Illinois D	epartment of Public	Health		The state of the s	FORM A	PPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008783		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		C 03/24/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		-1
151	N CARE SPRING VAL	1300 NOR		WOOD STREET		8 4
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 2322298/IL157756		₩		
W.	Focused Survey wa	n Control Survey/COVID-19 as conducted by Illinois lic Health on March 24th 2023.			ű.	
	Department of Fub	iic ricatur on March 24th 2025.	130			
S9999	Final Observations		S9999	2.		
	Statement of Licen	sure Violations:		₁ , ≡	Tr.	
-	300.610a) 300.696a) 300.1020a) 300.1020b)					e e ^r
	a) The facility procedures govern	esident Care Policies shall have written policies and ing all services provided by the		2 2	-	
	be formulated by a Committee consist	n policies and procedures shall Resident Care Policy ing of at least the advisory physician or the			-7	
40	medical advisory of of nursing and othe policies shall comp	ommittee, and representatives er services in the facility. The ply with the Act and this Part.		, a	D ⁰	A [*]
(3)	the facility.	s shall be followed in operating		3		0,0
i i	Section 300.696 In	fection Control		E 18	55	18
70 53	policies and proceed controlling, and pre	y shall establish and follow dures for investigating, eventing infections in the es and procedures must be				5 g
55	consistent with and the Control of Com	d include the requirements of municable Diseases Code, Sexually Transmissible		Attachment A Statement of Licensure Violate	tions	=

illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C IL6008783 03/24/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 NORTH GREENWOOD STREET APERION CARE SPRING VALLEY SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 Infections Code. Each facility shall monitor activities to ensure that these policies and procedures are followed. Section 300.1020 Communicable Disease **Policies** The facility shall comply with the Control of Communicable Diseases Code (77 III. Adm. Code 690). A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300,620 of this Part. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct COVID-19 testing on residents that displayed COVID-19 like symptoms for five residents (R2, R7, R15, R16 and R17) out of 16 residents reviewed for COVID-19 testing in a sample of 24. The facility also failed to perform COVID-19 testing on employees that displayed COVID-19 like symptoms prior to providing direct care and services to residents in the facility. This failure

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has the potential to cause COVID-19 infection to

all 80 residents residing in the facility.

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING IL6008783 03/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET **APERION CARE SPRING VALLEY** SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ŧΩ (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 2 S9999 Findings include: The facility's "Infection Control - Interim COVID-19" policy revised 10/31/22 documents "Screening of Visitors, Staff and Residents: Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: 1) a positive viral test for SARS-CoV-2 2) symptoms of COVID-19. or 3) close contact with someone with SARS-CoV-2 infection (for patients and visitors) or higher risk exposure (for healthcare personnel (HCP)). Staff: Instruct HCP to report any of the three above criteria to occupational health or another point designated by the facility so these HCP can be properly managed." The facility's "Interim COVID-19 Testing -Residents and Staff" policy revised 10/21/22 documents "Testing of Staff and Residents: Testing Trigger - Symptomatic individual identified. Staff, regardless of vaccination status, with signs or symptoms must be tested. Residents, regardless of vaccination status, with signs or symptoms must be tested. Testing of Symptomatic Individuals: Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. Symptoms include: 1) Temperature greater than 100.0 Fahrenheit. 2) Significant decrease in oxygen saturation from baseline or oxygen saturation less than 92%, cough, 3) Cough, cold symptoms. 4) Sore throat. 5) New loss of smell/taste. 6) Headache. 7) Chills. 8) Muscle pain. 9) GI (Gastrointestinal) symptoms (nausea, vomiting, diarrhea). If using an antigen test, a negative

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result should be confirmed be either a negative

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: B. WING IL6008783 03/24/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 NORTH GREENWOOD STREET APERION CARE SPRING VALLEY SPRING VALLEY, IL 61362 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 3 NAAT (molecular PCR The polymerase chain reaction (PCR) test for COVID-19 is a molecular test that analyzes your upper respiratory specimen, looking for genetic material (ribonucleic acid or RNA) of SARS-CoV-2, the virus that causes COVID-19.) or a second negative antigen test taken 48 hours after the first negative test and maintain transmission-based precautions until results are confirmed. Staff with symptoms or signs of COVID-19 must be tested and are expected to be restricted from the facility pending results of COVID-19 testing." The facility's census report dated 3/21/23 documents 80 residents residing in the facility. 1. On 3/21/23 at 8:14 AM, during an observation of medication administration, R2 noted to have cough and mucus hanging down from his nose. V3, Registered Nurse (RN), stated, "You don't look to good. You feeling ok?" R2 replied, "I don't feel well. I haven't felt well in days." V3 turned to surveyor and stated. "He's been like this for a couple of weeks. I'm going to give him a breathing treatment." On 3/21/23 at 9:03 AM, V2, Director of Nursing/Infection Preventionist (DON/IP) was asked for all infection control tracking documentation to include employee and resident symptoms tracking and screening along with employee and resident COVID-19 testing for the last month. V2, DON/IP, stated, "We haven't screened anyone in months. Our policy says we don't have to because our community transmission level is green. We just started wearing masks today. We haven't tested resident for COVID in months because we haven't had an outbreak or a positive employee." When asked

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about symptom tracking and COVID-19 testing

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6008783 03/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET **APERION CARE SPRING VALLEY** SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 for resident given R2's observed COVID-19 like symptoms, V2, DON/IP, stated, "(R2) didn't have to be tested for COVID because our community transmission is green. (R2) has another respiratory issue. We didn't test him." R2's medical record dated 3/14/23 documents. "Per report, resident had low-grade fever last night. Assessed resident this morning. Oxygen saturation is 91-92% on room air. Diminished breath sounds throughout lungs. Noted increased wet cough. Daughter at bedside. Primary care physician in facility and saw resident. Received order for stat chest X-ray and as needed Tylenol for fever." R2's medical record dated 3/14/23 documents. "Physician progress note. Patient with fever yesterday, had mild cough. Poor appetite last couple of days, sore throat per family member. Plan: 1. Reviewed therapy notes and discussed any issues with the patient. Continue current therapy regimen. 2. Patient with fever and cough since yesterday. Chest X-ray is pending. Has poor appetite, recommend COVID-19 swab." R7's medical record dated 3/8/23 documents. "Resident has a coarse, non-productive cough. Crackles auscultated to bilateral lower lobes. Oxygen saturation 93 % on room air. Medical doctor (MD) notified and order for Chest X-ray received. R7's medical record dated 3/8/23 documents. "Chest X-ray results are within normal limits. MD notified. No new order." The facility's monthly infection control log dated March 2023 documents that on 3/6/23 R16 had an onset of fever, cough, and shortness of

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6008783 03/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET APERION CARE SPRING VALLEY SPRING VALLEY, IL 61362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 5 breath, on 3/7/23 R15 had an onset of a cough and on 3/12/23 R17 had an onset of increased coughing, lowered oxygen saturation and colored phleam. On 3/21/23 at 3:20 PM, V2, Director of Nursing/Infection Preventionist, (DON/IP), stated "You asked for the resident COVID symptom tracking and testing, that COVID resident line list I gave is it. (R19) was the last resident we had and (V5, Dietary Housekeeping Supervisor) was the last employee we had that tested positive. We tested (R2) today around 11:00 am. I did see in the progress notes that the doctor wanted a COVID test on him (R2) last week, but he never wrote an order for it so we missed it. I'll be honest with you, the only reason we tested him today was because you're here in the building." The facility's COVID-19 Resident line listing and symptom tracking log documents the last resident to have symptoms and tested for COVID-19 was R19 on 11/20/22. The facility's COVID-19 Resident line listing and COVID-19 symptom tracking log does not include R2, R7, R15, R16, and R17. R2, R7, R15, R16 and R17's medical record does not document a COVID-19 test was performed. R7's medical record documents R7 tested positive for COVID-19 on 3/22/23. On 3/22/23 at 11:42 AM, V15, Regional Vice President of Operations (RVP), stated, "We don't need an order to test residents for COVID. If they have any of the symptoms identified by the CDC

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(Center for Disease Control) as COVID symptoms, then we should be testing."

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING IL6008783 03/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET **APERION CARE SPRING VALLEY** SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 On 3/23/23 at 9:50 AM, V15, RVP, stated, "I looked into those residents you asked me about. (R15, R16 and R17) were not tested for COVID prior to the outbreak. Yes, they should have been tested given their symptoms. (R2) should have been tested when staff identified his symptoms. Any resident that has COVID like symptoms should be tested immediately." 2. The facility's COVID-19 outbreak testing results dated 3/22/23, documents six of the nine residents, R9 through R14, that reside on C Hall tested positive for COVID-19. The facility's COVID-19 Staff line listing and symptom tracking log documents V5, Housekeeping/Dietary Supervisor (HDS), tested positive for community acquired COVID-19 on 3/16/23 with her last day of work on 3/13/23. On 3/21/23, at 1:45 PM V2, DON/IP, stated, "The last positive COVID we had was (V5, HDS). She tested positive on 3/16/23, but the last day she worked was 3/13/23. Therefore, it was community acquired. She wasn't here in the building to expose the residents." V2, DON/IP, was asked if there were any employees over the last month that have come to work with COVID like symptoms or that had an illness and went home due to illness. V2, DON/IP, replied "No, we haven't had any employees sick while here at work that went home or had to be sent home due to illness." On 3/21/23 at 2:55 PM, V5, HDS, confirmed a COVID-19 test was not conducted prior to her working on 3/16/23 and stated, "I came into work

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last Thursday (3/16/23) and I was sick. I went straight to my office around 6:30 AM. I called the

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 03/24/2023 IL6008783 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET **APERION CARE SPRING VALLEY** SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 7 doctor to get some medicine for my symptoms, but they wouldn't call any in. So, I left work around 11:30 AM, went home and did an at home COVID test. It was positive. I called (V2, DON/IP) the same day to let her know I tested positive and that I was at work." On 3/22/23 at 8:24 AM, V9, CNA, stated, "There's been a few CNAs that have worked while sick over the last few weeks. I don't know their names." On 3/22/23 at 8:25 AM, V10, CNA stated, "There's been a couple of employees that worked while sick, but I can't tell you their names." On 3/22/23 at 8:28 AM, V11, CNA, stated, "There were two employees who had to go home due to illness over the last couple of weeks. (V8, CNA) left her shift early sometime last week because she was sick and the other was (V7, CNA). She went home yesterday because she was sick. Those are the only two that I know of." On 3/22/23 at 8:31 AM, V2, DON/IP, stated, "(V7, CNA) went home yesterday (3/21/2023) due to respiratory symptoms, but her rapid test was negative. She was supposed to do a COVID PCR test before she left, but I forgot to collect it. When the employee has symptoms and tests negative on a rapid test, we must do a PCR test and send it to the lab. (V8, CNA) went home sick (3/15/2023) on her own accord. She wasn't sent home. I didn't find out until after she went home that she left because she was sick. I found out around 3:00 PM that day. I tried calling her the next morning to have her test, but she didn't answer her phone so I left her a message. This

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morning she came to work and when we told her she had to test due to an outbreak, she refused

PRINTED: 04/19/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING IL6008783 03/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH GREENWOOD STREET APERION CARE SPRING VALLEY SPRING VALLEY, IL 61362 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **(EACH CORRECTIVE ACTION SHOULD BE)** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 8 S9999 and left so we never did get her tested." On 3/22/23 at 8:44 AM, V7, CNA, stated, "I came to work sick vesterday. I didn't screen or test because I thought we didn't have to do that anymore. I got to work at 6:00 AM and around 11:00 AM (V2, DON/IP) tested me and sent me home. I showed up to work with a cough and congestion, but it got worse." V7's. Certified Nursing Assistant (CNA), timecard report documents V7 worked on 3/21/23 from 6:09 AM to 11:03 AM and worked on C Hall. V7's Point of Care COVID-19 testing sheet dated 3/21/23 and signed by V2, DON/IP, documents, "Is this person exhibiting any symptoms consistent with COVID-19? Yes." On 3/22/23 at 9:51 AM, V8, CNA, stated, "Last Wednesday (3/15/23) I got to work around 6:00 AM and wound up having to leave at about 10:00 AM because I was vomiting and had diarrhea. My symptoms actually started a few days prior to that. I was having a headache and body aches for a few days, but they stopped the day I went to work. The day I went to work, I only had the nausea and diarrhea, but I wound up vomiting, so I told the scheduler I was sick, and I went home. (V2, DON/IP) called me the next morning and told me that I needed to let her know if I left work. I never tested for COVID. I thought I would be ok."

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V8's, CNA, timecard report documents V8 worked on 3/15/23 from 6:00 AM to 10:13 AM

On 3/23/23 at 9:24 AM, V14, Housekeeping, observed in the hallway going into resident rooms and cleaning. During the interview with V14, her

and worked on C Hall.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 03/24/2023 IL6008783

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4200 MODTH CREENWOOD STREET

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		
3 g	voice sounded hoarse. V14 stated "Yeah, I've been sick over a week now. It started last week. I came to work (3/15/23) with a headache, sore throat, and stiff neck. After a couple of days of working, it started getting worse, so I went to the nurses' station and asked for a rapid test. It was negative, so I went back to work. I didn't tell anyone I was sick until I did the test. I'm housekeeping, so I go all over the facility."	3		#2 28
	On 3/23/23 at 9:50 AM, V1, Administrator, and V15, RVP, were informed of V14, Housekeeping, and requested V14's COVID-19 testing record.	-5		a ^r eg
	V14's, Housekeeping, timecard report documents V14 worked 7.5 hours on 3/15/23, 3/16/23, 3/17/23, 3/20/23, 3/21/23 and 3/22/23. The time report also documents V14 punched in to work on 3/23/23 at 6:28 AM, with no time punch out.			-Os
8	On 3/23/23 at 11:53 AM, V15, RVP, stated, "I just wanted to let you know that (V14, Housekeeping) tested negative on the rapid test when we did the whole facility, but because she's symptomatic, she has to do a PCR test. We did collect the PCR and sent her home, immediately after you informed us, and told her that she can't return to work until we get the PCR test results back. The	58 (5)		275
	employees have been in-serviced about not coming to work with COVID symptoms. If they're having symptoms, they have to notify management and get a rapid COVID test. If the rapid test is negative, and they're symptomatic, then they have to do a PCR test and can't return to work until we get the results. If the PCR is negative, they can return to work."			5 II
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