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 _____	07/10/2020

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff interviews the facility failed to (1) maintain flooring, furniture (bedside cabinets/dresser cabinets), elevators, heating and air-conditioning units, and shower rooms in good repair. (2) The facility failed to maintain the 5th floor linen closet and handrails throughout the 5th floor in a clean manner. (3) the facility failed to maintain clean resident room floors and bathroom floors. This was evident in 3 of 4 resident care units. (Unit 500, Unit 400 and Unit 300) Findings included: 1. Observations during the survey revealed the following housekeeping and maintenance issues: a. Observation on 6/29/20 at 1:25 PM revealed the corner of the floor behind room [ROOM NUMBER] A bed had a built up and accumulation of a dark brown colored substance. Observation on 6/30/20 at 9:22 AM of room [ROOM NUMBER] revealed no change. b. Observation on 6/29/20 at 1:30 PM revealed the bathroom floor tiles in room [ROOM NUMBER] had an accumulation of a dried brown colored substance. c. Observation on 6/29/20 at 1:50 PM in room [ROOM NUMBER] revealed 3 floor tiles had red colored dried stains. The floor tiles under the bed had rust colored stains. The toilet seat had brown colored stains. The corners of the floor tiles on entrance to the bathroom had a dried brown colored substance. Observation on 6/30/20 at 9:12 AM and 1:45 PM revealed no change in the observations of the floor. d. Observation on 6/30/20 at 9:17 AM revealed the bathroom floor corners in room [ROOM NUMBER] an accumulation of a brown colored substance. Observation on 7/1/20 at 10:00 am revealed no change in room [ROOM NUMBER]. e. Observation on 6/29/20 at 1:17 PM revealed in room [ROOM NUMBER]- A bed a broken and missing dresser drawer. Attempted interview with the resident was unsuccessful. Observation on 6/30/20 starting at 9:15 AM revealed no changes in room [ROOM NUMBER]-A. f. Observation on 6/29/20 at 1:20 PM in room [ROOM NUMBER] revealed broken and missing dresser drawers. Observation on 6/30/20 starting at 9:15 AM revealed no changes in room [ROOM NUMBER] g. Observation on 6/29/20 at 1:30 PM revealed in room [ROOM NUMBER] had 2 missing and broken dresser drawers. The parts of the dresser drawers were noted on the floor positioned under hanging clothes. Interview with Resident #34 during the observation on 6/29/20 at 1:32 PM stated he was transferred to this room (unsure of the exact date) and he recalled the dresser drawers were broken at that time. Observation on 6/30/20 at starting at 9:15 AM revealed no changes in room [ROOM NUMBER]. h. Observation on 6/29/20 at 1:44 PM of the 5th floor dining room revealed the corners of the floor tiles on entrance into the dining room had an accumulation of a dark brown colored substance. The white colored floor cove molding had numerous chipped areas throughout. Two (2) of the 2 front panels of the heating and air conditioning unit (HAVC) front panels were cracked and partially detached from the wall. There was an accumulation of brown colored particles like dirt and dust were noted in the crevices of the control panel. The wall had a panel behind this that was warped and partially detached from the wall. i. Observation on 6/30/20 starting at 9:05 AM of the 3rd floor dining room revealed 2 (two) HAVC units. One HAVC unit had a front panel partially detached. The door to the panel was detached and laying on the window edge. The filter had an accumulation of gray and white colored substance like dust. Observation on 6/30/20 starting at 9:05 AM of the 3rd floor dining room revealed the second unit was partially detached from the wall. The HAVC filter had an accumulation of gray and white colored substance like dust. Interview on 6/30/20 at 3:35 PM with the maintenance manager stated the filters were due to be cleaned. j. Observation on 6/29/20 starting at 1:05 PM revealed the facility had 2 separate elevators. There were chipped and missing floor tiles in the service elevator. The tracks of the service elevator had an accumulation of dark brown particles. Observation on 6/30/20 at 12:27 PM revealed no change in the status of the elevator or elevator tracks. k. Observation on 6/29/20 starting at 1:05 PM revealed the elevator tracks of the second elevator had an accumulation of a dark brown substance along with an empty candy wrapper. The corners of the second elevator floor had an accumulation of a dried brown colored substance. Observation on 6/30/20 at 12:27 PM revealed no change in the status of the elevator or elevator tracks. Interview on 7/1/20 on 10:46 AM with floor technician stated he was responsible for the elevators being clean every day and was unsure why the tracks had an accumulation of trash and dirt. l. Observation on 6/30/20 at 9:17 AM revealed a broken toilet paper holder in the bathroom of room [ROOM NUMBER]. The floor corners in the bathroom had an accumulation of a brown colored substance. Observation on 7/1/20 at 10:00 am revealed no change in room [ROOM NUMBER]. m. Observations on 6/29/20 starting at 2:20 PM throughout the 5th floor revealed the space in between the wall and the handrails had paper and an accumulation of dust and dirt in the corners. Observation on 7/1/20 at 10:30 am revealed no change. n. Observation on 6/29/20 at 1:27 PM revealed the bathroom sink water faucet knobs in room [ROOM NUMBER] were in a turn off position but continued to drip. Observation on 6/30/20 at 9:30 AM revealed no change. o. Observation on 7/1/20 at 12:35 PM of the 4th floor bathing/shower room revealed water leaked from the pipes under the sink. A gray basin was noted under the sink which collected the water. The vent had an accumulation of dust and dirt in the vent grate. The toilet seat had a yellow colored stained. p. Observation on 6/29/20 at 1:50 PM in room [ROOM NUMBER] the toilet seat had brown colored stains. Observation of room [ROOM NUMBER] on 6/30/20 at 9:12 AM and 1:45 PM revealed the toilet seat continued with a brown colored stain and red colored smears were noted. q. Observation on 6/29/20 at 1:56 PM of the 5th floor linen closet revealed multiple floor tiles had dried areas of a brown colored substance similar to dirt. The corners of the floor had an accumulation of a brown colored substance. A purple colored disposable glove was on the floor. On the floor behind the linen cart was a cloth brief, wash cloths and an unwrapped white colored unwrapped rolled gauze covered with dust. An interview on 6/29/20 at 2:00 PM with House Keeper (HK) #20 stated she was not sure who was responsible for cleaning the linen closet. Observation on 6/30/20 at 9:02 AM revealed no change in the 5th floor linen closet. r. Observation of 6/30/20 at 12:30 PM of the mechanical lift located on the 5th floor was conducted. The handle bar of the lift was covered with a blue colored sponge like material. This covering had an accumulation of a black colored substance. When touched part of the substance fell off. Interview on 7/1/20 at 10:57 AM with the Housekeeping manager (HK manager) stated there was no routine schedule for cleaning the lift. s. Observation of 6/30/20 at 12:40 PM of the base of the stand used to store the blood pressure equipment had an accumulation of black colored particles like dirt. t. Observation on 6/29/20 at 1:15 PM revealed the blue colored mattress on bed B in room [ROOM NUMBER] had turned a gray color, bottomed out and sagged in the middle. Interview on 6/29/20 at 2:22 PM with HK manager stated the daily routine for the housekeepers included the cleaning of the linen room. We were short of staff for a while, but I have hired enough staff as of last week (referring to week of 6/22/20). Interview on 6/30/20 at 12:50 PM with 3 corporate representatives and the administrator via phone was conducted. The administrator stated the contracted housekeeping company had not followed up on identified housekeeping problems and action plan and she always expected the facility to be clean and sanitary. Interview on 6/30/20 at 3:35 PM with the HK manager, 2 corporate representatives, maintenance director and the housekeeping corporate representative was held. The HK manager stated the facility had many resident room transfers and was unable to keep up with the routine HK work. The maintenance director stated he had not received any work orders for the identified concerns.

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1)
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to accurately code significant weight gain on the minimum data set (MDS) assessment for 1 of 3 residents reviewed for nutrition (Resident #17). Findings Included: Resident #17 was admitted to the facility on [DATE] and [DIAGNOSES REDACTED]. Review of the weight record for Resident #17 revealed a weight was recorded on 5/13/20 at 11:31 am of 127.6 pounds (lbs.). An additional weight recorded on 5/13/20 at 11:53 am was 138.4 lbs. Both weights indicated a wheelchair scale had been used. An admission MDS assessment dated [DATE] for Resident #17 identified his weight was 138 pounds (lbs.), he had a significant weight gain and was not on a physician ' s prescribed weight gain plan during the look-back period. An interview on 7/2/20 at 9:45 am with the Registered Dietitian (RD) revealed she had coded Section K (swallowing / nutritional status section) of the admission MDS assessment for Resident # 17. The RD stated she had made an error when she coded the resident for a significant weight gain. She explained she used the weights of 127.6 lbs. and 138.4 lbs. but because these were obtained on the same day the resident had not had a significant weight gain for either a 1 month or 6-month period. An interview on 7/2/20 at 2:00 pm with MDS Nurse #1 revealed the admission MDS for Resident #17 on 5/14/20 should not have been coded for a significant weight gain. She stated the two weights that were available for the resident did not meet the RAI (resident assessment instrument) guidelines for coding significant weight gain. MDS Nurse #1 added she would need to correct this MDS. An interview on 7/9/20 at 1:56 pm with the Administrator revealed the facility had made an error when coding Section K of Resident #17 ' s admission MDS. She stated this would need to be corrected.
F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews the facility failed to honor the food preferences for 1 of 3 residents reviewed for food palatability (Resident # 33). Findings Included: Resident #33 was admitted to the facility on [DATE] and [DIAGNOSES REDACTED]. An annual minimum data set ((MDS) dated [DATE] for Resident #33 identified her cognition was intact, she was on a mechanically altered diet, required extensive one-person assist with eating and had a significant weight loss during the look-back period. A care plan initiated 5/11/19 for Resident #33 stated she was at nutritional risk with a history of diabetes, [MEDICAL CONDITION], possible altered nutritional status and significant weight loss. Interventions updated 6/20/20 included a low concentrated sweets, finger food diet with double portions. A care plan initiated 5/11/19 for Resident #33 stated she had an activity of daily living self-care deficit related to confusion. Interventions included the resident was able to feed herself with supervision and set-up help. Review of the most recent physician's order [REDACTED]. An observation of breakfast meal service on 6/30/20 at 9:15 am revealed Resident #33 ' s breakfast meal plate contained oatmeal, pureed eggs and pureed sausage. The meal ticket was present on the meal tray and identified her diet as Finger Food, Double Portions, LCS (low concentrated sweets) and oatmeal was identified as a dislike. Nursing Assistant (NA) #1 was observed to bring Resident #33 her meal tray and prepare the resident to eat. NA #1 placed a spoon in the resident ' s hand to begin eating. The NA did not identify the resident had been served oatmeal which was listed as a dislike. Resident #33 was asked by this surveyor if she wanted to eat the oatmeal and she stated she didn ' t like oatmeal and would like to have 2 bowls of frosted flakes. An interview with NA #1 on 6/30/20 at 9:18 am revealed Resident #33 was able to feed herself after meal set-up and her diet had recently been changed to finger foods to help the resident eat more foods on her own. She stated she wasn ' t sure if the resident liked oatmeal and hadn ' t noticed the resident was served the oatmeal for breakfast. NA #1 added she would get the resident a different cereal. An interview on 7/2/20 at 11:19 am with the Dietary Manager (DM) revealed she had been out of the facility from 6/13/20 through 6/30/20. She explained during her absence if a resident ' s diet order was changed the kitchen staff would have handwritten the new diet order on the paper copies of the resident ' s meal tickets. The DM stated Resident #33 ' s current diet order was Finger Food, Double Portions, LCS. She added the resident ' s meal ticket identified oatmeal as a dislike. A follow-up interview on 7/2/20 at 1:15 pm with the DM revealed she had found that Resident #33 ' s diet had been changed to LCS, puree texture with double portions on 6/25/20 and changed again on 7/2/20 to regular with puree texture. She explained the kitchen staff received the diet order change and had started sending her a puree textured diet but had not changed her meal ticket. The DM stated the resident should not have received the oatmeal because it was identified as a dislike. An interview on 7/7/20 at 1:56 pm with the Administrator revealed she expected resident ' s food preferences to be honored. She stated the resident should have been offered an alternate food item.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews the facility failed to maintain clean nourishment rooms, label and date food items when opened, place a thermometer in the refrigerator and discard outdated foods in the walk in cooler and 2 of 2 nourishment rooms (5th and 3rd floor). The findings included: 1.a. An observation of the walk-in cooler on [DATE] at 8:25 am revealed two (2) 5-pound containers of cottage cheese had an expiration date of [DATE]. An interview with Cook #1 revealed the cottage cheese should have been discarded prior to the expiration date. An interview with the Dietary Manager (DM) on [DATE] revealed she had been out of the facility from [DATE] through [DATE]. She stated when she returned to work on [DATE] she found the expired cottage cheese and discarded it. The DM added the dietary staff should have discarded the cottage cheese by [DATE]. 2. a. Observation on [DATE] at 9:20 AM of the 5th floor nourishment room revealed: 1. Two (2) open cartons of milk were not dated. 2. A 4-ounce container of yogurt had an expiration date of [DATE]. 3. a. The floor space between the wall and the ice-machine had an accumulation of a dark substance in the corners and along the wall. There was a lunch box, plastic disposable glove, brown paper towels, and a piece of paper laying on the floor mixed with a dust like substance. b. The floor space between the ice-machine and refrigerator had a disposable glove and 6 floor tiles with a red-brown colored stain like rust. 4. The refrigerator portion did not have a thermometer. 5. a. The back panel of the freezer was stained with a red substance. b. The outside front of the refrigerator door had a brown-colored substance like dirt. 2 b. Observation of the 3rd floor nourishment room on [DATE] at 7:25 AM revealed: 1. In the refrigerator section: a. A container of pineapple chunks was opened and not dated. b. A container of watermelon pieces was not dated when opened or labeled with a resident name. The sell by date was [DATE]. c. A pureed snack was dated [DATE]. d. A package of sliced chicken bologna was opened and not dated. e. An 8-ounce carton [MEDICATION NAME] milk was opened and not dated. f. A restaurant-labeled Styrofoam container had a dried brown meat with a plastic fork laying on top. One divided portion of the container was broccoli and the other divided portion contained white colored rice that had dried. This container was undated. g. A 46-ounce container of apple sauce was opened and undated. h. A green colored container of unknown substance that looked like wilted lettuce and salad dressing was not labeled or dated. i. A pizza box containing slices of pizza was not dated. 2. In the freezer section (a) An open box of homestyle waffles was not dated when opened. Six (6) waffles were exposed and had ice crystals. (b) Clam chowder soup sitting in a plastic container was opened and undated. There was no lid to the container. (c). A bag of uncooked shrimp was opened was not dated when opened. The sell by date was [DATE]. 3. The bottom of the freezer had a dried red colored spilled. 4. The microwave had dried food debris. 5 The sink was soiled with multiple rust colored and black colored spots. 6. The floor corners had a buildup of a dark substance. 7. The white colored cove molding had a buildup of a black color substance. 8. The paper dispenser was empty, and the paper towel roll was sitting on the counter empty. Interview on [DATE] at 7:50 AM with the Housekeeping Manager (HM) and HK #3 was conducted. HM stated housekeeping was responsible for cleaning the nourishment room. HK #3 stated she just cleaned the nourishment room this morning (no specific time provided). Continued interview with HK #3 stated she mopped, swept, pulled trash and wiped the outside of the refrigerator and microwave. HK #3 stated she did not clean the baseboard or try to remove the buildup in the corners and did not notify the supervisor because she thought he already saw the condition of the nourishment room. Interview on [DATE] at 8:05 AM with Dietary Aide (DA) #1 stated she was given instructions to clean the refrigerator now but DA #5 usually cleaned the refrigerator out. Interview on [DATE] at 10:30 AM with the Dietary Manager stated she did not know who was responsible for maintaining the food items and cleanliness of the nourishment refrigerators. Interview on

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) [DATE] at 10:49 AM with DA #5 stated the facility had gone back and forth about whether housekeeping was responsible for cleaning the refrigerator or whether dietary was responsible. She added the facility did not have a policy to identify which department was responsible for cleaning nourishment room refrigerators. Interview on [DATE] at approximately 1:00 PM via the phone with the administrator stated dietary was responsible for cleaning the inside of the nourishment refrigerator and housekeeping was responsible for the outside portion of the refrigerator as well as the cleanliness of the nourishment room.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** 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 (1) implement their policies and procedures when 3 of 3 staff members (NA #2, NA #3 and Housekeeper #7), who were working on the facility's quarantine unit, were observed not wearing PPE including; gloves and/or a gown and not performing hand hygiene when they exited resident rooms or when exiting and entering the quarantine unit. The facility also failed to (2) maintain sanitary conditions in the stairwell used to enter and exit the COVID19 unit and (3) sanitize the mechanical lift between each resident use. These failures occurred during a COVID19 pandemic. Findings include: The facility's COVID19 policy and procedure dated 5-6-20 revealed in part; New onset of symptoms requires that the resident be moved away from a roommate within the room, the curtain pulled between them and the door closed pending a full assessment. A resident under investigation for COVID19 will be kept on enhanced droplet precautions. The facility's Handwashing/Hand Hygiene policy and procedure dated 8-2015 revealed in part; use an alcohol-based hand rub or soap and water before and after direct contact with residents, after contact with objects in the immediate vicinity of the resident, after removing gloves, before and after entering an isolation precaution setting and before and after assisting a resident with meals. Observations of the quarantine/observation unit on the 4th floor conducted on 7-1-20 at 12:43pm and 7-2-20 at 10:00am, it was noted the area was separated from the rest of the 4th floor by fire doors that contained 2 droplet precaution signs and isolation carts were placed outside of each resident room with gowns, gloves and foot coverings. The doors to the resident rooms were noted to be open. 1.During an observation of the 4th floor quarantine/observation unit on 7-1-20 at 12:45pm, 2 nursing assistants (NA), (NA #2 and NA #3) were passing out lunch trays to the residents. The NA's were noted not to be wearing a gown or gloves when entering resident rooms. The door to each resident room was open with no droplet precaution sign on the resident doors. While in the room, the NA's were observed touching the resident's over the bed table and items on the table in order to place the lunch tray in an appropriate position. NA #2 was observed leaving one resident room and entering another resident room without sanitizing or washing his hands. NA #2 was also observed on 7-1-20 at 12:50pm exiting and re-entering the quarantine/observation unit without washing or sanitizing his hands. NA #2 was interviewed on 7-1-20 at 12:55pm. The NA stated he had received education on the transmission of COVID19, infection control practices and handwashing practices. He stated he was not aware of what precautions the residents were on but he stated I know if I am providing personal care I have to put on gloves, gown and foot coverings but I think just regular care like passing trays is just standard precautions and we don't have to wear gloves or a gown. NA #2 also said he was not aware if resident doors needed to be kept closed on the quarantine/observation unit. The NA confirmed he had left and entered the quarantine/observation unit without sanitizing his hands and said, I got in a hurry and did not think about it. NA #2 acknowledged he touched surfaces such as the over the bed table, that was often touched by the resident and had not sanitized or washed his hands between exiting one resident room and entering another resident room. NA #2 said I should have sanitized my hands but was focused on delivering the meal trays. The facility Physician was interviewed on 7-6-20 at 9:48am. The physician stated he was not familiar with the quarantine/observation unit because he had been performing Telehealth visits but stated cross contamination can occur when delivering meal trays and that the employees working on the unit should be wearing gloves and sanitizing their hands between each resident. He also stated the resident doors should remain closed to decrease the likelihood of cross contamination. During an interview with the 4th floor unit manager on 7-1-20 at 1:05pm, the unit manager stated the quarantine/observation unit was on droplet precautions when providing direct resident care and standard precautions during routine care such as passing out meal trays or providing a fresh glass of water. She also stated staff should be sanitizing their hands before leaving or entering the unit. The Administrator was interviewed on 7-1-20 at 1:10pm. The Administrator stated the quarantine/observation unit should be a droplet precaution unit, but she had not seen the quarantine/observation unit because she had been working the COVID19 unit since her return to work. An interview occurred with the Director of Nursing (DON) on 7-1-20 at 1:12pm. The DON said she believed the quarantine/observation unit was a standard precaution unit and was not aware there were droplet precaution signs posted on the doors leading into the quarantine/observation unit. During an interview with the local health department on 7-1-20 at 1:47pm, the health department stated they had directed the facility, per CDC (Center for Disease Control) guidelines, the quarantine/observation unit needed to be treated the same as the COVID19 unit which included each resident being on droplet precautions. On 7-2-20 at 10:05am, Housekeeper #7, who worked on the quarantine/observation unit was observed to enter and exit Resident #34's room two times without wearing gloves or a gown and not perform hand hygiene. Housekeeper #7 was interviewed on 7-2-20 at 10:07am. The housekeeper stated she had received training on the transmission of COVID19 and what precautions were to be taken when a resident was on droplet precautions. She confirmed Resident #34 was on droplet precautions and stated she was to wear a mask, gown, gloves and foot coverings when cleaning the resident's room. She also acknowledged she had entered and exited Resident #34's room without proper PPE and she stated I had already finished cleaning the room. I was just moving his table back. The housekeeper was noted to reach into her housekeeping cart and retrieve a ball of blue material and she said my gowns right here and my gloves are right there as she pointed to the top of her housekeeping cart. The housekeeper acknowledged she should sanitize her hands between cleaning each resident room. The manager of housekeeping was interviewed on 7-2-20 at 11:05am. The manager stated he had provided education to all housekeeping staff on the transmission of COVID19, proper PPE protection when in a resident room and the required cleaning agents. He stated he would speak with the housekeeping staff about the importance of wearing their PPE when entering a resident room who was on droplet precautions. 2. The stairwell used for entering and exiting the COVID19 unit was observed on 6-30-20 at 12:00pm, 7-1-20 at 2:30pm and 7-2-20 at 9:55am. The landing of the stairwell was observed to have 10-15 bags of trash with approximately 5-8 bags not closed and 5-6 boxes closed and sealed marked biohazard against the far wall of the landing. Also noted, there were no biohazard bags for employees to discard their PPE once they left the COVID19 unit. There was a foul sour smell and multiple flies around the trash bags. NA #4 escorted this surveyor off the COVID19 unit to the landing of the stairwell on 6-30-20 at 1:40pm. The NA stated, I know there is a lot of trash here, but it is like this every day. She also stated there was not a biohazard bag for the PPE, and she stated, we just find an open trash bag and put it in there before we walk out the door. The housekeeping manager was interviewed on 7-2-20 at 11:05am. The manager acknowledged the trash build up in the stairwell leading in and out of the COVID19 unit. He stated, we have had an increase in the amount of trash since all the meals are now served on Styrofoam and it is hard to keep up with. The manager discussed housekeeping being on a 2-hour rotation schedule to collect and dispose of the trash in the stairwell and the responsibility of staff to call housekeeping if they noticed the trash needed collecting. During an interview with the Administrator on 7-6-20 at 11:00am by telephone, the Administrator stated the facility had a NA assigned to keep the stairwell to the COVID19 unit clean, but the NA left. She discussed she placed housekeeping on a 2-hour rotation cleaning and trash pick up cycle. The Administrator acknowledged that trash would backup in between the 2-hour housekeeping schedule but that she was trying to keep the area clean. She also stated she was unaware there were not biohazard bags available on the stairwell landing for staff to dispose of their PPE but would have biohazard bags in place. 3. During an observation of the 4th floor resident area on 7-2-20 at 10:15am, NA #5 was observed removing a mechanical lift from a resident room, placed the lift in the hallway and walked away. This surveyor waited 5 minutes and noted NA #5 had not returned to clean the mechanical lift. There were no sanitation wipes noted in the area. NA #5 was interviewed at 10:20am on 7-2-20. The NA stated she was supposed to sanitize the lift after each resident use and she said but we don't have access to the sanitary wipes, only the nurses have them in their medication cart so unless we go get one we cant wipe the lift down. NA #5 said she was educated on how COVID19 was spread and infection control practices. The observation continued 7-2-20 from 10:23am to 10:35am and revealed NA #5 did not return to sanitize the mechanical lift. The 4th floor unit manager was interviewed on 7-2-20 at 10:40am. The unit manager stated the NA's were aware that they needed to sanitize the mechanical lift between each resident use. She also stated the floor had run out of the Clorox wipes but she was going to supply to get some more. The Administrator was interviewed on 7-7-20 at 12:42pm by telephone. She stated staff had been in-serviced on the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) transmission of COVID19, infection control practices, PPE, droplet precautions and proper hand washing. The Administrator also said she was monitoring staff performance each shift and by camera/monitoring systems in the hallways.