Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008965	A. BUILDING: _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

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S 000	Initial Comments Complaint Investigation: 2048891/IL128563 300.610a), 300.1020a), 300.1210a), 300.1210b) 2049034/IL128726 300.610a), 300.1020a), 300.1210a), 300.1210b)	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.696a)c) 300.1020a) 300.1210a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.696 Infection Control	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): Section 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	S9999		

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S9999	Continued From page 2 restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These regulations were not met as evidence by: Based on observation, interview and record review the facility failed to properly prevent and contain COVID 19 and follow facility policies which affects all residents at the facility, failed to update Care plans for R2 & R3 for of 2 residents reviewed for care plans and ensure care plans are implemented for R3, for 1 of 3 residents reviewed for care plans, and failed to properly apply PPE to reduce the risk of COVID 19 spread which has the potential to affect all residents. On 11/25/2020 at 10:58 a.m., V1 (administrator) stated the facility current census is 46 residents. Per facility log sheets for COVID-19 positive residents: 35 residents have tested positive for COVID-19 with seven deaths. Per facility log sheets for COVID-19 positive staff: 34 staff R2's current Face Sheet notes R2 is a 93-year-old resident admitted on 10/25/16. The	S9999		

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S9999	Continued From page 3 same Face Sheet records the following diagnosis for R2: dementia, pressure ulcer, traumatic subarachnoid hemorrhage, hypertension. R2's current P.O.S. records R2 takes the following medication: amlodipine besylate 2.5 mg daily, multi vitamin B.I.D., levothyroxine sodium 75 mcg daily, melatonin 3 mg H.S. R2's current care plan has one COVID-19 focus area, handwritten as follows: Focus area: (R2) tested positive for Covid-19, 10/11/2020. Intervention is handwritten with only one intervention in place as: resident will remain in respiratory isolation. No psycho/social focus areas for COVID-19 prior to R2 being diagnosed with Covid-19 are noted on the care plan. R3's current Face Sheet notes R3 is an 85-year-old admitted on 1/6/2020. The same Face Sheet records the following diagnosis for R3: COVID-19 & Alzheimer's disease R3's P.O.S. records R3 takes the following medication: Aspirin 81 mg daily, Divalproex sodium tab DR 250 mg daily, Eliquis 5 mg daily, Divalproex sodium tab DR 500 mg HS, Fluphenazine 1 mg daily, Hydrochlorothiazide 12.5 mg daily, Potassium Chloride ER 20 meq BID, Lipitor 80 mg HS, Lasix 40 mg daily, Mirtazapine 15 mg HS. R3's current care plan was reviewed and noted to have a Focus area of "Resident has a memory loss/dementia. Intervention in place as follows: Cue, re-orient & supervise or assist as needed and was created on 4/3/2020. The care plan also has a Focus area - The resident has a respiratory infection r/t disease process COVID-19 tested positive on 12/1/2020 via rapid test and positive	S9999		

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S9999	Continued From page 4 12/2/2020 by lab test. Intervention in place in part is as follows: Resident to remain in respiratory isolation as per IDPH protocol, POA made aware. The care plan is noted to not address psycho/social needs of R3 for COVID-19 prior to R3 becoming positive for Covid-19. On November 25, 2020 this surveyor was screened at the facility front door. The facility uses a monitor system that records the visitor's picture and takes a wrist temperature. This surveyor was unable to obtain a correct temperature on wrist after coming in from the cold, with numerous attempts. This surveyor reviewed the staffing log in sheets with temperatures for 11/25/20. Twenty temperatures were observed to be logged in under 97 degrees Fahrenheit, including 3 as low as 93.9, 91.3 and 91.1. Staff had not attempted to re-due temperatures for accuracy. On November 25, 2020, at 12:00 pm on Holy Family A hall, residents were observed doing communal dining. This hall had 2 residents that tested positive for COVID-19; R13 and R14 on 11/17/2020. Residents were noted to be in the dining room at 4 feet X 4 feet tables not wearing masks while waiting for food to be delivered to tables. The following observations were made at each table: from each other with no masks on at a table. R8 was then brought to this same table and put side by side with R10 approximately 2 ft from each other with no masks. 4. R3 and R12 were observed sitting 4 feet across from each other wearing no masks at a table. 5. R4 was then moved to a table with R11 sitting 4 feet across from each other wearing no masks at a table.	S9999		

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There was a total of 10 residents in the area for eating, there was 6 workers observed in the same area.

On November 25, 2020, at 12:02 p.m., V6 (dietary/feeding assistant and V7 (dietary aide) observed at the kitchen counter in dining area wearing a N95 mask with the bottom band not being used around head, leaving bottom of mask not against V6 and V7's face. V6 observed to be wearing a pair of gloves. V6 observed passing out trays to residents in the dining area. V6 observed going from resident to resident, touching them and not changing gloves or sanitizing hands between assisting each resident. V6 noted to pick up glasses of fluid for a resident with the same gloved hands, gloved fingers observed down in the liquid that the resident was going to drink.

1. R4, R5 and R8, were all observed at the same table not wearing masks, waiting for lunch. R8 was approximately 2 feet from R4 and R4 was approximately 2 feet from R5 at one table.
2. R6 and R7 observed with no masks on at the same table, sitting side by side, approximately 2 feet apart.

On November 25, 2020, at 12:05 pm R3 and R8 were noted to be in hall on the side of the dining area, R3's body touching R8's wheelchair, with no distance between them. R3 and R8 were not wearing face masks. No staff were noted to attempt to separate the 2 residents to gain distance or attempt to put face masks on residents. On December 02, 2020, V2 (Director of Nursing, D.O.N.) stated R3's COVID-19 test

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came back today positive and had been moved to the COVID unit on Monday, November 30, 2020, due to COVID symptoms. R3 also noted to be placed across the table from R12 to eat on November 25, 2020 with no mask on either resident or coaching from staff to put on masks. V8 (CNA) observed helping R3 to that table with the bottom strap of V8's (CNA) N95 not around V8's head, allowing the mask to not be tight against V8's face.

On November 25, 2020 at 12:09 p.m., V8 after helping R3 to the dining table, was observed to assist R11 to the dining area. V8 did not wash hands between residents and did not assure R11 was wearing a mask prior to coming to the dining area.

On November 25, 2020, at 12:13 p.m. V9 (housekeeping) was observed cleaning on the Holy family A hall, wearing a N95 mask without the bottom strap around the back of V9's head, leaving the bottom of the mask loose against the bottom of V9's face. V9 stated V9 was not trained on how to don and doff PPE gear. V9 stated V9 didn't need trained and knew how to wear the PPE gear. This surveyor asked V9 if they knew they were not wearing the band on the N95 correctly. V9 stated yes, because it is too hard to breath with it on.

On November 25, 2020, at 12:18, V8 (CNA) was observed sitting in dining area feeding a resident. V8 was observed not wearing the bottom strap on V8's N95 mask and pulling the mask off of V8's face at bottom to take breaths while feeding the resident.

On November 25, 2020, at 1:49 p.m. V8 was again not wearing the band at the bottom of the

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S9999	Continued From page 7 N95 mask around V8's head. V8 stated they couldn't breathe if they put the band around their head. V8 stated V8 knew they were to wear the bottom band around V8's head but it is too hard to breath. On November 25, 2020, at 1:41 pm, V6 was again observed with V6's mask bottom band not around V6's head. This surveyor asked V6 a question and V6 pulled down the N95 mask to V6's chin to talk to this surveyor. This surveyor requested V6 put the mask in place. V6 stated V6 can't wear the bottom band around V6's head because it hurts V6's nose and could make a sore. V6 stated "We looked it up on the internet and it said it can cause abrasions and infections." This surveyor asked V6 if V6 was educated on importance of wearing mask appropriately to prevent spread of the virus. V6 then stated: "Do you want my nose to fall off?" V6 was asked if V6 was educated on hand hygiene and glove usage. V6 stated the facility does not want them to wear gloves when feeding residents and V6 wasn't wearing gloves feeding. V6 stated, yes, V6 wore gloves to pass trays and agreed V6 had touched the residents to assist them and had not changed gloves or washed hands between residents. V6 stated V6 knew they were to change gloves and clean hands between resident care. On 11/25/2020 at 1:35 p.m., while on tour of halls with V2 (D.O.N.), V3 (head of housekeeping/maintenance) noted to be coming off the elevator with a personal face mask. V2 stated: "Yes, it is mandatory for all staff to wear a N95 and face shield, I will show you the sign." V2 took this surveyor to employee entrance to show sign advising staff the following; "N95 mask & face shield are mandatory, not a choice." V2 showed this surveyor the area where staff enter	S9999		

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and are screened. This surveyor noted numerous temperatures recorded that were very low. V2 stated, "With it being so close to the door, staff come in still cold from outside, so it reads the wrist temperature low. When I come in, I wait if low and re-due it when I have a chance to warm up to the right temp." This surveyor pointed out to V2 that staff were not doing that and recording very low temperatures. V2 stated V2 had not educated staff to re-due temperatures if low. This surveyor asked if this is not a risk for the residents and staff at facility due to correct temperatures not being obtained at the door. V2 stated: "Yes."

11/25/2020 at 4:25 p.m. V20 (CNA) observed passing dinner trays to residents on second floor. V20 observed to don/doff gown and gloves appropriately with COVID-19 residents. However, V20 wore the same mask and shield to go in and out of rooms, including those positive for COVID.

On 11/25/2020, at 2:14 pm, V16 (activity aide) was observed sitting at a 4X4 table in the dining area coloring a paper. R2, R8 & R11 were not wearing masks and sitting at the table with V16. V16 was approximately 2 feet from R2 and R11. R8 was approximately 2 feet from R2 and R11. V16 was noted to not have V16's bottom band to V16's N95 mask around V16's head. V16 was asked by this surveyor if they were taught that the bottom band needed to be around the head to secure the mask against the face. V16 stated: "Yeah, I was taught, but it is too uncomfortable to wear." V16 continued to color and this surveyor asked V16 if they knew the residents were supposed to be wearing a mask and all should be 6 feet apart from each other. V16 stated: "I didn't put them here; I just came over here to color with them." V16 continued to color and did not attempt

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S9999	Continued From page 9 to separate the residents or place a mask on them. 11/25/2020, from 2:14 pm to 2:25 pm R8 was noted to wheel all over the hall wearing no mask, getting close to other residents. No staff were noted to attempt to have R8 wear a mask or redirect R8 to not be close to other residents. 11/25/2020 at 2:49 pm: V18 (ADON) stated V18 is the wound nurse and works other halls. V18 stated when V18 does wounds, V18 does the COVID unit last and then leaves. V18 stated; "I did that last night." V18 stated they did the COVID unit last night and is wearing the same mask and shield as V18 wore last night on COVID unit. V18 stated: "I have a fabric spray I keep in my purse; I spray the mask and then leave it out in the car for a little bit and put it in plastic bag when I get home. I use the same mask for 1 week then get a new one." On 11/25/2020 at 3:38 pm, V2 stated, "I can't speak for all of the staff individually to how they do it, but they have all been given N95 masks and shields. They have to have on face mask when coming in building, they change to one on unit that we keep in a sack for them when working the COVID unit. I don't stand up there and see what everybody is wearing out of here." This surveyor stated that I was told they were each given one, if that is the case, how do they leave one here in a bag and then have one to take home. V2 stated: "They are all professionals and know where the masks are kept, I can't police them all, they know how to get the masks they need. I am not the only one who hands out masks, I have two assistant DONs and a couple others they can get masks from, I can't keep track who has been given what for all of the staff. We just all pitch in and help.	S9999		

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No, nobody has been assigned the responsibility of making sure they all have 2 masks to wear." V2 was asked if they knew V18 (ADON) Was working with only one mask and taking it home and using it again the next day on other floors after being on the COVID positive unit and if V2 had a problem with that procedure. V2 stated: "Yes, I do have a problem with that, V18 should have put V18's mask in bag on the COVID unit floor and worn home a different mask. I see what you are saying, I know they have to have 2 masks to be able to do this, but they know where to get the masks, I am not here at change of every shift, they know where masks are available, they need to get those masks, I can't be responsible to say; do you have a another mask?"

11/25/2020 at 4:10 pm: V10 (RN) observed at the nurse's desk talking on phone on the COVID-19 positive floor. V10 was not wearing a shield and had face mask pulled down to chin, leaving V10's mouth and nose exposed as V10 talked on phone.

On 11/25/2020, at 4:16 p.m. R14, positive for COVID-19, on COVID-19 unit, observed in room sitting in recliner with door open to the hallway.

11/25/2020 at 4:19: V20 (Cert nurse aide) observed bringing R5 onto the COVID unit. R5 was brought up per wheelchair wearing a N95 mask and face shield by V20. V20 stated R5's COVID-19 test had just come back positive and V20 was bringing R5 to the COVID unit.

11/25/2020 at 4:22 p.m.: R5 observed in room, sitting in wheelchair, mask down around chin with door open to the floor.

11/25/2020 at 4:23 pm: R5 and R14 observed to

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S9999	Continued From page 11 be the only current positive COVID-19 cases on hall, both rooms at end of 2nd floor hall. One room (201) between both residents with 2 other residents in that room. Doors observed all to be open while on second floor of those 3 rooms. No division of COVID-19 resident's portion of the hall from non-positive resident was noted to be done. 12/2/2020 at 7:54 a.m.: R9 was observed at a dining room table wearing no mask and no staff observed trying 12/2/2020 at 08:00: R8 is Observed in wheelchair, going all over dining area and halls with no mask. R8 allowed to get less than 6 feet distance from other residents with no mask. No staff observed to redirect R8 or apply a mask. On 12/2/2020 at 2:00 pm: This surveyor expressed concerns about staff temperature logs not appearing to be monitored due to low temps being recorded daily and if there is somebody in charge of surveillance of these temperatures of staff daily. V2 stated V24 (ADON) and V2 are in charge of surveillance of staff screening temperatures for COVID 19. V2 stated we both look at it and V5 did some as well. V5 stated: "I only looked at the temperature logs of staff when administrator told me to and that was when another administrator was here, it was a total of 2 times the end of October beginning of September. V2 stated all the staff have been educated they have to sign in and take their temperatures. When I do mine, I will look at signatures above me, we sign in just like everyone else, I look at ones above me and I have never seen ones like 91 degrees. This surveyor asked, is there somebody doing surveillance to assure for the facility all the temperatures are accurate daily? V2 stated: "We	S9999		

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S9999	Continued From page 12 look at as many as we can that is all I can tell you. This surveyor again asked, is there somebody assigned to do surveillance of all sign in sheets for all staff temperatures daily, V2 stated "No." 12/2/2020, at 8:13 a.m., V2 stated: "My temperature was low too when I came and screened in, it was 96.1 F., so I did some things like straighten up the table and waited, then it read 96.8. I in-serviced the staff the next day after we talked. This surveyor asked if all staff were in-serviced. V2 stated: "Well I talked to some individuals, I didn't have them sign into in-service, and then I came in with 3 or 4 staff members and I told them. They said it is hard to wait to re-due though because they will be late for work." 12/2/2020, at 8:37 a.m. V2 stated V25 (RN, past employee) came to me and said "I have a cough, but I feel fine. "V25 is a smoker and V25 has a cough and V25 has behavior issues where V25 doesn't want to work. I asked V25 if V25 had a temp and V25 said no. I told V25 if you don't feel well, you need to go home, but if you stay, you need to change masks and put on a N95. I figured if V25 was really sick, V25 would tell me. V25 stayed then went home and got tested the next day. V25 was positive for COVID-19. 12/2/2020 at 9:00 a.m.: V26 (LPN) observed sitting behind nurse's desk when entered 2nd floor area. V26 stated V26 was the nurse assigned to the COVID unit this morning behind the plastic wall. This surveyor looked down the hall to see the plastic area opening standing wide open to the hall. V26 stated, "Yes, this is the same N95 and face shield I am wearing behind the zipper wall of plastic. (This is the area set up for the 3 positive COVID patients) V2 stated to	S9999		

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S9999	Continued From page 13 V26 you need to go back to that area now and that plastic wall cannot be left standing open. V2 took V26 back inside the plastic area. V2 advised V26 the N95 and face shield could not be worn out of the isolation area and must be changed. V26 then asked V2, even my face shield, I don't have any extra back here. V2 stated V2 would go get the staff extra face shields. V2 was observed trying to close the plastic wall and observed unable to close the wall. V2 stated: "The magnet won't work on the wall; I have to call maintenance." V2 walked away from the wall leaving it open to the hall of residents without COVID. 12/2/2020, 9:19 a.m. V4 (dietary supervisor) and V5 (activity director/assist dietary manager) were interviewed. This surveyor asked if V5 thought it was ok for residents to be several to a table with no masks on in the dining area. V5 stated: "That was not how it is supposed to be, they were told one resident to a table, and they have to wear masks, that has been that way since COVID started. There should not have been residents eating at the same tables, I got extra bedside tables so those that could, can eat in their rooms. Residents are supposed to have their masks on when out of rooms." 12/2/2020 9:30 a.m. V2 stated the facility has not fit tested any staff for the N95 masks they are wearing. V2 stated: "We sent 4 people to MOHA to get fit tested, and they sat there two hours without getting tested. We had them get back to work. V1 and I just talked about it yesterday we are going to look into seeing if we could find somebody to come here or we could find another place to fit test. V1 was going to get online and look."	S9999		

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S9999	Continued From page 14 12/2/2020 at 9:40 a.m.: Holy family A hall observed R6 and R11 sitting across from each other at a 4X4 dining room table, not wearing masks. R4 observed in the TV area watching TV in a specialized chair with mask down on chin. When this surveyor started talking about residents with no mask, staff placed masks on residents without difficulty, residents were not combative when applied. 12/2/2020, at 9:49 a.m. V26 (LPN) stated: "They just put that plastic wall up late Monday, at the end of my shift. This is the first day I worked back there, so I didn't know what was going on for sure." V26 stated V26 had not been educated on how to wear PPE gear behind the plastic wall and when coming out of the COVID positive unit. V26 stated: "I have had COVID-19, and I was out for about 10 days. I was sick up here for 3 days, just thought it was a sinus infection, but I went home and went to doctor and they tested me, and I was positive for COVID-19." This surveyor asked V26 if V26 told supervisors they were sick in those three days. V26 stated, "No, because I just thought it was a sinus infection." This surveyor asked V26 what V26's symptoms were on those 3 days. V26 stated, it was just flu like, I ached all over, sneezy, and then I had that feeling you get in middle of head, when you have a sinus infection that gives you a headache. V26 stated: "I mean, I know what the symptoms are, but when I got them, COVID was the farthest thing from my mind, I just thought it was a sinus infection." 12/2/2020 at 3:32 pm, V1 and V2 stated they did not know V26 (LPN) was working sick for 3 days with flu like symptoms. V2 stated: "The staff know the signs/symptoms of COVID and know they are not supposed to work if they have them and let us	S9999		

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S9999	Continued From page 15 know. They all know the signs/symptoms of COVID, because they do COVID assessments on residents every day. I can tell you the staff know how to do isolation. Working with COVID residents in isolation isn't any different than walking out of any other isolation room. When I talked to V26 about wearing V26's mask and face shield out of the COVID positive area earlier with us, V26 acknowledged that I was right." 12/2/2020, at 9:53 a.m. V27 (maintenance) was observed coming out of the COVID-19 isolation area from behind the plastic wall. V7 was wearing a gown, face shield and N95 mask. V27 was observed to walk down the hall with the contaminated PPE gear and was about to enter another area of the hall. V27 was stopped by this surveyor and asked if V27 knew they were not to wear that contaminated gear out of the COVID isolation area. V27 stated: "No, I didn't know that." V27 was asked if V27 had been trained in PPE gear use. V27 shook V27's head and said: "You have to ask my boss about that." V27 was observed to go back to the plastic area to take off the contaminated gear. V27 again came from the contaminated area after taking off gown and attempted to go into the closet again. This surveyor again stopped V27 and advised the face shield and mask needed to be changed as well. V27 stated: "well then what I am I supposed to wear?" 12/2/2020 at 3:32 pm, V1(Administrator) stated: "V27 (maintenance) came down and told me immediately about coming out of the COVID isolation area without taking off PPE gear and told me what you said to V27. I immediately educated V27 on that. V27 is full time here. V27 certainly did get training on PPE gear. V27 just went brain dead for a minute. We will re-educate V27 again."	S9999		

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S9999	Continued From page 16 12/2/2020, at 10:00 a.m. This surveyor asked V10 (RN) about having mask and shield off while talking at the desk on phone on 11/25/2020. V10 stated: "When people say they can't understand me, I take them off. "Yes, I know I am not supposed to do that, I am not going to do it anymore, I know." 12/2/2020 at 5:21 pm: V25 (LPN) (RN, former employee) stated: "Yes, I had a loss of smell and taste. I didn't go home from work because I was told unless we are running a fever, we are working by V2. I finally said I had enough and went home in the middle of the night, I had worked my evening shift and was staying over on nights, but to sick to make it any longer." On 12/3/2020 at 2:00 pm, V1 stated they were not able to put up a plastic wall barrier to block COVID Positive residents off from other residents due to : "With our maintenance supervisor out with COVID we couldn't locate that portable wall timely to get it installed, it was all related to COVID reasons." On 12/3/2020 at 2:00 pm: V2 stated V25 (RN, former employee) told me V25 didn't have a temperature. V2 stated, no, I didn't have V25 take V25's temperature, V25 told me V25 didn't have a temperature and I trusted V25. V2 stated: "I then asked V2 if V2 felt like they could work or needed to go home, V25 said no, I am fine, I can work. V25 said V25 had no smell and something about taste, then I asked V25 after V25 told me that, if V25 had a temp or felt sick. V25 said no and then I said, well do you need to go home. And V25 said no. Review of facility policy titled: "Feeding policy for	S9999		

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Holy Family unit during COVID outbreak Dining room," dated 10/1/2020 and revised 11/25/2020 stated the following in part:
All residents that are able to feed themselves and are not a special diet or do not demonstrate any problems with swallowing will eat their meal in their room. All residents that require assistance with cueing or need to be fed, will eat in the dining room. Residents will wear masks in the dining room and the mask will be removed during the meal and then be replaced. Residents in the dining room will be set up at tables with one person at the table. All residents will be set up to be 6 ft from each other. Staff will wear the proper PPE in the proper fashion as required. (N95 mask).

Review of facility policy/procedure titled: "N95 usage," dated 10/1/2020 and revised 11/25/2020 states the following:
Policy: N95 are to be routinely worn by all employees in the building,
Equipment: N95 mask, Hand hygiene station:
Procedure: Staff members working in the non COVID unit are to wear their N 95 mask on entering and remove it upon leaving the building. Should it become soiled, obtain a new one. Staff members working the COVID unit must place their N95 mask on entering the building and to their area. On arriving to their positive unit, they must change their N95 mask and place it in bag #1. Wear a surgical mask over your N95 mask on entering a positive resident room. Dispose of the surgical mask before leaving the residents room. Perform proper hand hygiene. On leaving the unit, remove your mask and apply your original mask placing it in bag 2 and storing it on the unit. Wash your hands.

Facility email sent to all family/guardians of

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S9999	Continued From page 18 residents dated 11/22/20, titled: "Results from testing 11/17/2020, have included in the email: "St. Joseph of Springfield COVID-19 infection Prevention & Response Action Plan." In part states: Under staff: Please don't enter the building if you are ill. Any staff who exhibit symptoms at work should keep their mask on, leave work, isolate at home, call medical provider, and notify your supervisor. Assuming state congregate dining and group activities may be offered while adhering to the core principles of COVID-19 infection prevention. This includes social distancing, wearing a face covering and appropriate hand hygiene by residents and staff. (A)	S9999		