STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, resident representative interviews and physician interviews the facility failed to honor 4 of 5 residents (Resident #1, #2, #3 and #4) choice to remain in the facility after testing positive for COVID19. Findings included: Review of the facility's Transfer or Discharge Documentation policy and procedure dated December 2016 revealed the following in part; each resident will be permitted to stay in the facility and not be transferred or discharged unless the resident's needs cannot be met in the facility. 1. Resident #1 was admitted to the facility on [DATE] and transferred to another Long-Term Care Facility on 5-28-20 after testing positive for COVID19. Resident #1 also had the following [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was minimally cognitively impaired. Resident #1's care plan dated 4-21-20 revealed a goal that the resident would be given the opportunity to make choices related to her treatment through collaboration with her responsible party. The interventions associated with the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or another physician's office. Review of Resident #1's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility. Resident #1's legal representative was interviewed on 6-4-20 at 2:27pm by telephone. The representative said she had received a call on 5-28-20 by the facility social worker that Resident #1 needed to be transferred to another facility because she tested positive for COVID. She also stated when she spoke with the social worker, she was not given the choice for the resident to remain in the facility I was told she had to be transferred or discharged . The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #1's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said some of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged . She also stated the choice for the resident to stay in the facility was not an option and said, we were told by corporate that they had to be transferred or discharged . During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives. 2. Resident #2 was admitted to the facility on [DATE] and transferred out of the facility on 5-28-20 due to testing positive for COVID19. Resident #2 was also diagnosed with [REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired. Resident #2's care plan dated 5-12-20 revealed a goal that he would be given the opportunity to make choices related to his treatment through collaboration with his responsible part. The interventions for the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or another physician's office. Review of Resident #2's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility. Resident #2's legal representative was interviewed by phone on 6-4-20 at 3:28pm. The representative said he was notified by the facility social worker of the transfer to another facility by telephone on 5-28-20 due to the resident testing positive for COVID. He also stated when he spoke with the social worker, he was not provided the option for Resident #2 to remain in the facility. He stated, I was just told he had to be transferred and that there were no other options. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #2's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said some of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged . She also stated the choice for the resident to stay in the facility was not an option and said, we were told by corporate that they had to be transferred or discharged . During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives. 3. Resident #3 was admitted to the facility on [DATE] and transferred to another facility on 5-28-20 related to testing positive for COVID19. Resident #3 was also diagnosed with [REDACTED].#3 was moderately cognitively impaired. Resident #3's care plan dated 5-14-20 revealed a goal that she would have a safe discharge to the community and her discharge arrangements would be completed prior to her discharge date . The interventions associated with the goal were in part; Explain discharge instructions to the resident and her representative. Review of Resident #3's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility. Resident #3's representative was interviewed by telephone on 6-4-20 at 4:02pm. The representative stated he had not received a call from the facility notifying him of the resident's transfer. He said, I was not told about the positive COVID test or the transfer until I called the facility to speak to her and was told she was moved to another floor due to testing positive and would be transferred to another facility that day (5-28-20). The representative said he had informed the social worker he did not want Resident #3 transferred to another facility but stated I was told either she had to be transferred or discharged . The representative stated he was not provided a choice for Resident #3 to remain in the facility. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #3's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) facility due to testing positive for COVID. The social worker said some of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged . She also stated the choice for the resident to stay in the facility was not an option and said, we were told by corporate that they had to be transferred or discharged . During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives. 4. Resident #4 was admitted to the facility on [DATE] and was transferred to another facility on 5-28-20 related to testing positive for COVID19. The resident was also diagnosed with [REDACTED].#4 was mildly cognitively impaired. Resident #4's care plan dated 5-18-20 revealed a goal that she would be given the opportunity to make choices related to her care through collaboration with her representative. The interventions associated with the goal were; contact my representative when impactful decisions need to be made, report any changes in my level of consciousness, increased behaviors, or other medical changes to my representative and my physician as needed. Review of Resident #4's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility. Resident #4's representative was interviewed on 6-5-20 at 9:07am by telephone. The representative said she was notified around 2:00pm on 5-28-20 by the facility social worker that Resident #4 needed to be transferred to(NAME)on 5-29-20 due to testing positive for COVID19. She explained she had informed the social worker; she would rather have Resident #4 remain in the facility and not be transferred. She stated the social worker informed her the resident had to be transferred or discharged . The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #4's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said some of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged . She also stated the choice for the resident to stay in the facility was not an option and said, we were told by corporate that they had to be transferred or discharged . During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and Resident Representative interviews, physician interview, Ombudsman interview and record review the facility failed to provide written notification to resident representatives and the Ombudsman of facility-initiated resident transfers to another Long Term Care Facility for 4 of 5 residents reviewed for transfers (Residents #1, #2, #3 and #4). Findings included: Review of the facility's Transfer or Discharge Documentation policy and procedure dated December 2016 revealed the following in part; each resident will be permitted to stay in the facility and not be transferred or discharged unless the resident's needs cannot be met in the facility. When a resident is transferred or discharged from the facility, notice would be provided to the resident and/or legal representative. 1.Resident #1 was admitted to the facility on [DATE] and transferred to another Long-Term Care Facility on 5-28-20 after testing positive for COVID19. Resident #1 also had the following [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was minimally cognitively impaired. Resident #1's care plan dated 4-21-20 revealed a goal that the resident would be given the opportunity to make choices related to her treatment through collaboration with her responsible party. The interventions associated with the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or other physician's office, Report any changes in my level of consciousness, increased behaviors, or other medical changes to my responsible party and my physician as needed. Review of the facility's progress note from 5-28-20 revealed Resident #1's representative was notified by phone of Resident's transfer to Pelican Health(NAME)on 5-29-20 by the facility's social worker. Another progress note written by Nurse #2 dated 5-28-20 was reviewed stating Resident #1's representative was notified of the residents transfer to(NAME)and that it would take about 2 hours. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer. Resident #1's legal representative was interviewed on 6-4-20 at 2:27pm by telephone. The representative said she had received a call from the facility social worker on 5-28-20 that Resident #1 needed to be transferred to another facility because she tested positive for COVID but stated she had not received anything in writing or a plan to have the resident return to the facility. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #1's legal representatives by telephone on 5-28-20 and explained the resident was being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives. During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing. Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 to another facility. She specified, they usually send me an email when there had been a discharge or transfer, but I have not received anything. She also stated she had not received a phone call about the transfer from anyone in the facility. 2. Resident #2 was admitted to the facility on [DATE] and transferred out of the facility on 5-28-20 due to testing positive for COVID19. Resident #2 was also diagnosed with [REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired. Resident #2's care plan dated 5-12-20 revealed a goal that he would be given the opportunity to make choices related to his treatment through collaboration with his responsible part. The interventions for the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or other physician's office, Report any changes in my level of consciousness, increased behaviors, or other medical changes to my responsible party and my physician as needed. Review of the facility's progress note from 5-28-20 revealed Resident #1's representative was notified by phone of Resident #2's transfer to Pelican Health(NAME)on 5-29-20 by the facility's social worker. Another progress note written by Nurse #2 dated 5-28-20 was reviewed stating Resident #2's representative was notified of the residents transfer to(NAME)and that it would take about 2 hours. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer. Resident #2's legal representative was interviewed by phone on 6-4-20 at 3:28pm. The representative said he was notified by the facilities social worker of the transfer to another facility by telephone on 5-28-20 due to the resident testing positive for COVID and was originally told the resident would not be transferred until 5-29-20 but then stated he received a call later that night (5-28-20) the resident was going to be transferred 5-28-20. The representative stated he had not received anything in writing about the transfer or the plan to

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) have the resident return to the facility. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #2's legal representatives by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives. During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing. Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 another facility. She specified, they usually send me an email when there had been a discharge or transfer, but I have not received anything. She also stated she had not received a phone call about the transfer from anyone in the facility. 3. Resident #3 was admitted to the facility on [DATE] and transferred to another facility on 5-28-20 related to testing positive for COVID19. Resident #3 was also diagnosed with [REDACTED].#3 was moderately cognitively impaired. Resident #3's care plan dated 5-14-20 revealed a goal that she would have a safe discharge to the community and her discharge arrangements would be completed prior to her discharge date . The interventions associated with the goal were in part; Provide written discharge instructions to me and my representative. Review of the facility's progress note written by Nurse #2 dated 5-28-20 revealed documentation that Resident #3's representative was notified of the transfer to the facility in(NAME)NC and that it will take about 2 hours. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer. Resident #3's representative was interviewed by telephone on 6-4-20 at 4:02pm. The representative stated he had not received a call from the facility notifying him of the resident's transfer. He said, I was not told about the positive COVID test or the transfer until I called the facility to speak to her and was told she was moved to another floor due to testing positive and would be transferred to another facility that day (5-28-20). The representative said he had not received anything in writing about the transfer or made aware of the facility's plan to have the resident return. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #3's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives. During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing. Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 to another facility. She specified, they usually send me an email when there had been a discharge or transfer, but I have not received anything. She also stated she had not received a phone call about the transfer from anyone in the facility. 4. Resident #4 was admitted to the facility on [DATE] and was transferred to another facility on 5-28-20 related to testing positive for COVID19. The resident was also diagnosed with [REDACTED].#4 was mildly cognitively impaired. Resident #4's care plan dated 5-18-20 revealed a goal that she would be given the opportunity to make choices related to her care through collaboration with her representative. The interventions associated with the goal were; contact my representative when impactful decisions need to be made, report any changes in my level of consciousness, increased behaviors, or other medical changes to my representative and my physician as needed. Review of the facility progress note written by the social worker dated 5-28-20 revealed the resident's represented was notified of the residents transfer to Pelican Health(NAME)to take place on 5-29-20. There was no further documentation regarding Resident #4's transfer. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred we have the capability to care for those residents here and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer. Nurse #2 was interviewed by phone on 6-4-20 at 3:35pm. The nurse stated he was the shift supervisor for the 3:00pm to 11:00pm shift. He confirmed nursing staff were to contact the residents' representatives to inform them of the transfer occurring in the evening of 5-28-20. He also stated he could not remember if the representative for Resident #4 was contacted but stated each representative was supposed to be contacted. Resident #4's representative was interviewed on 6-5-20 at 9:07am by telephone. The representative said she was notified around 2:00pm on 5-28-20 by the facility social worker that Resident #4 needed to be transferred to(NAME)on 5-29-20 due to testing positive for COVID19. She stated, a days' notice was ok with me because that gave me time to speak with her and make sure she was ok with the transfer and understood what was going on but then said she had received a call at 11:00pm on 5-28-20 from Pelican Health(NAME)that Resident #4 was in their facility. The representative stated she had not received a phone call from the facility informing her the resident was being transferred on 5-28-20 nor had she received anything in writing about the transfer or the plan to have the resident return to the facility. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #4's legal representatives by telephone and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20, she stated the nursing staff were supposed to contact each representative. She also stated she had not contacted the Ombudsman or sent written notification to the representatives. During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a sister facility because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing. Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 5 residents that were transferred on 5-28-20 to another facility. She specified they usually send me an email when there had been a discharge or transfer, but I have not received anything. She also stated she had not received a phone call about the transfer from anyone in the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the facility's Handwashing/Hand Hygiene policy and procedure, Infection Control policy and procedure and the facility's COVID19 policy and procedures, staff interviews and physician interview the facility failed to perform hand hygiene when a housekeeper entered and exited 2 of 2 resident rooms (Residents #1 and #2) who were on droplet precautions. This failure occurred during a COVID19 pandemic. Findings included: Review of the facility's Handwashing/Hand Hygiene policy and procedure dated August 2015 revealed in part; all personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections, use alcohol hand rub after contact with objects in the immediate vicinity of the resident and before and after entering isolation precaution setting. The facility's Infection Control policy and procedure, Transmission Based Precautions dated 4-24-20, was reviewed and revealed in part; remove gloves before leaving the resident room and perform hand hygiene. Review of the facility's COVID19 policy and procedure dated 5-6-20 was reviewed and revealed in part; remind staff that handwashing is the most important and effective preventive strategy. The Administrator was interviewed on 6-2-20 at 10:30am. The Administrator stated the facility had 5 residents' that had tested positive for COVID19 and had been discharged to a sister facility. She said the facility was using part of the 2nd floor for an observation unit and an Isolation unit. She explained the observation unit was sealed off from the rest of the 2nd floor by the fire doors and was used to monitor residents who had returned from the hospital, waiting for their COVID test results or new admissions needing to be observed for signs and symptoms of COVID19. The Administrator further

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) explained, the facility had placed a door to divide the observation unit from the isolation unit which was located at the end of the hall. During a continuous observation on 6-2-20 from 11:30am to 11:40am of the facility's observation unit, the observation revealed housekeeper (HK) #1 entered room [ROOM NUMBER] that was designated as a droplet precaution room as evidenced by a droplet precaution isolation sign on the residents door, without changing her gloves or performing hand hygiene and began cleaning room [ROOM NUMBER] by wiping down the dresser, over the bed table, cleaning the bathroom and moping the floor. When the HK was done in room [ROOM NUMBER], she exited the room without performing hand hygiene. HK #1 was then observed to walk across the hall and enter resident room [ROOM NUMBER], where another resident who was on droplet precautions resided and had a droplet precaution isolation sign posted on the door. HK #1 entered the room without changing her gloves or performing hand hygiene and began wiping down the dresser, over the bed table, bathroom and moping the floor. Once the HK completed her work in room [ROOM NUMBER], she then took her gloved hand and pushed on the door bar to exit the observation unit, walked onto the resident hall, walked approximately 25 feet to the housekeeping closet and opened the closet door without removing her gloves or performing hand hygiene. HK #1 was interviewed on 6-2-20 at 11:40am. The HK stated she had received training on proper hand hygiene in May 2020, which included removing her gloves and performing hand hygiene when she left a resident room that was on droplet precautions. The HK said she saw the droplet precaution signs on the resident's door, and she was aware she had not followed the training but stated I got distracted and needed to get new mop water and just did not think about it. The housekeeping manager was interviewed on 6-2-20 at 11:42am. The manager stated all the housekeeping staff had been in-serviced on COVID19 and how [MEDICAL CONDITION] is spread, infection control, isolation precautions, masks, gloves and hand hygiene. He said, they have been in-serviced about this at least 3 times in the last month. The Administrator was interviewed on 6-2-20 at 12:55pm. The Administrator stated the housekeeping manager had met with all the housekeepers that morning (6-2-20) in the lobby and reminded them of proper hand hygiene. She stated she would follow up with the housekeeping manager. During an interview with the facility physician on 6-2-20 at 1:04pm, the physician stated he did not feel the staff were not following proper infection control policies because of a lack of knowledge but rather trying to learn new behaviors. He also stated he did expect staff to follow proper procedure and perform hand hygiene when they exit a resident's room to prevent the spread of COVID19.