Amy Maurice

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

05/03/2023

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER DNY OF CROWN POINT LLC	STREET A 1555 S CROWN		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENT TERMS OF LEGISLATION OF THE PROPERTY OF LEGISLATION OF THE PROPERTY OF	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG E 0000	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEI ICIERCI I	DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/12/2023 Facility Number: 013452	E 0000		
	Provider Number: 013432 Provider Number: 155835 AIM Number: 201299290 At this Emergency Preparedness survey, Symphony of Crown Point LLC, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. 65 beds are certified for Medicare only. 3 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 56. Quality Review completed on 04/18/23			
E 0004 SS=F Bldg	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			
LABORATOR	LY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Any defiency statement 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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Administrator

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIE			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Federal, State an preparedness recomprehensive exprogram that measurements and the following elements and updated at lements do all of the "For hospitals and updated at lements do all of the "For hospitals and updated at lements do all of the "For hospitals and updated at lements do all of the "For hospitals and updated at lements and updated and upda	an. The [facility] must atain an emergency in that must be [reviewed], ast every 2 years. The plan following: 2 §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency puirements. The [hospital or op and maintain a mergency preparedness ets the requirements of this an all-hazards approach. The LTC facility must intain an emergency in that must be reviewed,						

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	AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	failed to review and Preparedness Plan (accordance with 42 practice could affect Findings include: Based on records re Director and Admir 09:38 a.m. and 1:03 were provided. One and one from a nurse nurses station had a other date could be was reviewed and u Based on an intervie Administrator was a updated, but they are and updating all EP	riew and interview, the facility update the Emergency EPP) at least annually in CFR 483.73(a). This deficient it all occupants. View with the Maintenance distrator on 04/12/23 between p.m., two copies of the EPP from the Administrators office es station. The EPP from the review date of 04/2020, no found to show the EPP binder pdated within the last year. Even during records review, the anaware when it was last e in the process of reviewing P plans and policies. Viewed with the Administrator frector during the exit	E 00	004	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haza approach has been reviewed a updated in 2 centrally located binders. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating plan prequirement will ensure no like concerns are identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficient practice does not recur, ie, who QA program will be put into plate and reviewed annually during and May QAPI meeting.	nts y the s ards and g the er e be ent at ace. d	05/12/2023
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2),	416.54(a)(1)-(2), 418.113(a) (1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) (1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2),					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	IDENTIFICATION NUMBER 155835	B. W			04/12/2023	
				_	DDDEGG CITY OT ATE 7ID COD	0 17 12/2020	
NAME OF P	PROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD MAIN STREET		
SYMPHO	ONY OF CROWN P	OINT LLC			N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	DATE	
	486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) (1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2),						
), §441.184(a)(1)-(2),					
		§482.15(a)(1)-(2),					
	- , , , , ,	§483.475(a)(1)-(2),					
), §485.68(a)(1)-(2),					
	- , , , , ,), §485.727(a)(1)-(2),					
), §486.360(a)(1)-(2),					
	§491.12(a)(1)-(2),	9494.62(a)(1)-(2)					
	[(a) Emergency Pl	an. The [facility] must					
		tain an emergency					
		n that must be reviewed,					
	and updated at lea	ast every 2 years. The plan					
	must do the follow	ring:]					
	(1) Be based on a	nd include a documented,					
	, ,	community-based risk					
	assessment, utiliz	ing an all-hazards					
	approach.*						
	(2) Include strated	ies for addressing					
		s identified by the risk					
	assessment.						
	* [For Hospices at	§418.113(a):] Emergency					
		e must develop and					
	-	gency preparedness plan					
		wed, and updated at least					
		e plan must do the					
	following:						
	(1) Be based on and include a documented,						
	facility-based and community-based risk assessment, utilizing an all-hazards						
	assessment, utiliz approach.	ing an an-nazarus					
		ies for addressing					
		s identified by the risk					
		ding the management of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155835 B. WING			JILDING	PLE CONSTRUCTION (X3) DATE SURVEY NG COMPLETED 04/12/2023				
	PROVIDER OR SUPPLIER			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	\Box	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at led do the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency prebe reviewed, and	s of power failures, natural ler emergencies that would s's ability to provide care. s at §483.73(a):] The LTC facility must stain an emergency in that must be reviewed, ast annually. The plan must stain include a documented, community-based risk sting an all-hazards ing missing residents. Gies for addressing is identified by the risk standards for addressing in the risk standards for addressing						
	facility-based and assessment, utiliz approach, includir (2) Include strateg emergency events assessment.	and include a documented, community-based risk ring an all-hazards ng missing clients. gies for addressing s identified by the risk						
	failed to maintain at Plan (EPP) that was documented, facility risk assessment, utili including missing re strategies for address identified by the risk	view and interview, the facility in Emergency Preparedness is (1) based on and includes a y-based and community-based lizing an all-hazards approach, residents and (2) included ssing emergency events is assessment in accordance 3(a) (1) and 42 CFR 483.73(a) (2).	E 00	006	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haza approach has been reviewed a	nts y the s	05/12/2023	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835		UILDING	ONSTRUCTION	(X3) DATE COMPL 04/12 /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Findings include: Based on records re and the Maintenance between 09:38 a.m. at the nurses station of a facility-based a assessment utilizing Based on interview the Administrator a aforementioned issufacility is in the proupdated. This finding was re-	eview with the Administrator e Director on 04/12/23 and 1:03 p.m., The EPP located contained no documentation nd community-based risk g an all-hazards approach. at the time of record review, cknowledged the ne and stated every EPP in the cess of being reviewed and viewed with the Administrator irector during the exit			updated in 2 centrally located binders. How will other residents havin potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating plan prequirement will ensure no like concerns are identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficient practice does not recur, ie, who QA program will be put into plate and reviewed annually during May QAPI meeting.	er e t e l be ent at ace. d		
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §483. §485.68(b), §485. §485.920(b), §486 §494.62(b).	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155835	B. W	ING		04/12/	2023
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this postion, risk processment of						
	' '	risk assessment at					
		of this section, and the					
	-	an at paragraph (c) of this					
		cies and procedures must					
		updated at least every 2					
	years.						
	*IFor LTC facilities	s at §483.73(b):] Policies					
	_	The LTC facility must					
	develop and imple						
	preparedness poli	icies and procedures, based					
	on the emergency	plan set forth in paragraph					
	' '	risk assessment at					
		of this section, and the					
	-	an at paragraph (c) of this					
	-	cies and procedures must					
	be reviewed and ι	updated at least annually.					
	*Additional Requir	rements for PACE and					
	*[For PACE at §46	60.84(b):] Policies and					
	_	PACE organization must					
	develop and imple	ement emergency					
	preparedness poli	icies and procedures, based					
	on the emergency	plan set forth in paragraph					
	(a) of this section,	risk assessment at					
		of this section, and the					
	· ·	an at paragraph (c) of this					
	-	cies and procedures must					
	_	nent of medical and					
	nonmedical emergencies, including, but not						
		uipment, power, or water					
		ed emergencies; and natural					
		threaten the health or					
		cipants, staff, or the public.					
	The policies and p	procedures must be					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 04/12/2023			ETED			
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		*[For ESRD Facilia and procedures. develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and to years. These emenot limited to, fire, failures, care-relat supply interruption likely to occur in the area. Based on record review and Preparedness Plan's at least annually in 483.73(a). This definition occupants. Findings include: Based on records read the Maintenance between 09:38 a.m. the EPP were proviewed and the Maintenance between the procedures are in the were reviewed and Based on an interviewed and Based on an interviewed are in the procedures are in the procedure	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water in, and natural disasters ine facility's geographic view and interview, the facility I update the Emergency (EPP) Policies and Procedures accordance with 42 CFR icient practice could affect all	E 00	013	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haza approach has been reviewed a updated in 2 centrally located binders. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating plan p requirement will ensure no like concerns are identified. What measures will be put into place and what systematic	nts y the s ards and g the er	05/12/2023

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/12/2023			ETED	
	PROVIDER OR SUPPLIED			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	-	eviewed with the Administrator Director during the exit			changes will be made to ensure the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficie practice does not recur, ie, who QA program will be put into plate and reviewed annually during May QAPI meeting.	e I be ent at ace.	
E 0018 SS=F Bldg	and (v), 441.184(483.475(b)(2), 48 485.920(b)(1), 48 Procedures for Tr §403.748(b)(2), § (ii) and (v), §441. §482.15(b)(2), §4 §485.625(b)(2), § (1), §494.62(b)(1) [(b) Policies and preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon. The policies and preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon the emergency (b) Policies and preparedness polon the emergency (a) of this section paragraph (a)(1) communication preparedness polon the emergency (b) Policies and preparedness polon the emergency (c) Office and preparedness polon the emergency (d) Office and preparedness polon the emergency (e) Office and preparedness polon the emergency (a) of this section paragraph (a)(1) of this section pa	procedures. The [facilities] I implement emergency icies and procedures, based y plan set forth in paragraph , risk assessment at of this section, and the an at paragraph (c) of this ies and procedures must be lated at least every 2 years facilities]. At a minimum, rocedures must address					
	on-duty staff and	em to track the location of sheltered patients in the ring an emergency. If					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BUILDING COMPLETED B. WING 04/12/2023				ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	on-duty staff and s relocated during the must document the	sheltered patients are ne emergency, the [facility] e specific name and eiving facility or other						
	§483.73(b), ICF/III §460.84(b):] Polici system to track the and sheltered resi ICF/IID or PACE] emergency. If on- residents are reloc emergency, the [F PACE] must docu	A41.184(b), LTC at Ds at §483.475(b), PACE at ies and procedures. (2) A e location of on-duty staff dents in the [PRTF's, LTC, care during and after an -duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other						
	*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.							
	procedures. (2) Sa	485.920(b):] Policies and afee evacuation from the udes consideration of care						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MUL A. BUIL B. WING	DING	NSTRUCTION	(X3) DATE : COMPL 04/12 /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	responsibilities; tra of evacuation local alternate means of external sources of the vacuation local alternate means of external sources of the vacuation of the actual donor information, and savailability of reconstruction of the vacuation of the vacuation of the vacuation of on-duty in the LTC facility is emergency. If on-dute residents are relocated to the vacuation of the receinn accordance with deficient practice of the vacuation of the vac	86.360(b):] Policies and system of medical at preserves potential and mation, protects otential and actual donor ecures and maintains the rds. 94.62(b):] Policies and afe evacuation from the	E 001	8	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haze approach has been reviewed a updated in 2 centrally located binders. The update includes to system to track the location of duty staff and sheltered patienthe facility's care during an emergency. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating plan the	nts y the ards and the on tts in	05/12/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/12/2023		
	PROVIDER OR SUPPLIER			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0029	Based on interview the Administrator are and stated that all or are currently being. The finding was distand Maintenance D	at the time of record review, eknowledged the condition of the EPP plans and policies reviewed and updated. Cussed with the Administrator frector at exit conference.		149	includes the aforementioned tracking system per requireme will ensure no like concerns ar identified. What measures will be put into place and what systematic changes will be made to ensur the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficien practice does not recur, ie, who QA program will be put into plate and reviewed annually during the May QAPI meeting. During the review Administration will ensure and tracking system is in	e be ent at ace. d the	BAIL
SS=F Bldg	441.184(c), 482.19 484.102(c), 485.69 485.727(c), 485.99 491.12(c), 494.620 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.9 §485.68(c), §485.19 §494.62(c). (c) The [facility] man emergency preplan that complies local laws and mu	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	FICATION NUMBER A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER		•	1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	to review and updat Preparedness Plan's least annually in acc 483.73(a). This define occupants. Findings include: Based on records reand the Maintenanch between 09:38 a.m. the EPP were proving office and a nurses an urses station had a had no other date the EPP's Communication updated within the linterview during restated all of the EPF currently being review.	certain the Administrator e Director on 04/12/23 and 1:03 p.m., two copies of ded from the Administrator's station, the EPP located at the review date of 04/2020, but hat could be found to show the dion Plan was reviewed and last year. Based on an cords review, the Administrator's plans and policies are	E 00	029	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haza approach has been reviewed a updated in 2 centrally located binders. The update includes the facility communications plan. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating the emergency preparedness planincludes the aforementioned communication plan per requirement will ensure no like concerns are identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficient practice does not recur, ie, who QA program will be put into plate and reviewed annually during the program of the EPP policy will be updated and reviewed annually during the put into plate and rev	nts y the s ards and he g the e be ent at ace. d the is	05/12/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		l í	JILDING	INSTRUCTION	_ []	COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER			1555 S	ADDRESS, CITY, STATE, ZIP CO MAIN STREET N POINT, IN 46307	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) place.	HOULD BE	(X5) COMPLETION DATE
E 0036 SS=F Bldg	484.102(d), 485.6: 485.727(d), 485.9: 491.12(d), 494.62: EP Training and T §403.748(d), §416: §441.184(d), §466: §483.73(d), §485.9: §485.920(d), §486: §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625: 485.727, CMHCs: §486.360, and RH Training and testir develop and maint preparedness trair that is based on the in paragraph (a) or assessment at paragraph training and testing, plan at paragraph training and testing, plan at paragraph training and testing, plan at paragraph training and testing. *[For LTC facilities and testing. The Land maintain an elements of the second content of	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting 5.54(d), §418.113(d), 1.84(d), §482.15(d), 475(d), §484.102(d), 525(d), §485.727(d), 1.360(d), §491.12(d), 1.3, PRTFs at §441.184, 1.3, PRTFs at §442.15, 1.4, CORFs at §485.68, 1.4, CORFs at §485.68, 1.4, CORFs at §491.12:] (d) 1.5, 1.5, 1.5, 1.5, 1.5, 1.5, 1.5, 1.5,					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/12/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	of this section, risl (a)(1) of this section at paragraph (b) of communication plates section. The train	an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least					
	testing. The ICF/II maintain an emergand testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) ocommunication plasection. The train must be reviewed 2 years. The ICF/II	A83.475(d):] Training and D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ling and testing program and updated at least every IID must meet the evacuation drills and training					
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation prograupdated at every 2 Based on record rev	view and interview, the facility	E 0036	What corrective actions will be	00.12.2020		
		updated the Emergency (EPP) Training and Testing		accomplished for those reside found to have been affected be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BUILDING			(X3) DATE : COMPL 04/12/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
SYMPHO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Plan at least annual 483.73(a). This defi occupants. Findings include: Based on records re and the Maintenanc between 09:38 a.m. the EPP were provi office and a nurses the nurses station ha no other date could Training and Testin updated within the interview during reacknowledged the a all EPP policies and of being reviewed a	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION Ity in accordance with 42 CFR cient practice could affect all Eview with the Administrator the Director on 04/12/23 and 1:03 p.m., two copies of the ded from the Administrators the Station. The EPP located from the Administrators and a review date of 04/2020, the found to show the EPP's the Plan was reviewed and the state of the Administrator the state of the process The STATEMENT OF DEFICIENCIE The Administrator of the Administrator o		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- haza approach has been reviewed a updated in 2 centrally located binders. The update includes a training and testing plan. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The facility is confident that reviewing and updating the emergency preparedness plan includes the aforementioned training and testing plan per requirement will ensure no like concerns are identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Staff has been educated on the location of the EPP plan. How the corrective actions will monitored to ensure the deficient practice does not recur, ie, wh QA program will be put into plate the EPP plan will be updated reviewed annually during the NA QAPI meeting. During this revented the program will ensure the Administration will ensure the	rds and a g the be ee be ent at ace. and May	(X5) COMPLETION DATE
					training and testing plan is reviewed and up to date.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER		1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
K 0000 Bldg. 01	Licensure Survey w Department of Heal	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000		
	483.90(a). Survey Date: 04/14 Facility Number: 0 Provider Number: AIM Number: 201	13452 155835			
	At this Life Safety (portion of Symphor first floor, was foun Requirements for Po Medicare/Medicaid Life Safety From Fi National Fire Protect	Code survey, the health care by of Crown Point LLC, the d not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 Edition of the cition Association (NFPA) 101, SC), Chapter 19, Existing			
	Type V (111) const: A 2 hour fire wall is into two separate bu building is subdivid compartments. Sep healthcare occupand residential occupand horizontal floor/ceil The rated floor/ceil hour rated construct contains a theater ro staff do occupy on of facility has a fire ala detection in the corr	ity was determined to be of ruction and fully sprinklered. It is provided to divide the facility wildings. Each separate and into two smoke aration between the first floor by and the second floor by is provided by a 2 hour ing assembly and fire barriers. In any system is supported by 2 by 2 by 2 by 2 by 3 by 4 by 5 by 5 by 6 by 6 by 6 by 6 by 6 by 6			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident sleeping ro protected by a 300 l generator.	rm system installed in all oms. The building is fully kW diesel powered emergency					
	certified only for M	dedicare, 3 beds are dually are and Medicaid. At the time ensus was 56.					
		residents have customary ered. All areas providing re sprinklered.					
Quality Review completed on 04/18/23							
K 0100 SS=E Bldg. 01	Section 18.1 and of that are not addre- K-tags, but are de along with the app NFPA standard cit on Form CMS-256	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included	V 01	00	What corrective actions will be		05/12/2022
	failed to maintain la smoke barrier doors 4.6.12.3 requires ex obvious to the publi shall be either main deficient practice co staff, residents, and Findings include: Based on observation Director on 04/12/2	atching hardware on 1 of 2 in the Theater Hall. LSC isting life safety features ic if not required by the Code, tained or removed. This ould affect approximately 20	K 01	OO .	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? Latching hardware was repaire and tested to ensure positive latching occurred. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All smoke barrier doors were tested to ensure positive latching accomplished to the same deficient practice will be identified and what corrective actions will be taken?	nts y the ed e	05/12/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/12/2023		
	PROVIDER OR SUPPLIER DNY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	the Theater Room of the second floor was provided with latching hardware but failed to latch when tested three times. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		occurred. No like concerns we identified. What measures will be put into place and what systematic changes will be made to ensu the deficient practice does not recur? Maintenance has been educar on the requirement for all smo barrier doors to positively latch when closing. How the corrective actions will monitored to ensure the defici practice does not recur, ie, who QA program will be put into plantine plantine processes will complete a monthly safety audit that includes testing of smoke barrier doors to ensure they positively latch. The resu this audit will be submitted to a QAPI committee for 6 months ensure continued compliance.	re ted ke n I be ent ate ace. ee		
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories					
	non-sprinklered and sprinklered					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/12/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	2 II (111) non-sprinklered	One story					
	sprinklered	Maximum 3 stories					
	3 II (000) non-sprinklered	Not allowed					
	4 III (211) sprinklered 5 IV (2HH) 6 V (111)	Maximum 2 stories					
	throughout by an	Not allowed Maximum 1 story s must be sprinklered approved, supervised in accordance with section					
	9.7. (See 19.3.5) Give a brief descriconstruction, the ribasements, floors located, location of dates of approval.	iption, in REMARKS, of the number of stories, including on which patients are if smoke or fire barriers and Complete sketch or attach the building as appropriate.					
	Based on observation review, the facility construction type in	on, interview, and record failed to maintain the building 1 of 1 fire barriers. This bull affect over approximately	K 0161	What corrective actions will be accomplished for those reside found to have been affected be deficient practice? The cited doors have been replaced with fire doors consist	nts y the		
	Director during a to to 3:28 p.m. on 04/3 separation doors in	ons with the Maintenance our of the facility from 1:14 p.m. 12/23, The two hour fire C-hall near room C101 had rating of 20 minutes. Based on		with construction type to creat 2- hour fire barrier. How be identified and what corrective actions will be taken? A review fire barriers and construction of has been completed to ensure construction type is maintained	e a v of data		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835			ILDING	instruction 01	(X3) DATE : COMPL 04/12/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3:00 p.m., the Life Sthat the separation very smoke wall. Upon it observation, the Mathey were unaware higher rating and again doors were 20 minut	the Maintenance Director at Safety building plans showed was a two hour fire barrier and interview at the time of intenance Director stated that that the doors had to be a greed that the ratings on the tes. Viewed with the Administrator irector at the exit conference.			fire barriers. No like concerns were identified. What measure will be put into place and what systematic changes will be mato ensure the deficient practice does not recur? Maintenance been educated on this requirement. How the correctifications will be monitored to ensure the deficient practice do not recur, what QA program who be put into place. Maintenance Director/Designee will complet monthly review to ensure fire care consistent with construction type requirement. The results the audit will be brought to the QAPI committee monthly basis 6 to ensure continued compliance.	de e nas ve oes will e e a doors n	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of were continuously respectively.	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility 8 corridor means of egresses maintained free of eficient practice affects	K 02	211	What corrective actions will be accomplished for those resider found to have been affected by deficient practice? The scale was removed from the corridor. How will other residents having	nts / the he	05/12/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Based on an observe facility with the Malbetween 1:14 p.m. a hall next to the dialistationary resident supportruding into the on an interview at the Maintenance Direct the hall and was observed.	ation during a tour of the intenance Director 04/12/23 and 3:28 p.m., in the C resident yesis room there was a scale against the wall corridor about two feet. Based he time of observations, the or agreed that the scale was instructing the corridor. Assed with the Maintenance histrator at exit conference.			potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A review of all 8 corridors has been completed to ensure each egress was free from obstructions. No like concerns were identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Maintenace has been educated the requirement to ensure all means of egress are free of obstructions. How the corrective actions will monitored to ensure the deficipractice does not recur, , what program will be put into place. Maintenance Director /Designwill complete a weekly audit or 8 corridors to ensure each egris free from obstructions. The results of the audit will be brout to the QAPI committee monthifor no less than 6 months to ensure continued compliance.	ch s c c c c c c c c c c c c c c c c c c	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155835		r í	JILDING	nstruction 01	(X3) DATE COMPL 04/12 /	ETED	
	ROVIDER OR SUPPLIER			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
			1	<u> </u>	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
		d means of egress shall not					
		a latch or a lock that					
	•	f a tool or key from the					
	special locking arr	s using one of the following					
		OR SECURITY THREAT					
	LOCKING	ON SECONT TIMEAT					
		king arrangements for the					
Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall							
		_					
	•	pid removal of occupants					
		of locks; keying of all					
	•	ed by staff at all times; or					
	-	means available to the					
	staff at all times.						
	18.2.2.2.5.1, 18.2.	2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENTS	6					
	Where special lock	king arrangements for the					
	safety needs of the	e patient are used, all of					
	the Clinical or Sec	urity Locking requirements					
	are being met. In a	addition, the locks must be					
	electrical locks that	t fail safely so as to					
	-	of power to the device; the					
	building is protecte						
	•	r system and the locked					
		by a complete smoke					
	-	or is constantly monitored					
		ation within the locked					
		he sprinkler and detection					
	•	ged to unlock the doors					
	upon activation.	2.2.5.2. TIA 42.4					
	18.2.2.2.5.2, 19.2.						
	DELAYED-EGRES						
	ARRANGEMENTS	5					

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX GACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, super detection system automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2. Based on observation failed to ensure 1 of	g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in (2.1.6.3 shall be permitted as in buildings protected approved, supervised ection system and an sed automatic sprinkler 2.4 on and Interview, the facility ft 8 delayed egress locking	K 0222	What corrective actions will be accomplished for those reside	nts		
	arrangements were LSC 7.2.1.6.1(3) where process shall release egress within 15 section approved by the author application of required in 7.2.1.5.1 conditions: (a) The force shall refer to the force shall recontinuously applied.	installed in accordance with hich states an irreversible e the lock in the direction of conds, or 30 seconds where hority having jurisdiction, a force to the release device 10 under all of the following not be required to exceed 15 lbf and be required to be d for more than 3 seconds.		found to have been affected by deficient practice? Door settings have been adjust to allow for emergency 15 sectogress. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken?	y the sted ond graphs of the steel s		
	(c) The initiation of	the release process shall		All 8 delayed egress locking d	UUIS		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>			COMPL	ETED		
155835		155835	B. WING 04/12			/2023			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
				1555 S MAIN STREET					
SYMPHO	NY OF CROWN P	OINT LLC		CROWN POINT, IN 46307					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	activate an audible	signal in the vicinity of the			were tested to ensure required	d			
	door opening.				settings were in place. No like				
	(d) Once the lock ha	as been released by the			concerns were identified.				
		to the releasing device,							
		y manual means only. This			What measures will be put into	0			
	_	ould affect approximately 15			place and what systematic				
	residents and staff in				changes will be made to ensu	re			
					the deficient practice does not				
	Findings include:				recur?				
					100411				
	Based on observation	on during a tour of the facility			Maintenance has been educat	ted			
	with the Maintenan	ce Director on 04/12/23			on the requirement to ensure	that			
		and 3:18 p.m., the A-hall exit		emergency egress doors are					
	_	A117 was equipped with a 15			functioning with a 15 second				
		ess. When the exit door was			delay.				
		ole process to release the lock							
		er testing twice. Based on			How the corrective actions will	l be			
		e of observation, the			monitored to ensure the defici				
		for tried two times to activate			practice does not recur, , what				
		I stated the delayed egress			program will be put into place.				
		revious, but will need to be			program will be put into place.				
	fixed.	10 110 415, 0 410 1111 110 04 10 00			The Maintenance Director/				
					Designee will complete a mon	thly			
	The finding was rev	viewed with the Maintenance			audit of all emergency egress	шпу			
	_	lministrator during the exit			doors to ensure they are				
	conference.	ministrator during the exit			functioning with a 15 second				
	conference.				delay. The results of this audit	varill			
	3.1-19(b)								
	3.1-19(0)				be brought to the QAPI Comm				
					monthly for no less than 6 mo				
					to ensure continued compliand	Je.			
		1				I			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BUIL B. WINC	DING	NSTRUCTION 01	(X3) DATE : COMPL 04/12 /	ETED	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire extiraccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.		IAU			DATE
	Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K32; Based on observation failed to ensure 1 of protected as a hazar door that would auto	N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops froms (exceeding 64 n Rooms lons) frage Rooms/Spaces eet) classified as Severe	K 032	21	What corrective actions will be accomplished for those resider found to have been affected by deficient practice? A self- closing mechanism has	nts / the	05/12/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/12/2023			
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	20 residents and staff in the C-hall. Findings include: Based on observations the Maintenance Director on 04/12/23 between 1:14 p.m. and 3:28 p.m., the C-hall dialysis room (which contained a 28-gallon trash container and biohazard waste container) was not self-closing but did latch and close into the frame. Based on interview at the time of observation, the Maintenance Director agreed the dialysis room had more than 32 gallon waste containers in 64 square foot area and was not protected like a hazardous area. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		been installed on dialysis doo How will other residents havin potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A review of all hazardous are was completed. No like cond were identified. What measures will be put int place and what systematic changes will be made to ensu the deficient practice does not recur? Maintenance has been educa on the requirement for "hazard areas to be equipped with a s closing mechanism. No like concerns were identified. How the corrective actions wil monitored to ensure the defici practice does not recur, ie, wh QA program will be put into pl Maintenance Director/ Design will check to ensure the self- closing mechanism on the dia door is in working order month The results of the audit will be brought to the QAPI committe monthly for no less than 6 mo to ensure continued complian	as seems o re t ted dous elf- I be ent nat acce. ee lysis nly. e enths			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BU	A. BUILDING <u>01</u> COMP			SURVEY ETED /2023	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(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
	fuel fired, the devi * is chimney or ve * takes air for com * provides for a co from occupied are 19.5.2.2 Based on observation failed to ensure 1 of provided with intak	nt connected. bustion from outside. ombustion system separate	K 0	522	What corrective actions will be accomplished for those reside found to have been affected by deficient practice?	nts	05/12/2023
	This deficient pract rich with carbon morphysical problems for the physical physica	on with the Maintenance on with the Maintenance on had fuel-fired dryers with a had automatic louvers that the dryers are running, but the room when the dryers are an interview at the time of the intenance Director stated the sly work, but agreed that the had automatic louvers that the room when the dryers are an interview at the time of the louvers that the had automatic louvers did not an does not allow for fresh air the room when the dryers are an interview at the time of the louvers that the had automatic louvers are the name of the louvers are the			A new motor has been installed the automatic louvers and they were tested to ensure they operautomatically when the dryers were running. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The dryer vent louvers were teand observed opening automatically when the dryers were running. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Maintenance has been education the requirement to ensure to louvers were in working order would allow for fresh air to completely enter the room when	y ened g the ested ore ed the and	
					the dryers were running. How the corrective actions will monitored to ensure the deficipractice does not recur, ie, who QA program will be put into plants.	be ent at	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPL B. WING 04/12/1			LETED		
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC			•	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Maintenance Director /Design will complete a monthly check	iee	(X5) COMPLETION DATE	
					aforementioned dryer louvers ensure they are opening automatically. The results of audit will be brought to the QA committee monthly for no less than 6 months to ensure continued compliance.	to the API		
K 0920 SS=E Bldg. 01	Extens Electrical Equipm Extension Cords Power strips in a used for compone patient-care-relat (PCREE) assemt assembled by qu the conditions of the patient care v non-PCREE (e.g except in long-ter do not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care other UL standard used with general cords are not used wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 90,	patient - Power Cords and patient care vicinity are only ents of movable ed electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension id as a substitute for fixed are. Extension cords used emoved immediately upon purpose for which it was ets the conditions of 10.2.4. 19), 10.2.4 (NFPA 99), 400-8 16(D) (NFPA 70), TIA 12-5 on and interview, the facility	K 0	920	What corrective actions will be	e	05/12/2023	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/12/2023		
	PROVIDER OR SUPPLIER ONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(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 APPROPRIA DEFICIENCY)	DATE		
	failed to ensure 2 of 2 power strips and extension cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 staff and 2 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/12/23 between 1:14 p.m. and 3:28 p.m., a refrigerator (high power draw equipment) and microwave (high power draw equipment) was plugged into and supplied power by a power strip in the Admissions Director office. Furthermore, an oxygen concentrator machine loocated in room A118b was plugged into and supplied power from an outlet installed on a lamp. Based on interview at the time of observations, the Maintenance Director acknowledged the power strip was supplying power to two pieces of high power draw equipment and the extension cord in the resident room. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		accomplished for those reside found to have been affected by deficient practice? The refrigerator, microwave an oxygen concentrator were removed from the power strip plugged directly into the wall. How will other residents having potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Observation rounds of all Resistoms and office spaces. No licconcerns were identified. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Staff have been educated on the requirement for high power equipment to be plugged directint the wall rather than using power strips. How the corrective actions will monitored to ensure the deficient practice does not recur, ie, who QA program will be put into plate Maintenance Director /Designal will complete a weekly observed audit of resident rooms and of spaces to ensure no high-powel equipment is plugged into powel strips. The results of the audit be brought to the QAPI commitmently for no less than 6 mon to ensure continued compliance.	y the nd and g the ident ike o re the ettly be ent at ace. ee ation fice ver ver will ittee nths		

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OND NO. OPEN OF THE CONTROL OF THE C							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155835	B. WING		04/12/2023		
					<u> </u>		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET				
SYMPHONY OF CROWN POINT LLC			CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE

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