STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. BUILDING -- B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF CROWN POINT LLC	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
E 0000 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 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 0000		
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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	05/03/2023

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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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF CROWN POINT LLC	1555 S MAIN STREET CROWN POINT, IN 46307

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	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 04/12/23 between 09:38 a.m. and 1:03 p.m., two copies of the EPP were provided. One from the Administrators office and one from a nurses station. The EPP from the nurses station had a review date of 04/2020, no other date could be found to show the EPP binder was reviewed and updated within the last year. Based on an interview during records review, the Administrator was unaware when it was last updated, but they are in the process of reviewing and updating all EPP plans and policies. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0004	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and updated in 2 centrally located binders. How will other residents having the 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 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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP policy will be updated and reviewed annually during the May QAPI meeting.	05/12/2023
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2),			

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	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), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of			

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	the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2).	E 0006	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and	05/12/2023

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	This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 04/12/23 between 09:38 a.m. and 1:03 p.m., The EPP located at the nurses station contained no documentation of a facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the time of record review, the Administrator acknowledged the aforementioned issue and stated every EPP in the facility is in the process of being reviewed and updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		updated in 2 centrally located binders. How will other residents having the 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 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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP policy will be updated and reviewed annually during the May QAPI meeting.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must			

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	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be			

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	reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 04/12/23 between 09:38 a.m. and 1:03 p.m., two copies of the EPP were provided. One from the Administrators office and one from a nurses station. The EPP located at the nurses station had a review date of 04/2020, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EPP's Policies and Procedures are in the process of being reviewed and updated and acknowledged the issue.	E 0013	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and updated in 2 centrally located binders. How will other residents having the 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 per requirement will ensure no like concerns are identified. What measures will be put into place and what systematic	05/12/2023

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP policy will be updated and reviewed annually during the May QAPI meeting.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If			

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	on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[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. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care			

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	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. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include: Based on record review with the Administrator and the Maintenance Director on 04/12/23 between 09:38 a.m. and 1:03 p.m., the EPP located at the nurses station did not have a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency nor had a system to track the location for on-duty staff.	E 0018	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and updated in 2 centrally located binders. The update includes the system to track the location of on duty staff and sheltered patients in the facility's care during an emergency. How will other residents having the 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 that	05/12/2023

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	Based on interview at the time of record review, the Administrator acknowledged the condition and stated that all of the EPP plans and policies are currently being reviewed and updated. The finding was discussed with the Administrator and Maintenance Director at exit conference.		includes the aforementioned tracking system 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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP policy will be updated and reviewed annually during the May QAPI meeting. During this review Administration will ensure said tracking system is in	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].			

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	155835	A. BUILDING -- B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF CROWN POINT LLC	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
	Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 04/12/23 between 09:38 a.m. and 1:03 p.m., two copies of the EPP were provided from the Administrator's office and a nurses station, the EPP located at the nurses station had a review date of 04/2020, but had no other date that could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated all of the EPP plans and policies are currently being reviewed and updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and updated in 2 centrally located binders. The update includes the facility communications plan. How will other residents having the 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 that includes 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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP policy will be updated and reviewed annually during the May QAPI meeting. During this review Administration will ensure said communication plan is in	05/12/2023

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			place.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on			

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	the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing	E 0036	What corrective actions will be accomplished for those residents found to have been affected by the	05/12/2023

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	Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 04/12/23 between 09:38 a.m. and 1:03 p.m., two copies of the EPP were provided from the Administrators office and a nurses station. The EPP located from the nurses station had a review date of 04/2020, no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator acknowledged the aforementioned condition and all EPP policies and procedures are in the process of being reviewed and updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		deficient practice? The Emergency Preparedness plan based on a facility and community- based risk assessment using an all- hazards approach has been reviewed and updated in 2 centrally located binders. The update includes a training and testing plan. How will other residents having the 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 that 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 be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. The EPP plan will be updated and reviewed annually during the May QAPI meeting. During this review Administration will ensure the training and testing plan is reviewed and up to date.	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/14/2023 Facility Number: 013452 Provider Number: 155835 AIM Number: 201299290 At this Life Safety Code survey, the health care portion of Symphony of Crown Point LLC, the first floor, was 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 second floor contains a theater room that skilled residents and staff do occupy on certain days and times. 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	K 0000		

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	wired to the fire alarm system installed in all resident sleeping rooms. The building is fully protected by a 300 kW diesel powered emergency generator. The facility has 68 certified beds. 65 beds are certified only for Medicare, 3 beds are dually certified for Medicare and Medicaid . At the time of the survey, the census was 56. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/18/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 2 smoke barrier doors in the Theater Hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 20 staff, residents, and visitors.. Findings include: Based on observation with the Maintenance Director on 04/12/23 between 1:14 p.m. and 3:28 p.m., the set of smoke barrier doors to the left of	K 0100	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Latching hardware was repaired 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	05/12/2023

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	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 were identified. 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 educated on the requirement for all smoke barrier doors to positively latch when closing. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. Maintenance Director/Designee will complete a monthly safety audit that includes testing of smoke barrier doors to ensure they positively latch. The results of this audit will be submitted to the QAPI committee for 6 months to ensure continued compliance.	
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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	2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation, interview, and record review, the facility failed to maintain the building construction type in 1 of 1 fire barriers. This deficient practice could affect over approximately 15 residents and staff in C-Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:14 p.m. to 3:28 p.m. on 04/12/23, The two hour fire separation doors in C-hall near room C101 had been tagged with a rating of 20 minutes. Based on	K 0161	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The cited doors have been replaced with fire doors consistent with construction type to create a 2- hour fire barrier. How be identified and what corrective actions will be taken? A review of fire barriers and construction data has been completed to ensure construction type is maintained in	05/12/2023

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	record review with the Maintenance Director at 3:00 p.m., the Life Safety building plans showed that the separation was a two hour fire barrier and smoke wall. Upon interview at the time of observation, the Maintenance Director stated that they were unaware that the doors had to be a higher rating and agreed that the ratings on the doors were 20 minutes. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		fire barriers. 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? Maintenance has been educated on this requirement. How the corrective actions will be monitored to ensure the deficient practice does not recur, , what QA program will be put into place. Maintenance Director/Designee will complete a monthly review to ensure fire doors are consistent with construction type requirement. The results of the audit will be brought to the QAPI committee monthly basis for 6 to ensure continued compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects approximately 12 residents and staff. Findings include:	K 0211	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The scale was removed from the corridor. How will other residents having the	05/12/2023

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	Based on an observation during a tour of the facility with the Maintenance Director 04/12/23 between 1:14 p.m. and 3:28 p.m., in the C resident hall next to the dialysis room there was a stationary resident scale against the wall protruding into the corridor about two feet. Based on an interview at the time of observations, the Maintenance Director agreed that the scale was in the hall and was obstructing the corridor. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		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 on the requirement to ensure all means of egress are free of obstructions. How the corrective actions will be monitored to ensure the deficient practice does not recur, , what QA program will be put into place. Maintenance Director /Designee will complete a weekly audit of all 8 corridors to ensure each egress is free from obstructions. The results of the audit will be brought to the QAPI committee monthly for no less than 6 months to ensure continued compliance.	

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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 be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable 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 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and Interview, the facility failed to ensure 1 of 8 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall	K 0222	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Door settings have been adjusted to allow for emergency 15 second egress. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All 8 delayed egress locking doors	05/12/2023

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(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
	activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect approximately 15 residents and staff in A-hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/12/23 between 1:14 p.m. and 3:18 p.m., the A-hall exit door next to room A117 was equipped with a 15 second delayed egress. When the exit door was tested, the irreversible process to release the lock was not initiated after testing twice. Based on interview at the time of observation, the Maintenance Director tried two times to activate the delay egress and stated the delayed egress had been working previous, but will need to be fixed. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		were tested to ensure required settings were in place. 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? Maintenance has been educated on the requirement to ensure that emergency egress doors are functioning with a 15 second delay. How the corrective actions will be monitored to ensure the deficient practice does not recur, , what QA program will be put into place. The Maintenance Director/ Designee will complete a monthly audit of all emergency egress doors to ensure they are functioning with a 15 second delay. The results of this audit will be brought to the QAPI Committee monthly for no less than 6 months to ensure continued compliance.	

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	155835	A. BUILDING 01 B. WING	04/12/2023

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 dialysis rooms were protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient practice could affect approximately	K 0321	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A self- closing mechanism has	05/12/2023

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	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 door. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A review of all hazardous areas was completed. 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? Maintenance has been educated on the requirement for "hazardous areas to be equipped with a self-closing mechanism. No like concerns were identified. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. Maintenance Director/ Designee will check to ensure the self-closing mechanism on the dialysis door is in working order monthly. The results of the audit will be brought to the QAPI committee monthly for no less than 6 months to ensure continued compliance.	
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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	excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observation with the Maintenance Director on 04/12/23 between 1:14 p.m. and 3:28 p.m., the laundry room had fuel-fired dryers with a fresh air intake that had automatic louvers that would open when the dryers are running, but when a dryer was turned on the louvers did not open. This condition does not allow for fresh air to completely enter the room when the dryers are turned on. Based on an interview at the time of observation, the Maintenance Director stated the louvers did previously work, but agreed that the louvers did not open when the dryer was in operation. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0522	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A new motor has been installed in the automatic louvers and they were tested to ensure they opened automatically when the dryers were running. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? The dryer vent louvers were tested and 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 educated on the requirement to ensure the louvers were in working order and would allow for fresh air to completely enter the room when the dryers were running. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place.	05/12/2023

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			Maintenance Director /Designee will complete a monthly check of aforementioned dryer louvers to ensure they are opening automatically. The results of the audit will be brought to the QAPI committee monthly for no less than 6 months to ensure continued compliance.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility	K 0920	What corrective actions will be	05/12/2023

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	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 residents found to have been affected by the deficient practice? The refrigerator, microwave and oxygen concentrator were removed from the power strip and plugged directly into the wall. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Observation rounds of all Resident rooms and office spaces. 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? Staff have been educated on the requirement for high power equipment to be plugged directly into the wall rather than using power strips. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what QA program will be put into place. Maintenance Director /Designee will complete a weekly observation audit of resident rooms and office spaces to ensure no high- power equipment is plugged into power strips. The results of the audit will be brought to the QAPI committee monthly for no less than 6 months to ensure continued compliance.	

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