STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

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** This resulted in two deficient practice statements: 1. Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 3/13/20, The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), observation, interview and record review, the facility failed to ensure adherence to infection control practices to prevent the transmission of the Coronavirus (COVID-19) as evidenced by failure to: 1) follow appropriate protective personal equipment (PPE) guidelines in the observation rooms for COVID-19 residents on contact and droplet precautions; 2) properly disinfect shared medical equipment after each use and; 3) adhere to social distancing. This had the potential to affect all 17 residents in MyRehab1, 17 residents in 2EFG and 27 residents in 3HJ units. This failure had a high likelihood of causing serious harm or death to the residents given their congregate nature, age, and underlying medical conditions. At the time of the survey, the facility had 21 residents who tested positive for COVID-19 and 41 residents who were on observation units (MyRehab1, MyRehab2 and 1E). There were 22 staff who tested positive for COVID-19. The facility was in a county which had sustained community transmission, especially in the nursing home setting. The Immediate Jeopardy began on 5/21/20 when the facility failed to: 1) follow appropriate protective personal equipment (PPE) guidelines when entering and exiting R2 and R3's room (both residents in the COVID-19 Observation Unit) 2) properly disinfect shared medical equipment after each use in the Observation unit using an EPA-approved disinfectant under List N and; 3) follow social distancing among five (R4, R5, R6, R7, and R8) residents in the common activity area on the 2EFG unit and among 17 (R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, and R25) residents in the dining room on the 3HJ unit. Staff were present during observation on both units. The Administrator and Director of Nursing were informed of the Immediate Jeopardy on 5/22/20 at 3:11pm. The Immediacy was removed when the removal plan was accepted on 5/27/20 at 2:51pm and was verified as implemented on May 29, 2020 at 3:44pm. Findings include: Review of the CDC's Responding to Coronavirus (COVID-19) in Nursing Homes revised on 4/30/20 under Considerations for the Public Health Response to COVID-19 in Nursing Homes revealed, .Resident Cohorting .Assign dedicated resident care equipment (e.g. vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit. Further review of the same document under Considerations for new admissions and readmissions revealed, .Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of a 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 .However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. Retrieved on 05/26/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes- responding.html A. During the entrance interview on 5/21/20 at approximately 11:00am, the Administrator and the Director of Nursing (DON) were asked if the facility had any confirmed cases of residents with COVID-19 or persons under observation. The Administrator stated they had residents who tested positive for COVID-19 on isolation in their COVID unit. The DON added the facility also had observation units namely: the MyRehab1 (MR1), MyRehab2 and unit 1E. The DON explained the residents on MR1 were new admissions, readmissions and under observation for 10 days. Both were asked about the 10-day observation period in lieu of the 14 day-observation period per the CDC Guidelines. The DON stated they took into consideration the number of days the residents were under observation in the hospital hence the decision to put them on a ten-day observation. Both were informed to review the CDC guidelines rigorously to ensure the facility followed the appropriate number of days for the observation period. During an observation on 5/21/20 at approximately 2:30pm, in the MyRehab1 (COVID-19 Observation unit), Nurse Aide (NA) 1 was observed to exit R2's room with the Mobile Vital Signs Machine (MVSM) in tow. NA1 had his gloves on. NA1 immediately entered R3's room without removing his used gloves, without donning an isolation gown and without disinfecting the MVSM. Since NA1 did not close the door of R3's room and the bathroom door was wide open, NA1 was observed inside the room to take R3's vital signs. NA1 then went to the bathroom to empty R3's urinal. Afterwards, NA1 exited the bathroom without performing hand hygiene, and still wearing the same gloves, went back to R3's room, took the MVSM, and exited R3's room. NA1 was observed to only remove his gloves when he was outside R3's room. NA1 was about to enter the next room when he was stopped by the surveyor and was asked about the above-mentioned observations. NA1 stated, I know, I know. I should have used the gown. When asked about the lack of hand hygiene and what the facility's process was in disinfecting the MVSM in between resident's use, NA1 did not provide an answer. The unit manager (UM) who was nearby was asked about cleaning and disinfecting the MVSM. The UM stated, We used the bleach wipes. The UM asked NA1 to retrieve the disinfecting wipes that staff used to disinfect the shared MVSM. NA1 took a tub of hand sanitizing wipes from the basket attached to the roll stand of the MVSM that he had used earlier. After checking the tub, the UM verbalized the wipes were not the correct disinfecting wipes. NA1 refuted the DON's statement and said, This is what we've been using. The UM later found a tub of bleach wipes and confirmed they were the appropriate disinfecting wipes. When asked what the dwell time was for the said wipes to reach its full efficacy, the UM responded, I am not aware if there's one. The UM was asked to check the label affixed on the tub. After reading the label the UM stated, It's for one minute. The UM was also asked about NA1's lack of hand hygiene. The UM explained that NA1 should have removed his gloves and performed hand hygiene before he exited R2's room. When asked about the use of an isolation gown. The UM explained that staff members in the observation unit were expected to don isolation gowns prior to entering and providing care to residents. The UM described the process as follows: A. Staff members were issued one gown prior to the start of their shift. Staff wrote their names on their gown. B. Don the gown prior to entering and providing care to residents. C. Remove the gown in the Clean Room (a room where staff could hang the gowns when not in use) and reuse the same gown as needed for the entire shift unless it was visibly soiled. The UM was asked about MR1's staffing considerations during this time. The UM explained MR1 was staffed accordingly with two nurses and three nursing assistants on a regular day. The UM further explained that although staff had specific room/resident assignments they were expected to help other residents regardless of assignments. Review of the MR1's daily census for 5/21/20 revealed there were 17 residents residing on the unit during the survey. Review of the 17 residents' demographics revealed their age ranged from 65 to [AGE] years old. Further review of the 17 residents' hospital discharge summaries indicated presence of underlying chronic medical conditions such as hypertension, [DIAGNOSES REDACTED], [MEDICAL CONDITION], asthma, different types [MEDICAL CONDITION] and heart failure, to name a few. According to the CDC, Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)

high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including [MEDICAL CONDITION] (e.g., Carbapenemase-producing organisms, [MEDICAL CONDITION]) Review of R2's electronic health record (EHR) revealed R2 ([AGE] years old) was admitted to the facility on [DATE] from an acute care hospital with [DIAGNOSES REDACTED]. Further review of the same EHR under nursing progress notes dated 5/11/20 signed by (name of nurse) 11:11am, indicated, Went out with transport in stable condition for Orthopedic appointment. Review of R3's EHR revealed R3 ([AGE] years old) was admitted to the facility on [DATE] from an acute care hospital with [DIAGNOSES REDACTED]. On 5/21/20 at approximately 3:45pm, the DON was notified of the observation in the MR1 unit. The DON stated she expected staff to follow proper PPE use especially in the observation unit and echoed the earlier explanation provided by the MR1 UM. In addition, the DON explained that staff should have disinfected the MVSM in between resident's use for infection control purposes. The DON was queried about the extended length of time R2 had stayed in the observation unit. The DON replied, She went out for an outside appointment. That's why she's still under observation. The DON further explained that every time a resident went out for an outside appointment the 10-day observation period automatically restarted. The DON indicated the facility did not accept residents who tested positive for COVID-19. When asked whether R2 was re-tested for COVID-19 after her outside appointment on 5/11/20. The DON stated, I do not think so but I can give you her test results from the hospital. Review of the said COVID-19 test report provided by the DON indicated R2 tested negative for COVID-19. The said test was performed on 4/20/20 in the hospital and four days prior to her admission to the facility. It was reiterated to the DON that a single negative test did not negate the fact that the resident could still be exposed or would not become infected in the future, and this was precisely why the CDC emphasized the use of all PPE and strict adherence to the 14-day observation period in the observation unit. During a follow up interview on 5/29/20 at 1:45pm, the DON was asked what she considered were high-contact patient care activities. The DON stated that she considered showering, providing hygiene and transferring (residents) as high-contact care activities. When asked about the emptying of R3's urinal in the toilet, the DON confirmed, That too is a high-contact care since there's a possibility of splashing. Review of the facility's Coronavirus, Screening, Prevention and Care policy revised on 5/14/20 under III Policy Implementation indicated .2. Reinforcement of preventive measures with HCPs such as: a) Standard Precautions b) Use of PPE c) Hand hygiene d) Respiratory hygiene and cough etiquette e) Proper handling and cleaning of the environment, linens and resident care equipment .4. New admissions and readmissions will be placed on Contact-Droplet Precautions and monitored for symptoms for a minimum of 10 days . Review of the facility's Infection Prevention and Control Plan revised on 5/2/20 under Hand Hygiene: General Statement Good hand hygiene is a requirement of Standard Precautions. Hand hygiene is performed before and after each care contact for which hand hygiene is indicated by acceptable professional practice, utilizing designated time frames and products. Alcohol based hand rub (ABHR) is the preferred method, however, hands should be washed with soap and water when they are visibly soiled, before or after eating or handling food, after using the restroom and after caring for a resident with known or suspected [MEDICAL CONDITION] or norovirus infection .under Gloves indicated, .Gloves should be removed promptly after use and hands should be washed or sanitized to avoid transfer of microorganisms to other individuals or the environment . Further review of the same document under Resident/Client Care Equipment: General Statement revealed, .Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned. Manufacturer's recommendations for cleaning and disinfection are followed . Review of the Edan (manufacturer of the facility's MVSM) Monitor User Manual under Chapter 8 Maintenance and Cleaning dated 4/12 indicated, Regular cleaning of the monitor shell and the screen is strongly recommended. Use only non-caustic detergents such as soap and warm water (+40 /+104) monitor shell. Do not use strong solvents such as [MEDICATION NAME] or trichloroethylene. Take extra care when cleaning the screen of the monitor because it is more sensitive to rough cleaning methods than the housing. Do not permit any liquid to enter the monitor case and avoid pouring it on the monitor while cleaning. Do not allow water or cleaning solutions to enter the measurement connectors. Wipe around, except connector sockets .3. This company has no responsibility for the effectiveness of controlling infectious diseases using these chemical agents. Please contact infectious disease experts in your hospital for details. 4. Please disinfect timely to prevent the cross infection between patients . Review of a CDC article titled Coronavirus Disease 2019 (COVID-19) dated April 30, 2020 under Older Adults revealed, Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness. Under Older Adults are at Higher Risk revealed, 8 out of 10 deaths in the U.S. have been in adults [AGE] years old and older. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html 2. On 5/21/20 at 11:33am, seven residents were observed in the common activity area of the 2EFG unit. R4, R5, R6, R7, and R8 were next to each other while sitting in their wheelchairs. There was approximately two feet distance in between these residents. R4, R5, R6, R7, and R8 were not wearing any cloth face covering or face masks. None of the residents had tissue paper with them that could be used to cover their nose and mouth if they sneezed or coughed. Registered Nurse2 (RN2), Certified Nursing Assistants (CNA2 and CNA3) were present in the area but failed to assist residents to practice social distancing. At 12:40pm, when CNA2 was asked if there was at least six feet distance between R4, R5, R6, R7, and R8, CNA2 stated, No. R4 tested positive for COVID-19 on 5/26/20. A. Review of R4's medical record revealed R4 was [AGE] years old. R4's [DIAGNOSES REDACTED]. Review of R4's Nursing Follow-up note dated 5/22/20 at 1:11pm revealed, .Resident confused wandering around the unit by herself, up on wheelchair. Review of R4's Nursing Follow-up note dated 5/23/20 at 2:05pm revealed, Resident confused, wandering around the unit by herself, up on wheelchair. Assisted to washroom and bed. Wander guard LLE (left lower extremity). Safety/fall risk precautions . Review of R4's [MEDICAL CONDITION] Note dated 5/26/20 at 3:23pm revealed, Review of Symptoms: occasional cough .Transferred to 2C .Assessment and Plan: Covid 19 + Asymptomatic .Plan: Isolation .Respiratory toilet [MEDICATION NAME] . Review of R4's Nursing Follow-up note dated 5/27/20 at 10:12am revealed, .Resident confused, wandering around all over the unit by herself, up on wheelchair. Assisted to washroom and bed .4:10pm Per DON (Director of Nursing) and ADON (Assistant Director of Nursing), resident tested COVID-19 positive, and transferred back to room [ROOM NUMBER] 4B unit. MD informed. Endorsed to 4A unit staff. Review of R4's lab result revealed nasal swab was collected on 5/22/20. R4's result dated 5/26/20 revealed, Positive [DIAGNOSES REDACTED]-CoV-2 (severe acute respiratory syndrome coronavirus 2 - the [MEDICAL CONDITION] that can cause COVID-19) B. Review of R5's medical record revealed R5 was [AGE] years old. R5's [DIAGNOSES REDACTED]. C. Review of R6's medical record revealed R6 was [AGE] years old. R6's [DIAGNOSES REDACTED]. D. Review of R7's medical record revealed R7 was [AGE] years old. R7's [DIAGNOSES REDACTED]. R7's MD Progress Note dated 5/14/20 revealed [DIAGNOSES REDACTED]. E. Review of R8's medical record revealed R8 was [AGE] years old. R8's [DIAGNOSES REDACTED]. 3. On 5/21/20 at 11:58am, 19 residents were observed in the dining room of 3HJ unit. There were seven tables in the dining room. The 17 residents at six different tables were seated close to each other. This was verified by Registered Nurse3 (RN3). There were other staff present in the dining area but the staff failed to remind these residents on social distancing: R9, R10 and R11 were sitting at the first table. They were approximately two to three feet away from each other at the time of observation. R12, R13 and R14 were sitting at the second table. They were approximately two to three feet away from each other at the time of observation. R15, R16 and R17 were sitting at the third table. They were approximately two to three feet away from each other at the time of observation. R18, R19 and R20 were sitting at the fourth table. They were approximately two to three feet away from each other at the time of observation. R21, R22 and R23 were sitting at the fifth table. They were approximately two to three feet away from each other at the time of observation. R21, R22 and R23 were sitting at the fifth table. They were approximately two to three feet away from each other at the time of observation. R24 and R25 were sitting at the sixth table. They were approximately two to three feet away from each other at the time of observation. A. Review of R9's medical record revealed R9 was [AGE] years old. R9's [DIAGNOSES REDACTED]. Review of R10's medical record revealed R10 was [AGE] years old. R10's [DIAGNOSES REDACTED]. C. Review of R11's medical record revealed R11 was [AGE] years old. R11's [DIAGNOSES REDACTED]. D. Review of R12's medical record revealed R12 was [AGE] years old. R12's [DIAGNOSES REDACTED]. E. Review of R13's medical record revealed R13 was [AGE] years old. R13's [DIAGNOSES REDACTED]. F. Review of R14's medical record revealed R14 was [AGE] years old. G. Review of R15's medical record revealed R15 was [AGE] years old. R15's [DIAGNOSES REDACTED]. H. Review of R16's medical record revealed R16 was [AGE] years old. R16's [DIAGNOSES REDACTED]. I. Review of R17's medical record revealed R17 was [AGE] years old. R17's MD progress note dated 5/21/20 revealed [DIAGNOSES REDACTED]. J. Review of R18's medical record revealed R18 was [AGE] years old. R18's [DIAGNOSES REDACTED]. K. Review of R19's medical record revealed R19 was [AGE] years old. L. Review of R20's medical record revealed R20 was [AGE] years old. R20's MD Discharge note dated 5/26/20 revealed [DIAGNOSES REDACTED]. M. Review of R21's medical record revealed R21 was [AGE] years old. R21's [DIAGNOSES REDACTED]. Review of R22's medical record revealed R22 was [AGE] years old. R22's [DIAGNOSES REDACTED]. Review of R23's medical record revealed R23 was [AGE] years old. R23's [DIAGNOSES

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) REDACTED]. P. Review of R24's medical record revealed R24 was [AGE] years old. R24's [DIAGNOSES REDACTED]. R24's MD progress note dated 5/21/20 revealed [DIAGNOSES REDACTED]. Review of R25's medical record revealed R25 was [AGE] years old. R25's [DIAGNOSES REDACTED]. During interview with the DON on 5/29/20 at 1:42pm, when asked about her expectation from staff on social distancing especially during meals and activities, the DON stated, We did the education on social distancing and how it is up to staff to intervene when they (residents) are not following social distancing and redirect them. We applied the x mark on the floor as guide for the staff. When asked about additional measures being implemented to other residents that may have had contact with R4, the DON stated So our 2F unit is like an observation unit, everybody (staff) is using PPE. They're all dementia and Alzheimers. (Staff) Checking on residents every 8 hours including spO2 (oxygen saturation in the blood) and retest them (residents) on Tuesday. We did just retest them again yesterday morning 5/28 and are waiting for the result. Review of facility's policy titled Coronavirus, Screening, Prevention and Care dated 5/14/2020 under III. Policy Implementation revealed, 3. Following the direction of CDC, CMS, and state and local authorities regarding .b) Restrictions of: 5) Group activities, including communal dining. According to QSO-20-14-NH Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised) dated March 13, 2020, under Guidance for Limiting the Transmission of COVID-19 for Nursing Homes revealed, Additional guidance: 1. Cancel communal dining and all group activities, such as internal and external group activities .3. Remind residents to practice social distancing and perform frequent hand hygiene . In a CDC article titled Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs) dated May 21, 2020 under #3. Prevent spread of COVID-19 revealed, Actions to take now: Cancel all group activities and communal dining. Enforce social distancing among residents. Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html In a CDC article titled Social Distancing dated May 6, 2020, revealed, Limiting face-to-face with others is the best way to reduce the spread of coronavirus disease 2019 (COVID-19) .Social distancing, also called physical distancing, means keeping space between yourself and other people outside of your home. To practice social or physical distancin .Stay at least 6 feet (about 2 arms' length) from other people, do not gather in groups .In addition to everyday steps to prevent COVID-19, keeping space between you and others is one of the best tools we have to avoid being exposed to this virus and slowing its spread locally and across the country and world. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html 2. Based on observation, interview and record review, the facility failed to ensure adherence to infection control practices to prevent the transmission of the Coronavirus (COVID-19) as evidenced by failure on: social distancing; proper storage of clean linens; and proper doffing of personal protective equipment. This had the potential to affect all 214 residents who had not yet tested positive for COVID-19 in the facility. Findings include: 1. On 5/21/20 at 11:52am, Registered Nurse3 (RN3) was observed sitting in front of the computer in 3HJ nurses' station wearing a face mask. Group Therapy Staff (E5) was observed in a squat-kneel position wearing a face mask, next to RN3. There was approximately one to one and a half feet distance between RN3 and E5. Review of facility's policy titled Coronavirus, Screening, Prevention and Care dated 5/13/20 under IV. Procedure revealed, The primary goal is to prevent COVID-19 from being introduced within the campus. Prevention efforts include 1. Providing training and communication for associates, residents, resident representatives and other campus visitors on COVID-19 which may include: .d) Maintaining social distancing, when possible, of 6 feet or greater. In a CDC article titled Preparing for COVID-19 in Nursing Homes dated May 19, 2020, under Implement Social Distancing Measures revealed, Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Remind HCP (healthcare personnel) to practice social distancing and wear a face mask (for source control) when in break rooms or common areas. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 2. A. On 5/21/20 at 12:48pm, a clean linen cart was observed inside the laundry room. There were four folded flat sheets exposed and a folded black leather jacket on top of the clean linen cart. There was no barrier or covering on the black leather jacket and was laying on top of one of the flat sheets. The Director of Facilities/EVS (E1) and Laundry Staff (E6) were present during the observation. E6 stated that the black leather jacket belonged to another laundry staff. When asked if any item could be placed on top of the clean linen cart, both E1 and E6 stated, No. B. On 5/21/20 at 12:57pm, a tall clean linen cart was observed along the hallway of My Rehab 1 which was an Observation Unit. There were three clean cloth underpads laying on top of the clean linen cart. On the opposite end of the unit, another clean linen cart was observed with several linen exposed, on top of the linen cart. During interview with the DON on 5/29/20 at 1:42pm, when asked if other supplies including personal items could be placed on top of the clean linen cart, the DON stated, No. Review of facility's policy titled Infection Prevention and Control Plan dated 5/6/20 under Linen, revealed, Clean linen must be covered until it is used and stored on carts with a solid bottom. In a CDC article titled Appendix D - Linen and laundry management dated March 27, 2020 under Best practices for management of clean linen revealed, Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. https://www.cdc.gov/hai/prevent/resource-limited/laundry.html 3. A. Observations on 5/21/20 at 1:06pm on My Rehab 1 Unit revealed Registered Nurse4 (RN4) was coming out of R1's room wearing personal protective equipment (PPE): mask, face shield, gown and gloves. RN4 proceeded to walk the hallway to the end of the unit. R1 was in a contact and droplet precautions room. A printed PPE guide with pictures was observed on top of the isolation set-up outside of R1's room. Review of the facility's printed PPE guide revealed, PPE required for COVID contact-droplet precaution .Before exiting remove in this order. Gloves, goggles, gown, mask, hand sanitizer B. Observations on 5/21/20 at 1:22pm on My Rehab 1 Unit revealed Housekeeping Staff (E4) was cleaning inside room [ROOM NUMBER]. E4 was wearing PPE: mask, face shield, gown and gloves. room [ROOM NUMBER] was a contact and droplet precautions and a recently emptied room. A PPE guide was observed on top of the isolation set-up outside of the room. With gloves on, E4 was observed to be talking on her mobile phone while cleaning inside room [ROOM NUMBER]. E4 stated she was cleaning the room because the resident moved. When asked if she could be cleaning and be on the phone at the same time, E4 stated she was talking to a relative. Still with PPE on, E4 stepped out of the room approximately one to two feet away from the door. E4 stepped back into the room after the surveyor called her attention. During interview with the DON on 5/29/20 at 1:42pm, when asked what PPE she expected the staff to keep on upon leaving an observation room, the DON stated that staff could keep their eye shield and mask and added, Because the facility was in a crisis capacity, this is the expectation. Hand hygiene would be an expectation. It is a good practice to do hand hygiene. The eye protection, they can leave it on and take it off and disinfect it. When asked about her expectation from housekeeping staff when cleaning and disinfecting a Contact and Droplet Precaution room and if staff could use their mobile phone while doing the task, the DON stated, If they are going to do any cleaning, then they have to wear all PPE. No staff should be using the phone in the unit. Review of facility's policy titled Infection P