STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145803	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY EVANSTON HEALTHCARE	**820 FOSTER STREET EVANSTON, IL 60201**

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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely notification to facility residents, families and/or family representatives, on the facility status related to COVID-19, for 3 of 3 residents (R1, R2 and R3) admitted to the facility with a confirmed infection of COVID-19. This facility failure has the potential to affect all 94 residents. Findings include: Per Facility face sheet, R1 was admitted from a local hospital on [DATE] with a [DIAGNOSES REDACTED]. R2 was admitted from a local hospital on [DATE] with a [DIAGNOSES REDACTED]. At 11:35 am, V1 further stated, that these 3 residents (R1, R2, and R3) acquired COVID- 19 in the community so facility residents and their representative notification were not done, as notification needed to be done if COVID -19 was acquired in the facility. At 1:11 pm, V1 said that Cumulative reporting is done by the facility, to residents and their representatives if COVID infection was facility acquired, and therefore R1, R2 and R3 were excluded in the Cumulative report. Facility Policy titled, Communicating and Facility Reporting About COVID-19 in LTCF revised 4/29/2020 stated in part; Facility will provide notification to staff, residents, residents' next of kin and guardians and the Department of Public Health when persons working or residing in facility are diagnosed with [REDACTED]. Facility will update residents and their representatives weekly, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurring.

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.