resident #5 resided with Resident #6, who is negative for COVID-19 at the time Resident #5's test result showed positive for COVID-19. She expected nursing staff to have moved

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Resident #5 as she instructed on 8/4/20. She verified both Resident #5 and Resident #6 still resided in the same room on 8/5/20 at the time of the observation. The administrator said housekeeping staff deep cleaned/sanitized the room on 8/5/20. She said Resident #6 remained in the room, quarantined and monitored by nursing staff for signs/symptoms of COVID-19. Observations on 8/7/20 at 6:50 A.M., showed the following: -Resident #5 in a different room with another resident the facility identified as positive. Staff placed red tape around the exterior of the doorframe; -Resident #6 remained in his/her original room. The red tape was removed from around the doorframe. Staff failed to place yellow tape around the exterior of the doorframe to indicate the resident had been exposed. During an interview on 8/7/20 at 8:13 A.M., the administrator said she could not locate test results for Resident #6. There must have been an oversight and the resident was not tested . The COVID status of the resident was unknown. 2. Review of Resident #13's medical record, showed the following: -An admission face sheet, showed an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observations of the secured unit on 8/7/20, showed from 6:54 A.M. until 7:05 A.M., Resident #5 sat in his/her wheelchair wearing a facemask in the TV area across from the nurses' station. Resident #13 lay in a geri-chair (reclining wheeled chair) in the TV room adjacent from Resident #5, approximately 6 feet apart from each other. Resident #13 did not wear a facemask. Nurse J sat at the nurses' station facing the two residents. Nurse J identified the two residents and verified Resident #5 was positive and Resident #13 was negative for COVID. At 6:57 A.M., Certified Nurse Aide (CNA) G arrived at the nurses' station and asked why Resident #5 was out of his/her room. Nurse J said Resident #5 missed his/her transportation to an appointment and was placed in the TV room by his/her roommate. CNA G said the resident should not be out of his/her room. Both staff members walked away from the nurses' station. Residents #5 and #13 remained in the TV area. At 7:05 A.M., CNA G, who wore two surgical masks, donned gloves and wheeled Resident #5 into his/her room. CNA G then exited the room without doffing the gloves or closing the door. CNA G failed to properly don an N95, goggles, hair covering and gown prior to entering the room. CNA G failed to doff the gloves inside the room before exiting. A sign posted on the resident's door, showed, Presumed COVID-19 positive, before entering room, please put on N95 (respiratory) mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. Observation inside the room, showed no biohazard waste barrels. During an interview on 8/7/20 at 11:26 A.M., CNA G said he/she worked with both positive and negative residents on the same shift. Red tape indicated a positive resident, yellow tape indicated a resident who was being observed and no tape meant the resident was negative. He/she has been educated on what PPE to wear into red rooms, which included head cover, goggles, N95 mask, shoe covers, gown and gloves, which go over the sleeves of the gown. When finished with the PPE, everything should be removed and discarded in the contamination can, except goggles and masks. Hands should be washed before coming out of the room. Doors to red and yellow rooms should remain closed at all times. If going into a yellow room, staff only have to wear masks, goggles and gloves. During an interview at 8/7/20 at 9:32 A.M., the the Director of Nursing (DON), said staff should have immediately moved Resident #5 to his/her room, and the door should be closed at all times to contain [MEDICAL CONDITION]. Staff should wear appropriate PPE for their protection and gloves should always be changed to prevent further spread of [MEDICAL CONDITION]. Housekeeping and everyone was responsible to make sure the biohazard barrels were inside resident rooms. They discovered on 8/5/20, they did not have enough barrels and have ordered more. 3. Review of Resident #9's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Review of Resident #10's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observations on 8/5/20 at 7:49 A.M. and 9:45 A.M., showed Resident #9 and #10 resided in the same room. Staff placed red tape around the exterior of the doorframe to indicate a positive resident. Staff failed to separate the positive resident from the negative resident. Observations on 8/7/20 at 6:49 A.M. and 9:45 A.M., showed the following: -Resident #10 moved to a different room with another resident the facility identified as positive. Staff placed red tape around the exterior of the doorframe; -Resident #9 remained in his/her original room. The red tape was removed from around the doorframe. Staff failed to place yellow tape around the exterior of the doorframe to indicate the resident had been exposed. Further observations on 8/7/20 at 6:50 A.M., showed Resident #10 walked away from the nurses' station and did not wear a facemask. The resident stopped the surveyor and grabbed his/her shirt and commented on it. The resident then continued to walk down the hall towards his/her room. At 7:05 A.M., CNA G brought the resident's roommate into the room and left without closing the door. At 7:07 A.M., Resident #10 walked out of the room and started to walk down the hall. CNA F stopped and told the resident he/she needed to go back to his/her room. The resident returned to his/her room. CNA F walked away and the door to the room remained open. At 7:13 A.M., the door remained open as several staff passed by. During an interview on 8/7/20 at 7:20 A.M., CNA F said staff were trained to wear PPE into rooms with red tape, which included gown, N95, surgical mask, gloves, hair and shoe coverings. Staff should sanitize hands before donning PPE and after doffing. The door to rooms with red tape should remain closed to keep the germs inside. CNA F then donned gloves and closed the door to Resident #10's room. He/she then walked across the hall to a room with no tape on the exterior of the doorframe and wearing the same gloves, opened the door and went inside. Further observations of the doors with red tape on the secured unit, showed an additional sign which stated: CDC Guidelines: Effective 7/23/20; -Instructions for putting on PPE before entering a red room: -Sanitize hands; -Put on gown; -Put on N-95 mask; -Put on surgical mask; -Put on goggles; -Put on gloves-cover gown cuffs; -Instructions for taking off PPE before leaving a red room: -Remove gloves; -Remove gown; -Place gown and gloves in red trash bag and leave room; -Remove goggles; -Remove face mask; -Wash/sanitize hands; -All staff must follow the above directions step by step. These directions will be posted on outside of Red Room door. 4. Review of Resident #7's medical record, showed the following: -An admission date of [DATE]; -[DIAGNOSES REDACTED]. Review of Resident #8's medical record, showed the following: -An admission date of [DATE]; -[DIAGNOSES REDACTED]. Observations on 8/5/20 at 7:49 A.M. and 10:10 A.M., showed Resident #7 and #8 resided in the same room. Staff placed red tape around the exterior of the doorframe to indicate a positive resident. Staff failed to separate the positive resident from the negative resident. Observations on 8/7/20 at 6:50 A.M. and 9:45 A.M., showed the following: -Resident #7 moved to a different room with another resident the facility identified as positive. Staff placed red tape around the exterior of the doorframe; -Resident #8 remained in his/her original room. Staff failed to place yellow tape around the exterior of the doorframe to indicate the resident had been exposed. During an interview on 8/7/20 at 11:26 A.M., CNA D said when residents were tested positive for COVID-19, they were moved to a single room without another roommate, unless the other roommate is also positive for COVID-19. The residents should be placed on isolation for up to 14 days. The CNA said no positive COVID-19 resident should be placed in a negative resident's room. The positive resident's door should be kept closed at all times and the positive resident should not be allowed to leave their room due to infection control. During an interview on 8/7/20 at 11:00 A.M., Nurse C said all positive COVID-19 residents should be isolated in a private or single room without a roommate unless both residents in the same room are positive. He/she said staff place red tape above and around the positive resident's door to indicate which residents are positive for COVID. When residents were admitted from the hospital, the residents were placed in a room with yellow tape above/around the edges of the door to indicate the resident in the room was on quarantine and should remain on quarantine for 14 days. The positive resident should be maintained on isolation for up to 14 days and/or if asymptomatic and should be retested prior to being taken off of isolation. He/she said every resident and staff member were tested every week at the facility. Nurse C said no positive resident should be in a room with a negative resident. The positive resident's door should be kept closed at all times. Review of the facility's COVID-19 Action Plan, dated 4/6/20, showed the facility failed to address any measures for deterring or containing [MEDICAL CONDITION] among residents. The action plan addressed how employees should be screened/monitored and steps to be taken to keep the employee safe if an employee cared for a resident with symptoms or a positive diagnosis. During an interview on 8/7/20 at 8:44 A.M., MDS Coordinator B (previous DON) said the facility did not have a COVID-19 policy/procedure regarding how to manage residents who test positive for COVID-19 and/or how to contain the residents with COVID-19. The MDS coordinator said he presented the COVID-19 Action Plan to the facility's corporate office for approval and noticed the Action Plan policy did not address how to manage and/or contain residents positive for COVID-19 when he presented the policy. The MDS Coordinator said he brought that to corporate's attention. He verified the facility did not have a policy specific to how to manage and/or prevent the spread of COVID-19 for residents. During an interview on 8/7/20 at 10:06 A.M., the DON said she was not aware there were positive residents on the secured unit prior to the survey team informing her on 8/5/20. She was only aware of positive residents on the 400 unit. She would have expected the residents exposed to positive residents be retested immediately and placed on observation. During interviews on 8/5/20 at 8:05 A.M. and on 8/7/20 at 9:32 A.M., the administrator said they realized the positive residents on the secured unit had remained in the same room as their negative roommates after the state surveyors began asking questions on 8/5/20. The positive residents were moved together on 8/5/20. The negative

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) roommates were being tested today during the facility wide testing, and were on observation. The administrator was not aware there needed to be a designated area for residents who were COVID-19 positive. They had their first positive test result on 7/24/20 and began making room changes. They were in the process of making a COVID-19 hall, but were having difficulty with some residents who did not want to move. They were trying to keep positive residents together. Staff knew which residents were on observation because their rooms were outlined with yellow tape. Staff were inserviced on what the red and yellow tape indicated prior to 8/4/20. The maintenance director was responsible to ensure the correct tape was posted around the doorframes. The administrator said there was not a specific policy in place regarding how to manage residents who tested positive for COVID-19 and/or how to contain the residents with COVID-19. They have had in-services. She began at the facility on 3/2/20, and expected there to be a policy in place before she started. The facility was in the process of being purchased, and she was dealing with the transition. The company that purchased the facility on 5/1/20, was currently reviewing and writing policies for the facility. The facility does not have an Infection Preventionist (IP) currently, but is in the process of hiring a Physician's Assistant (PA) who will be the facility's IP. The administrator said she is currently responsible for tracking all positive COVID-19 cases within the facility. She said the former DON was responsible for tracking all other infections within the facility. The current DON who recently started at the facility, will be responsible for tracking all other infections within the facility. During an interview on 8/10/20 at 12:15 P.M., the social worker for the facility's medical director, said the doctor would have expected staff to move the positive residents out of the same room as negative residents right away. The residents who had been exposed should have been retested immediately. The facility should have followed their policy and procedure. The facility did not have anything in place prior to this. 5. Review of Resident #11's medical record, showed the following: -An admission face sheet, showed an original admission date of [DATE], and a current admission date of [DATE]; -[DIAGNOSES REDACTED]. Observations of Resident #11's room on 8/4/20 at 7:50 A.M., 8:47 A.M. and 10:20 A.M., showed a sign posted on the resident's door, Presumed COVID-19 positive, before entering room, please put on N95 (respiratory) mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. Staff placed yellow tape on the exterior of the doorframe. Staff failed to correctly identify the positive status of the resident. During an interview on 8/7/20 at 9:32 A.M., the administrator said she did not know why the tape on Resident #11's was yellow since he/she tested positive on 8/3/20. 6. Observation of the kitchen on 8/5/20 from 7:36 A.M. until 7:38 A.M., showed the dietary manager (DM) walked in, out and throughout the kitchen without a facemask. During an interview at 7:38 A.M., the DM said he expected staff to wear a facemask at all times. He did not have on a facemask because he was cooking. He agreed he should wear a facemask while preparing food. Further observation of the kitchen on 8/5/20 at 9:26 A.M., showed the following: -One dietary aide scrubbed dishes with his/her facemask pulled down to his/her chin with his/her nose and mouth exposed; -Two dietary aides stood next to the food prep table with their masks pulled down under their chins with mouths and noses exposed; -The DM stood inside the kitchen with his mask pulled down under his chin with his mouth and nose exposed. During an interview at 9:27 A.M., the DM said he was responsible for ensuring dietary staff wear masks properly. Observation on 8/7/20 at 7:15 A.M., showed Floor Technician A with his/her facemask underneath his/her chin, buffing the floors next to the nurse's station between the 200 and 300 Halls. At 7:18 A.M., the floor technician positioned his/her facemask over his/her nose and mouth. During an interview at 7:18 A.M., Floor Technician A said he/she should have a facemask at all times that covered his/her nose and mouth. The floor technician said he/she received an in-service at the facility regarding the proper way to wear a facemask, and a facemask should be worn at all times when in the facility. During an interview on 8/7/20 at 9:33 A.M., the administrator and DON said they expected all staff to wear facemasks and should cover their nose/mouth at all times when they are in the building to prevent the spread of the COVID-19 virus. It was not appropriate for staff to wear their facemasks below their chin. 7. During an interview on 8/5/20 at 7:30 A.M., the ADON verified Residents #1, #2, #3 and #4 were in designated positive COVID-19 rooms due to testing positive for COVID-19. He said the red tape above the resident's door indicated the resident was positive for COVID-19. Review of Resident #1's medical record, showed the following: -Admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observation of Residents #1's room, at the front of the 400 Hall, showed the following: -On 8/5/20 at 7:49 A.M. and 9:30 A.M., of a sign posted on the resident's door, Presumed COVID-19 positive, before entering room, please put on N95 (respiratory) mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. The two isolation biohazard bins positioned directly outside of the resident's room in the hallway. -On 8/7/20 at 6:52 A.M., the two isolation biohazard bins remained positioned directly outside of the resident's room in the hallway. There was no red isolation bin and/or linen bins inside the resident's room. -The room directly across from Resident #1 was occupied by a non-COVID resident. 8. Review of Resident #2's medical record, showed the following: -Admission face sheet with a readmission date of [DATE]; -[DIAGNOSES REDACTED]. Observations of Resident #2's room, showed the following: -On 8/5/20 at 7:49 A.M. and 9:30 A.M., a sign posted on the resident's door, Presumed COVID-19 positive, before entering room, please put on N95 mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. The two isolation biohazard bins were positioned directly outside of the resident's room in the hallway. -On 8/7/20 at 6:58 A.M., one bin, marked linen, positioned directly outside of the resident's room and no isolation bins positioned inside of the resident's room. 9. Review of Resident #3's medical record, showed the following: -Admission face sheet with an admission date of [DATE] and readmission date of [DATE]; -[DIAGNOSES REDACTED]. Review of Resident #4's medical record, showed the following: -Admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observations of Resident #3 and #4's shared room, showed the following: -On 8/5/20 at 7:50 A.M. and 9:30 A.M., a sign posted on the door, Presumed COVID-19 positive, before entering room, please put on N95 mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. The two isolation biohazard bins positioned directly outside of the residents' room in the hallway; -On 8/7/20 at 7:00 A.M., one yellow linen bin positioned directly outside of the residents' room in the hallway; -The room directly across from Resident #3 and #4 occupied by a non-COVID resident. 10. Review of Resident #12's medical record, showed the following: -Admission face sheet with an admission date of [DATE] and readmission date of [DATE]; -Laboratory test result, dated 7/31/20 and completed 8/2/20, showed positive test result for COVID-19. Observation of Resident #12's room, showed the following: -Room located in the middle of the 400 hall; -On 8/7/20 at 6:58 A.M., a sign posted on the resident's room door, Presumed COVID-19 positive, before entering room, please put on N95 mask, disposable mask on top of N95 mask, gloves, gown and goggles. Upon exiting the room, please dispose of disposable masks, gowns, goggles and gloves in the red isolation garbage bin. No isolation biohazard bins located inside of the resident's room. 11. Observations of the 300 hall on 8/5/20 at 7:46 A.M. and 9:05 A.M., showed the following: -rooms [ROOM NUMBERS] with red tape around the doorframe and a small cabinet containing PPE on the outside of the room; -No biohazard waste bins inside or outside of the room. 12. Observations of room [ROOM NUMBER] on 8/5/20 at 7:48 A.M., 8:50 A.M. and 10:20 A.M., showed red tape around the exterior doorframe and two large trash receptacles with lids outside of the room, approximately 6 feet from the doorway of the room. One trash receptacle had a yellow plastic liner and marked linen and the other had a red plastic liner and marked trash. During an interview on 8/5/20 at 10:44 A.M., the DON said she expected the biohazard bins to be positioned inside each of the positive resident's rooms to ensure all PPE used by staff were contained within the resident's room. The biohazard bins should not be positioned outside of the positive COVID-19 resident's room due to infection control. 13. Observation of room [ROOM NUMBER], identified as a COVID-19 positive room with red tape around the exterior of the door frame on 8/5/20 from 8:47 A.M. to 9:03 A.M., showed one resident in a wheelchair wearing a mask and another resident standing beside the bed closest to the door without a mask. Housekeeper E wore a gown, hair covering, surgical mask with tissue visible from inside, gloves and an N95 mask hanging around his/her neck. He/she did not wear eye protection. He/she came out of the room with a trash can and stood at the cleaning cart positioned approximately 4 feet outside of the room. He/she placed the trash can on top of the cart. He/she placed three liners inside of the trash can, obtained from under the cart, and took it back inside the room. He/she came out of the room, changed gloves without sanitizing his/her hands, obtained a clean rag and spray bottle and entered the room. He/she sprayed down the vanity and wiped it off. Housekeeper E then came back out of the room, placed the used rags in a plastic bag hanging off of the cleaning cart and obtained more rags. He/she then went into the bathroom inside the room. He/she wiped down the windowsills, air conditioning unit, bedside table closest to the window and TV. He/she came out of the room, placed the used rag