STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	06/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00399113, IN00399778, IN00403415, IN00409265, and IN00411293. Complaint IN00399113 - Federal/State deficiencies related to the allegations are cited at F684, F690, F697 and F9999. Complaint IN00399778 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00403415 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00409265 - Federal/State deficiencies related to the allegations are cited at F677 and F695. Complaint IN00411293 - Federal/State deficiencies related to the allegations are cited at F677 and F697. Survey dates: June 20 and 21, 2023. Facility number: 013688 Provider number: 155844 AIM number: 201352370 Census Bed Type: SNF/NF: 13 SNF: 40 Residential: 23 Total: 76 Census Payor Type: Medicare: 37 Medicaid: 8	F 0000	**Symphony of Chesterton Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** Symphony of Chesterton Kindly requests a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Mehay	Administrator	07/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Other: 8 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/22/23.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to a dependant resident related to completing scheduled bathing for 1 of 7 residents reviewed for ADL care. (Resident H) Finding includes: On 6/21/23 at 12:55 p.m., Resident H was lying in bed. The resident indicated she had only received one sponge bath since admission and would have preferred a few more showers. Record review for Resident H was completed on 6/21/23 at 2:20 p.m. Diagnoses included, but were not limited to diabetes mellitus, arthritis, and hypertension. The resident was admitted to the facility on 6/8/23. The Admission Minimum Data Set (MDS) assessment, dated 6/15/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 1 person assistance for personal hygiene. The resident had not	F 0677	POC for F677 -ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? · No harm came to Resident H related to alleged deficient practice. · Resident H shower preference reviewed with resident and ADL care/shower was offered and provided. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents have the potential to be affected by this alleged deficient practice. · A full house audit was completed to ensure showers/baths are being provided as scheduled. What measure will be put into	07/06/2023

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	received bathing during the assessment period. A Guest Preference, not dated, indicated the resident was admitted on 6/8/23. The resident preferred a shower/bed bath on the day shift on Tuesdays and Fridays. A Shower Sheet, dated 6/16/23, indicated the resident had received a sponge bath. There was no documentation to indicate the resident had received any other bathing since prior to admission on 6/8/23. Interview with the Unit Manager on 6/21/23 at 4:05 p.m., indicated she could not provide any documentation the resident had been offered any bathing prior to 6/16/23. This Federal tag relates to Complaints IN00399778, IN00403415, IN00409265, and IN00411293. 3.1-38(a)(3)		place or what systemic changes you will make to ensure that the deficient practice do not reoccur? · Nursing staff was educated on the importance of providing timely ADL care to all residents who require assistance, including but not limited to showers/baths. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place? · DON/Designee will monitor 10 dependent residents weekly on alternating shifts to ensure ADL care has been provided and showers/baths have been provided based on resident preferences. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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	Based on observation, record review, and interview, the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being related to a resident not being reviewed or monitored after a fall with a major injury for 1 of 3 residents reviewed for falls. (Resident F) Finding includes: On 6/20/23 at 9:05 a.m., Resident F was observed in her room sitting on her bed. She had abrasions on her left cheek and arms, and sutures on her left eyebrow. She indicated she had fallen off the bed last week and hit her head. The resident's record was reviewed on 6/20/23 at 2:40 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, general muscle weakness and chronic obstructive pulmonary disease. The Admission Minimum Data Set assessment, dated 6/11/23, indicated the resident was cognitively intact and required extensive assistance of one staff for bed mobility and transfers. A Progress Note, dated 6/16/23, indicated the resident came back from the hospital. No new orders but had skin tears to her right and left forearms and a laceration to her left eye with stitches. A Physician's Order, dated 6/16/23, indicated to monitor skin tears to right and left forearms and stitches to left eyebrow for signs of infection. The Fall Care Plan indicated the resident was at	F 0684	POC for F684-Quality of Care What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? · No harm came to Resident F related to alleged deficient practice. · Neurological status remained unchanged while in the facility. · All areas are healing without difficulty or signs of infection. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by this alleged deficient practice. · A full house audit was completed to ensure that all falls, including those with major injuries, were documented, reported to the Administrator immediately, and had follow up monitoring assessment completed. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff educated on proper fall notifications and fall follow-up assessment with documentation. o Timely notifications to physician, family, and management are completed and documented, o Fall documentation is completed timely, o Monitoring is initiated and	07/06/2023

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	risk for falls. Interventions included, but were not limited to, ensure the resident was positioned correctly on bed after care and ensure proper footwear when mobilizing or ambulating. There was no fall event documented. There was no review of the incident by the Interdisciplinary Team (IDT) or revisions to the Fall Care Plan. There were no neurological checks completed. Interview with the Interim Director of Nursing (IDON) on 6/20/23 at 3:25 p.m., indicated she was not aware of the fall but would look into it. Interview with the IDON on 6/21/23 at 9:50 a.m., indicated there had been Internet issues the weekend of 6/16/23 and some residents' information had not been saved in the computer. She had spoken to the nurse on duty who indicated the fall had been documented, family and Physician notified and neurological checks initiated, but it had not saved in the computer. The fall event occurred on Friday evening and was somehow overlooked when the management team returned on Monday morning. There was no documentation of completed neurological checks, post fall assessments, or fall review by the IDT. This Federal tag relates to Complaint IN00399113. 3.1-37(a)		ongoing as indicated such as neurological assessments and injury assessment, management, and ongoing documentation until areas of injuries are resolved, o Appropriate interventions to prevent further falls are placed and documented, o And appropriate follow-up care is provided, communicated, and documented. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? · DON/Designee will monitor 10 residents weekly who sustained a fall with and without injuries to ensure proper notifications are completed and documented, fall documentation is completed timely, monitoring is initiated and ongoing as indicted, appropriate interventions are placed and documented, and appropriate follow-up care is provided, communicated, and documented. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure care and services were provided to a resident with an indwelling catheter for 1 of 3 residents reviewed for urinary catheters. (Resident E)	F 0690	POC for F690- Bowel/Bladder Incontinence, Catheter, UTI What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?	07/06/2023

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	Finding includes: Resident E's record was reviewed on 6/20/23 at 12:33 p.m. The resident was admitted on 3/27/23. Diagnoses included, but were not limited to, encounter for orthopedic aftercare and muscle weakness. The Admission Minimum Data Set assessment, dated 4/2/23, indicated the resident was cognitively intact and required extensive assistance of one for toileting and transfers. The resident had an indwelling urinary catheter. The Catheter Care Plan indicated to measure and record urinary output per guidelines. There was no documentation of output for the resident recorded during the stay at the facility. Interview with the Unit Manager on 6/21/23 at 1:22 p.m., indicated CNAs should empty the catheter bags every shift and record the urine output. There was no documentation for the resident's urinary output. The current policy, "Indwelling Catheter", was received from the Interim Director of Nursing, on 6/21/23, indicated, "...4. Output will be documented in the medical record daily for all shifts, on all residents with an indwelling catheter...." This Federal tag relates to Complaint IN00399113.		· No harm came to Resident E related to alleged deficient practice. · Resident E no longer resides here in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Full house audit was complete to ensure that care and services are provided, and monitoring of urine output is documented for residents with an indwelling catheter every shift. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff educate on proper assessment with monitoring and documentation of urinary output for residents with indwelling catheter. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? · DON/Designee will monitor 10 resident charts weekly to ensure necessary care and services are provided and urinary output is monitored and documented for residents with an indwelling catheter. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months.	

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			Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure respiratory care provided was consistent with professional standards of practice related to no order for oxygen for a resident receiving oxygen and a resident with dual orders for oxygen for 2 of 3 residents reviewed for respiratory care. (Residents F and D) Findings include: 1. On 6/20/23 at 9:05 a.m., Resident F was observed in her room sitting on her bed. She had a nasal cannula in place and oxygen was flowing at 2 liters per minute (lpm) The resident's record was reviewed on 6/20/23 at 2:40 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, general muscle weakness and chronic obstructive pulmonary disease (COPD).	F 0695	POC for F695-Respiratory/Tracheostomy Care and Suctioning What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? · No harm came to either Resident F nor Resident D related to alleged deficient practice. · Resident F oxygen orders were immediately clarified and adjusted to reflect the correct flow rate. · Resident D chart was immediately reviewed and order was obtained from Clinician and entered into Resident D's chart. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	07/06/2023

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	The Admission Minimum Data Set assessment, dated 6/11/23, indicated the resident was cognitively intact and required extensive assistance of one staff for bed mobility and transfers and used oxygen in the previous 5 days. The current Oxygen Care Plan indicated the resident was on oxygen therapy related to COPD. Interventions included to administer oxygen per Physician Orders. A Physician's Order, dated 6/4/23, indicated oxygen at 2 lpm to maintain an oxygen saturation of 92% or greater. Another Physician's Order, dated 6/4/23, indicated oxygen at 3 lpm to maintain a oxygen saturation of 92% or greater. Interview with the Interim Director of Nursing (IDON), on 6/21/23 at 9:50, indicated she had clarified the order and corrected it. The order should have been for 3 lpm of oxygen. 2. The record for Resident D was reviewed on 6/20/23 at 9:41 a.m. Diagnoses included, but were not limited to, pneumonia and acute respiratory failure with hypoxia. The Admission Minimum Data Set assessment, dated 4/21/23, indicated the resident was cognitively intact and had not used oxygen prior to admission. A Respiratory Note, dated 4/27/23, indicated the resident was placed on 2 lpm of oxygen and her oxygen saturation was 93%, this was discussed with Nursing. A Nurse Practitioner note, dated 5/15/23, indicated to monitor pulse oximetery before and after nebulizer treatments and oxygen as needed to		· All residents receiving oxygen therapy and/or with oxygen orders have the potential to be affected by this alleged deficient practice. · A Full house audit of all guest on oxygen therapy was completed to ensure orders were properly placed and flow rate being delivered was accurate. · A Full house audit of all guests on oxygen therapy was completed to ensure no duplicate orders exist. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur? · Nursing staff was educated on ensuring that residents receiving oxygen therapy has proper orders placed in chart and flow rate being delivered was accurate. · Nursing staff was educated on ensuring that residents receiving oxygen therapy does not have duplicate orders in their chart. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place? · DON/Designee will monitor 10 residents weekly that are receiving oxygen therapy to ensure residents have an order for oxygen and no duplicate order exists, and flow rate being administered is accurate. · DON/Designee will present	

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	augment therapy. There was no Physician's order for oxygen. During an interview with the IDON on 6/21/23 at 9:50 a.m., she was made aware there was no order for oxygen. There was no additional information provided. This Federal tag relates to Complaint IN00409265. 3.1-47(a)(6)		summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure prescribed pain medication was available on admission for a resident experiencing pain for 1 of 4 residents reviewed for pain. (Resident P) Finding includes: Resident P's record was reviewed on 6/21/23 at 2:17 p.m. The resident was admitted to the facility on 5/19/23. Diagnoses included, but were not limited to, encounter for orthopedic aftercare and aneurismal bone cyst. The Admission Minimum Data Set assessment, dated 5/26/23, indicated the resident was cognitively intact and had been having occasional pain rated 6 out of 10, and received as needed	F 0697	POC for F697- Pain Management What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? · No harm came to Resident P related to alleged deficient practice. Resident P no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents receiving pain medication have the potential to be affected by this alleged deficient practice.	07/06/2023

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	pain medications in the past 5 days. A Physician's Order, dated 5/19/23, indicated to give Percocet (a strong opioid pain medication with acetaminophen) 5 milligrams (mg)/ 325 mg, every four hours as needed for mild to moderate pain. The pain assessment completed on 5/19/23 during the 3-11 shift, indicated the resident's pain was 5 out of 10. There was no documentation on the May 2023 Medication Administration Record (MAR) the Percocet had been administered. There were no progress notes related to the resident's complaint of pain or interventions attempted. Interview with LPN 1 on 6/21/23 at 3:45 p.m., indicated he was the resident's nurse the evening of 5/19/23. She was complaining of pain, but there was not a hard prescription available to give the Percocet. He indicated he offered to elevate her legs and give an ice pack. He gave Tylenol per the facility's standing order. He did not document interventions or Tylenol given. Interview with the Unit Manager on 6/21/23 at 3:45 p.m., indicated the procedure was to call the Physician on duty and request a hard prescription to be sent to the pharmacy. They could then receive authorization to remove the medication from the Cubex (an automated prescription medication dispensing device). The on-duty Physician had been notified, and indicated she would be in the facility that evening and provide the prescription. She was unsure what happened, or why the resident did not receive any Percocet on 5/19/23.		· Full house audit was completed to ensure residents have pain prescribed medication available on admission. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff was educated on ensuring that all residents have their prescribed pain medication available on admission. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place? · DON/Designee will monitor 10 admissions a week to ensure that prescribed pain medication was available upon admission. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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	This Federal tag relates to Complaints IN00399113 and IN00411293. 3.1-37(a)			
F 9999 Bldg. 00	3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to report a fall that resulted in a major injury to the State Agency in a timely manner for 1 of 3 residents reviewed for falls. (Resident F) Finding includes:	F 9999	**F9999 Administration and Management** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Reportable was completed immediately for resident F. **2) How the facility identified other residents:** All residents who have falls with	07/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	06/21/2023

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

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	On 6/20/23 at 9:05 a.m., Resident F was observed in her room sitting on her bed. She had abrasions on her left cheek and arms, and sutures on her left eyebrow. She indicated she had fallen off the bed last week and hit her head. The resident's record was reviewed on 6/20/23 at 2:40 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, general muscle weakness and chronic obstructive pulmonary disease. The Admission Minimum Data Set assessment, dated 6/11/23, indicated the resident was cognitively intact and required extensive assistance of one staff for bed mobility and transfers. A Progress Note, dated 6/16/23, indicated the resident came back from the hospital. No new orders but had skin tears to her right and left forearms and a laceration to her left eye with stitches. Interview with the Administrator on 6/20/23 at 3:45 p.m., indicated he had not been aware of the resident's accident or injuries and had not reported it to the State Agency. He indicated he would do so at that time. This state finding relates to Complaint IN00399113.		injuries have the potential to be affected by the alleged deficient practice. IDT reviewed all prior reportable for timeliness and reviewed all prior falls with injury. IDT identified no other concerns. **3) Measures put into place/ System changes:** Administrator educated on reporting guidelines. IDT educated on reporting guidelines. **4) How the corrective actions will be monitored:** Director of Nursing or designee will audit all falls every week for 4 weeks then 1 time a week for 4 weeks to ensure that all falls with injury are reported timely. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	