STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF CHESTERTON LLC	**2775 VILLAGE POINT CHESTERTON, IN 46304**

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 0886 **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 record review and interview, the facility failed to immediately implement COVID-19 outbreak testing for all residents and staff upon an identification of a new positive case in the facility. (Resident B) This had the potential to affect the 64 residents currently residing in the facility. Finding includes: Record review for Resident B was completed on 9/22/20 at 2:29 p.m. [DIAGNOSES REDACTED]. The resident was admitted to the facility on [DATE]. The resident was tested for COVID-19 on 9/18/20 using Point of Care (POC) testing. The Rapid COVID Test Report, dated 9/18/20, indicated the resident was positive for COVID-19. Interview with RN 1 and the Administrator on 9/22/20 at 12:05 p.m. indicated the resident had tested positive for COVID-19 on 9/18/20. Isolation precautions were implemented at that time. No further testing of any residents or staff had been completed upon identification of the new positive case in the facility. They had not completed any outbreak testing because all facility staff had been tested [DATE], the results were received 9/18/20, and all the results were negative. They felt the resident had not acquired COVID-19 while in the facility but prior to admission. They planned to start testing all residents and staff today. 3.1-18 (a) 3.1-18 (b)

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.