STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING -- B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF DYER	1532 CALUMET AVENUE DYER, IN 46311

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/23/23 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Emergency Preparedness survey, Symphony of Dyer was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 68. Quality Review completed on 02/27/23	E 0000	Symphony of Dyer 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. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	
K 0000 Bldg. 01	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/23/23 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Life Safety Code survey, the certified portion of Symphony of Dyer, the first floor, was	K 0000	Symphony of Dyer 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. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	Administrator	03/06/2023

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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	found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 Comprehensive beds and had a census of 68 at the time of this visit. Quality Review completed on 02/27/23		consideration.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 2 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This	K 0225	**POC for K225 Stairways and Smokeproof Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/24/2023

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	deficient practice could affect at least 20 residents, staff and visitors using the C5 and A5 exit stairwells. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 1:10 p.m. 02/23/232 the exit stairwell identified as C5 stairwell had approximately 50 medium sized cardboard boxes full of personal protective equipment (PPE) stacked on three wooden pallets stored in the stairwell on the lower level. Additionally, a resident room bathroom door was stored in the stairwell. Observed at 2:12 p.m. with the Maintenance Director, approximately 20 cardboard boxes full of facemasks and faceshields on a wooden pallet stored in the A5 stairwell. Based on interview at the time of the observations, the Maintenance Director stated the PPE was stored in the stairwell since there currently isn't any available storage in the facility. The Maintenance Director agreed the aforementioned stairwells on the lower level was used for storage which could interfere with egress. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**practice?** · No residents were affected by this alleged deficient practice. **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. · Boxes containing PPE in stairwell C5 and A5 have been moved out of the stairwells. · Bathroom door was removed from stairwell. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Maintenance team, central supplies, and management team were educated on not storing items in stairwell areas. **How will the corrective actions(s) be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place? · Administrator/Designee will audit all 3 stairwells weekly to ensure no items are being stored in stairwell. · The Administrator/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. **Date of compliance: 02/24/2023**	