DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155840	B. WING			R-C 03/13/2023	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 1532 CALUMET AVENUE DYER, IN 46311		1 03/	13/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Paper compliance to the Recertification and		{F 0	00}			
		ey and the Investigation of 31 and IN00399166					
	Review date: March 13, 2023						
	Facility number: 0134 Provider number:1556 AIM number: 201330	840					
	Symphony of Dyer was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper compliance review to the Recertification and State Licensure Survey and complaint investigation.						
AROPATORY	DIRECTOR'S OR PROVIDED/	SUPPLIER REPRESENTATIVE'S SIGNATUR	25		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.