STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145479	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATRIUM HEALTH CARE CENTER	1425 WEST ESTES AVENUE CHICAGO, IL 60626

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-,[DATE]-NH revised on [DATE], Nursing Home guidance from the Centers for Disease Control (CDC), and observation, interview, and record review, the facility failed to: restrict staff from working after receiving positive COVID-19 test results; screen all staff prior to the beginning of their shift for all the potential signs and symptoms of COVID-19; increase monitoring and restrict residents that had been exposed to COVID-19 from coming in contact with residents that had not been exposed, for three residents (R9, R10, and R11); and failed to increase monitoring of confirmed COVID-19 positive residents for eight residents (R1, R2, R3, R4, R5, R12, R7, and R13). This resulted in actual harm for four residents (R1, R2, R3, and R4) with confirmed [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19, when: R1 and R2 died in the facility, R3 was hospitalized and died , and R4 was hospitalized , after the facility failed to increase monitoring of vital signs and respiratory signs and symptoms. The facility's failures had the potential to affect all 145 residents in the facility and resulted in an Immediate Jeopardy (IJ) to their health and safety. The IJ began on [DATE], when the facility received R3's confirmation of COVID-19 and failed to increase monitoring of R3's temperature, oxygen saturation, and respiratory status. The facility is located in a county with sustained community transmission, many active cases of COVID-19 and many deaths have occurred. The facility had 88 confirmed cases of COVID-19 and five associated deaths at the time of the survey. The Administrator was notified of the Immediate Jeopardy [DATE] at 11:30 am. Findings include: 1. According to the Centers for Disease Control's (CDC), Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, .Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection ., retrieved [DATE] from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html. According to the Illinois Department of Public Health's (IDPH), COVID-19 Control Measures for Long Term Care Interim Guidance, .If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory [MEDICAL CONDITION] infection: Obtain Vitals (temperature, heart rate, respirations) AND pulse oximetry every 4 hours (Q4hours) {twice a shift}. Blood pressure can be taken every 8 hours ., retrieved [DATE] from https://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/long-term-care-guidance. Review of the Centers of Disease Control and Prevention (CDC) guidelines titled, If You Are Immunocompromised, Protect Yourself From COVID-19 last reviewed on [DATE], specified, Many conditions and treatments can weaken a person's immune system ('making them immunocompromised'). Some of these include: Cancer Bone marrow transplant Solid organ transplant Stem cells [MEDICAL CONDITION] treatment Genetic immune [MEDICAL CONDITION] of oral or intravenous corticosteroids or other medicines called immunosuppressants that lower the body's ability to fight some infections .) Risk of Severe Illness from COVID- 19 People with weakened immune systems are at higher risk of getting severely sick from [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19. They may also remain infectious for a longer period of time than others with COVID-19, but we cannot confirm this until we learn more about this new virus . Review of Medscape Medical titled Almost 90% of Covid-19 Admission Involve Comorbidities by(NAME)Frankl, dated [DATE] indicated, The hospitalization rate for COVID-19 is 4.6 per 100,000 population, and almost 90% of hospitalized patients have some type of underlying condition, according to the Centers for Disease Control and Prevention . The hospitalization rate, based on COVID-NET data for [DATE]-28, increased with patient age. Those aged [AGE] years and older were admitted at a rate of 13.8 per 100,000, with 50- to [AGE] year-olds next at 7.4 per 100,000 and 18- to [AGE] year-olds at 2.5, they wrote. The patients aged [AGE] years and older also were the most likely to have one or more underlying conditions, at 94.4%, compared with 86.4% of those aged ,[DATE] years and 85.4% of individuals who were aged ,[DATE] years, the investigators reported. Hypertension was the most common comorbidity among the oldest patients, with a prevalence of 72.6%, followed by cardiovascular disease at 50.8% and obesity at 41%. In the two younger groups, obesity was the condition most often seen in COVID-19 patients, with prevalences of 49% in 50- to [AGE] year-olds and 59% in those aged ,[DATE] . Review of National Center for Biotechnology Information (NCBI) article, titled Oxygen Saturation by Dr. Brant B. Hafen, updated [DATE], specified, Oxygen saturation is an essential element in the management and understanding of patient care. Oxygen is tightly regulated within the body because hypoxemia (lack of oxygen) can lead to many acute adverse effects on individual organ systems. These include the brain, heart, and kidneys . Pulse oximetry can provide a rapid tool to assess oxygenation accurately. It is particularly useful in emergencies for this reason. Cyanosis (bluish discoloration to the skin) may not develop until oxygen saturation reaches about 67%. As such, pulse oximetry is extremely useful because the signs and symptoms of hypoxemia may not be visible on physical examination . The human eye's ability to detect hypoxemia is poor. The presence of central cyanosis, blue coloration of the tongue and mucous membranes, is the most reliable predictor; it occurs at an oxyhemoglobin saturation (measures how well oxygen is available in the blood for an individual) of about 75%. Pulse oximetry provides a convenient, noninvasive method to measure blood oxygen saturation continuously. It can also help to eliminate medical errors . a. Review of R1's electronic medical record (EMR) medical diagnoses, revealed R1 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R1's Progress Notes revealed the following: [DATE] at 6:44 pm, COVID-19 Lab result received, Detected (positive) Dr. (doctor) .made aware with order to continue to monitor temp . [DATE] at 4:33 pm, At 4:03, pm, on rounds, resident noted lethargic, non responsive to name. With absence of vitals. Code blue immediately called with CPR (cardiopulmonary resuscitation) initiated. 4:05 pm, 911 called, 4:15 pm, 911 crew arrived on unit with CPR still in progress . Review of R1's Report of Laboratory Results, date reported [DATE], revealed R1 was positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of the facility's resident temperature log and R1's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R1's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. Review of the facility's Infection Tracking, dated [DATE], revealed R1 died in the facility on [DATE]. b. Review of R2's EMR medical diagnoses, revealed R2 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R2's Progress Notes revealed the following: [DATE] at 6:01 pm, COVID-19 Lab result received, Detected (positive) Dr (doctor) .made aware with order received to monitor resident on droplet /contact precautions with all services rendered in the room. Resident currently asymptomatic, Temp (temperature): will continue to monitor resident for symptoms of Co-vid 19 like fever, chills, coughing, SOB, sore-throat, wheezing, rapid pulse, repeated shaking with chills, headache, loss (sic) of taste or smell. [DATE] at 2:53 pm, .At 2:20pm, during rounds resident was noted unresponsive code blue called, CPR (cardiopulmonary resuscitation) initiated. At 2:25pm, 911 arrived in the building, CPR continued. At 2:37pm resident pronounced (sic) dead by 911 paramedics . Review of R2's Report of Laboratory Results, date reported [DATE], revealed R2 was positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of the facility's resident temperature log and R2's

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 0880

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 1)

EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R2's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. c. Review of R3's EMR medical diagnoses, revealed R3 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R3s Progress Notes revealed the following: [DATE] at 3:30 pm, COVID-19 Lab result received, Detected (positive) Dr. (doctor) .made aware with order to continue to monitor temp (temperature) and 02-sat (oxygen saturation) . [DATE] at 11:21 am, At 11:20am, resident noted lethargic but responsive to touch only .02-sat (oxygen saturation) 90% on room air. NP (nurse practitioner) .made aware with order to transfer to .Hospital ER (emergency room) for medical evaluation. Order noted. Resident reassessed with [REDACTED]. [DATE] at 7 pm, At 6:00 pm, received a call from nurse .that resident is admitted (to the hospital) with DX (diagnosis) of positive COVID-19, bilateral pneumonia, acute [MEDICAL CONDITION] with apoxia (sic), [MEDICAL CONDITION] and [MEDICAL CONDITION] (low blood sodium) . Review of R3's Report of Laboratory Results, date reported [DATE], revealed R3 was positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with

COVID-19. Review of the facility's resident temperature log and R3's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R3's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. Review of the facility's Infection Tracking, dated [DATE], revealed R3 died at the hospital on [DATE]. d. Review of R4's EMR medical diagnoses, revealed R4 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R4's Progress Notes revealed the following: [DATE] at 5:56 pm,

COVID-19 Lab result received, Detected (positive) Dr (doctor) .made aware with order received to monitor resident on droplet /contact precautions with all services rendered in the room. Resident currently asymptomatic, Temp (temperature): will continue to monitor resident for symptoms of Co-vid 19 like fever, chills, coughing, SOB, sore-throat, wheezing, rapid pulse, repeated shaking with chills, headache, loss (sic) of taste or smell. [DATE] at 10:58 pm, Resident received in the room alert, verbally responsive and oriented to self and place with episode of forgetfulness and confusion. Redirection provided as needed. Resident noted with elevated temp. 100.6 .On continuous oxygen 2L via N/C (nasal cannula), pulsating at 78% (oxygen saturation below 90% is considered low) .911 called .resident transferred to nearest hospital . [DATE] at 6:43 am, .hospital informed that resident is admitted with DX of Covid19 infection . Review of R4's Report of Laboratory Results, date reported [DATE], revealed R4 was positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of the facility's resident temperature log and R4's EMR, dated [DATE] to [DATE], revealed no evidence the

facility was monitoring R4's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. e. Review of R5's EMR medical diagnoses, revealed R5 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R5's Progress Notes revealed the following: [DATE] at 11:04 pm, At 3:00 pm .readmitted from .Hospital .readmitted with DX (diagnosis) of [DIAGNOSES REDACTED] (low blood calcium, Pneumonia due to [DIAGNOSES REDACTED] associated COVID-19, Septic Shock and UTI (urinary

tract infection) . Review of the facility's resident temperature log and R5's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R5's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. f. Review of R12's EMR medical diagnoses, revealed R12 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R12's Progress Notes revealed

the following: [DATE] at 2:13 pm, .resident Temp (temperature) = 102.2 .MD (medical doctor) notified . [DATE] at 4:08 pm, .COVID-19 Lab result received. Detected critical (positive) .Dr. (doctor) .made aware with order to continue to monitor temp and O2 (oxygen)-sat (saturation) . Review of the facility's resident temperature log and R12's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R12's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. g. Review of the R7's EMR medical diagnoses, revealed R7 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R7's Progress Note, dated [DATE] at 7:35 pm, revealed, Readmission note: readmitted .from .hospital .with admitting dx. (diagnosis) of Upper respiratory infection and positive for Covid-19 . Review of the facility's resident temperature log and R7's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R7's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. h. Review of the R13's EMR medical diagnoses, revealed R13 was [AGE] years old and had [DIAGNOSES REDACTED]. Review of R13's Progress Notes revealed the following: [DATE] at 11:04 am, 1045am resident noted with lethargy and coughing .o2 sat (oxygen saturation) 90% room air, notified Dr (doctor) .with order to transfer to .hospital . [DATE] at 9:22 pm, Per ER Nurse resident is admitted with Dx (diagnosis) of Covid19 . [DATE] at 9:21 pm, At 7 pm readmitted .from .Hospital .Resident with Dx (diagnosis) of Covid19 . Review of the facility's resident temperature log and R13's EMR, dated [DATE] to [DATE], revealed no evidence the facility was monitoring R7's temperature, oxygen saturation, and respiratory signs and symptoms at the frequency recommended by the CDC and IDPH guidance for confirmed COVID-19 positive residents. During an interview on [DATE] at 1:30 pm with the Administrator, when asked why Employee (E1) was allowed to work until 7:30 pm after the DON became aware of E1's positive COVID-19 test results that afternoon, the Administrator stated, I assume with the concern with CNA (certified nursing assistants) staffing it was probably just overlooked at the time. When asked if the known COVID-19 positive staff, that were allowed to work, were in contact with residents and staff that were negative for COVID-19 or had an unknown COVID-19 status, the Administrator agreed that the logistics of the facility did not allow for the known positive staff to only interact with known confirmed COVID-19 positive residents and staff, and the Administrator stated, When I rethought this I was also concerned about that fact. During an interview on [DATE] at 4:06 pm with the Administrator and the Vice President of Quality Assurance (V.P. of Quality Assurance), the V.P. of Quality Assurance confirmed that there was no evidence in records to indicate the facility increased monitoring after R1, R2, R3, R4, R5, R12, R7, and R13 were confirmed to have [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19.

During the same interview, when asked what is the risk to the resident if the facility does not increase monitoring for residents with confirmed COVID-19, the V.P. of Quality Assurance stated, By not increasing the monitoring it does not allow us to know .We put the resident at risk .When the resident is identified positive the identification of worsening condition could be missed. During the same interview on [DATE] at 4:06 pm, with the Administrator and the V.P. of Quality Assurance, when asked if increased monitoring of known COVID-19 positive residents could have avoided the outcomes of hospitalization and/or death for R1, R2, R3, and R4, the Administrator and V.P. of Quality Assurance confirmed that increased monitoring by nursing staff could have potentially avoided the residents' outcomes. At the time of the interview: R1 and R2 had died in the facility; R3 died after being transferred to the hospital; and R4 had been hospitalized for [REDACTED]. 2. According to the CDC's, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, . Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive). Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them ., retrieved [DATE] from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html. a. Review of R8's Progress Note, dated [DATE] at 5:37 pm, revealed, 5pm On assessment resident noted with elevated temperature of 100.9 noted with wheezing to bilateral lower lobes with shortness of breath .o2 (oxygen) desaturated at 80% (values under 90% are considered low) .Dr (doctor) .was notified .gave order for the resident to be transferred to .hospital for evaluation . Review of the facility's Infection Tracking, dated [DATE], revealed R8 had a positive COVID-19 test collected on [DATE]. Further review revealed R8's symptom onset was [DATE]. Review of the facility's Census Detail Report, dated [DATE], revealed that R8 had three roommates, R9, R10, and R11, at the time when R8 had onset of symptoms associated with COVID-19. Review of R9, R10, and R11's EMRs revealed no evidence that the facility increased monitoring or restricted R8's roommates from coming in contact with other residents after possible exposure to COVID-19 per the CDC guidance. Further review of the facility's Infection Tracking, dated [DATE], revealed the following: R9 had a positive COVID-19 test collected on [DATE] and the facility initiated contact and droplet isolation for R9 on [DATE]. R10 had a positive COVID-19 test collected on [DATE] and the facility initiated contact and droplet isolation for R10 on [DATE]. R11 had a positive COVID-19 test collected on [DATE] and the facility initiated contact and droplet isolation for R11 on [DATE]. 3. Observation on [DATE] at 12:10 pm through the kitchen door windows revealed the Dietary Supervisor standing and talking to Employee (E2). The Dietary Supervisor and E2 were standing within six feet of one another and neither the Dietary Supervisor nor E2 were wearing a face covering to prevent the transmission of COVID-19. During a follow-up interview on [DATE] at 12:15am, with the Dietary Supervisor, when asked why neither the Dietary Supervisor nor E2 were wearing masks while standing within six feet of one another and talking, the Dietary Supervisor stated, I just came out of the bathroom. When asked what the facility's

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) instructions were regarding the wearing of masks around other staff members, the Dietary Supervisor stated, As long as we are not right on top of each other. I feel like I'm in trouble here. When asked what the recommended distance is to don the mask, the dietary supervisor stated, within six feet. The Dietary Supervisor then confirmed that the Dietary Supervisor and E2 were within six feet of each other and neither were wearing masks. 4. Review of the facility's Employee Temp Log and time cards, dated [DATE] to [DATE] revealed the following: [DATE], there was no evidence Nursing Assistant (NA1) had been screened for an elevated temperature or signs and symptoms of COVID-19 prior to starting her shift. In addition, there was no evidence Licensed Practical Nurse (LPN1) and LPN2 were screened for signs and symptoms of COVID-19 prior to starting their shifts. Further review revealed no evidence E5 was screened for an elevated temperature prior to starting his shift. [DATE], there was no evidence LPN1, NA2, NA3, NA4, E3, or E4 had been screened for an elevated temperature or signs and symptoms of COVID-19 prior to starting their shifts. In addition, there was no evidence LPN3 was screened for signs and symptoms of COVID-19 prior to starting her shift. [DATE], there was no evidence the Administrator had been screened for an elevated temperature or signs and symptoms of COVID-19 prior to starting his shift. In addition, there was no evidence NA6, NA4, NA7, or NA8 were screened for signs and symptoms of COVID-19 prior to starting their shifts. [DATE], there was no evidence NA5 had been screened for an elevated temperature or signs and symptoms of COVID-19 prior to starting her shift. In addition, there was no evidence E2 was screened for signs and symptoms of COVID-19 prior to starting her shift. E2 is the employee that was observed standing within six feet and talking to the Dietary Supervisor without face coverings on [DATE] at 12:10 pm. 5. Review of NA9's Report of Laboratory Results, date reported [DATE], revealed NA9 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA9's timecards revealed NA9 was allowed to work on [DATE], [DATE], and [DATE] despite the positive test result on [DATE]. Review of NA10's Report of Laboratory Results, date reported [DATE], revealed NA10 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA10's timecards revealed NA10 was allowed to work on [DATE] and [DATE] despite the positive test result on [DATE]. Review of NA11's Report of Laboratory Results, date reported [DATE], revealed NA11 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA11's timecards revealed NA11 was allowed to work on [DATE], [DATE], and [DATE] despite the positive test result on [DATE]. Review of NA12's Report of Laboratory Results, date reported [DATE], revealed NA12 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA9's timecards revealed NA12 was allowed to work on [DATE] and [DATE] despite the positive test result on [DATE]. Review of NA13's Report of Laboratory Results, date reported [DATE], revealed NA13 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA13's timecards revealed NA13 was allowed to work on [DATE], [DATE], and [DATE] despite the positive test result on [DATE]. Review of E1's Report of Laboratory Results, date reported [DATE], revealed E1 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of E1's timecards revealed E1 was allowed to work on [DATE] until 7:30 pm despite the positive test result on [DATE]. Review of Assistant Director of Nursing's (ADON) Report of Laboratory Results, date reported [DATE], revealed the ADON tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of the ADON's timecards revealed the ADON was allowed to work on [DATE] despite the positive test result on [DATE]. Review of NA14's Report of Laboratory Results, date reported [DATE], revealed NA14 tested positive for [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] associated with COVID-19. Review of NA14's timecards revealed NA14 was allowed to work on [DATE], and [DATE] despite the positive test result on [DATE]. During an interview on [DATE] at 4:15 pm, with the Administrator, revealed, when asked why NA9, NA10, NA11, NA12, NA13, E1, the ADON, and NA14 were allowed to work after receiving positive results for [DIAGNOSES REDACTED]-CoV-2, the Administrator stated, I'm Jewish and Friday is the Sabbath so I leave early. The DON (Director of Nursing) received the results Friday ([DATE]). We (the Administrator and the DON) discussed and CDC guidance says staff could work on COVID positive units. The Administrator confirmed that the facility did not have a unit dedicated only to confirmed COVID-19 positive residents. During the same interview, the Administrator stated, We would have been short a CNA (certified nursing assistants) if we didn't (allow the confirmed positive staff to work). When asked why E1, a dietary staff member, was allowed to work until 7:30 pm on [DATE] after receiving positive results for [DIAGNOSES REDACTED]-CoV-2, the Administrator offered no explanation. During an interview on [DATE] at 4:06 pm, with the Administrator and the V.P. of Quality Assurance, when asked what was the risk of allowing confirmed COVID-19 positive staff to continue to work, the Administrator stated, Risk of infection being spread. When asked the risk of not screening all employees prior to their shift, the Administrator confirmed that these failures could also increase the risk of [MEDICAL CONDITION] being spread. Review of the facility's Infection Prevention and Control Policy and Procedure: Coronavirus Disease (COVID-19), revision date [DATE], revealed: Coronavirus Disease (COVID19) is a [MEDICAL CONDITION] respiratory infection that emerged from an animal source but now seems to be spreading from person-to-person via droplets. The incubation period (from time of exposure to an infectious agent until signs and symptoms appear) is estimated at ,[DATE] days but can range from ,[DATE] days. Symptoms of [MEDICAL CONDITION] include fever, cough, shortness of breath, severe lower respiratory infection/[DIAGNOSES REDACTED] and may also include nasal congestion, sore throat, diarrhea, and nausea. While some individuals ill with [MEDICAL CONDITION] may be asymptomatic or have mild illness, older individuals, particularly those with underlying health conditions, have shown greater susceptibility to [MEDICAL CONDITION] and often experience much more serious illness and outcomes. This potential for more serious illness among older adults, coupled with the more closed, communal nature of the nursing home environment, represents a risk of outbreak and a substantial challenge for nursing homes .The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Illinois Department of Public Health (IDPH) to include identification and isolation of any suspected cases . The Administrator was notified that the Immediacy was removed on [DATE], after the surveyor verified implementation of an acceptable removal plan on [DATE] at 3:37 pm that included: 1. Observations of the facility's employee screening process. 2. Review of In-Service Education records dated [DATE] and verifying interviews with staff regarding: increased monitoring of confirmed COVID-19 residents, employee screening, and circumstances in which employees should not be allowed to work. 3. Review of resident records and resident logs to verify appropriate temperature, oxygen saturation, and respiratory symptom monitoring for confirmed COVID-19 residents. After removal of the Immediacy, the noncompliance remained at the level of actual harm that is not Immediate Jeopardy until sustained compliance is verified.