PRINTED: 10/30/2023

EPARTMENT OF HEALTH AND HU	FORM APPROVED		
ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	155844	B. WING	10/11/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD	

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CHESTERTON LLC			'ILLAGE POINT FERTON, IN 46304	
			TERTON, IN 46304	775)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 0000	REGULATORY OR LSC IDENTIFYING INFORMATION	IAG	DELICE NO.	DATE
0000				
Bldg. 00				
Ü	This visit was for a Recertification and State	F 0000	This plan of correction shall serve	
	Licensure Survey and included the Investigation		as this facilities' credible allegation	
	of Nursing Home Complaints IN00411671,		of compliance Preparation,	
	IN00414039, IN00417763, and IN00418635. This		submission, and implementation	
	visit included a State Residential Licensure		of the plan of corrections does not	
	Survey.		constitute an admission of or	
			agreement with the facts and	
	Complaint IN00411671 - No deficiencies related to		conclusions set forth in this survey	
	the allegations are cited.		report Our plan of correction is	
			prepared and executed as a	
	Complaint IN00414039 - No deficiencies related to		means to continuously improve	
	the allegations are cited.		the quality of care and to comply	
			with all applicable state and	
	Complaint IN00417763 - No deficiencies related to		federal regulatory requirements.	
	the allegations are cited.		The facility respectfully requests	
			paper compliance Thank you for	
	Complaint IN00418635 - No deficiencies related to		your consideration,	
	the allegations are cited.			
			Respectfully,	
	Survey dates: October 3, 4, 5, 6, 10, and 11, 2023			
	Facility number: 013688			
	Provider number: 155844		Kevin Mehay	
	AIM number: 201352370		1.com mondy	
	24.55.25.75		Symphony of Chesterton	
	Census Bed Type:		27prioriy or oriodorion	
	SNF/NF: 13		317-525-3537	
	SNF: 34			
	Residential: 22			
	Total: 69			
	Census Payor Type:			
	Medicare: 19			
	Medicaid: 11			
	Other: 17			
	Total: 47			

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

(X6) DATE

TITLE

Kevin Mehay Administrator 10/26/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 1 of 21

10/30/2023 PRINTED:

EFAKTMENT OF HEALTH AND HUP	FORM AFFROVED		
ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	155844	B. WING	10/11/2023
		STREET ADDRESS, CITY, STATE, ZIP COD	

NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT SYMPHONY OF CHESTERTON LLC CHESTERTON, IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/13/23. F 0694 483.25(h) SS=D Parenteral/IV Fluids Bldq. 00 § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and F 0694 POC for F694 Parenteral/IV 10/26/2023 interview, the facility failed to ensure the **Fluids** intravenous (IV) antibiotic run time infused What corrective action(s) will according to the physician's order for 1 of 1 IV be accomplished for those medications observed. (Resident 6) resident(s) found to have been affected by the deficient practice? Finding includes: No harm came to Resident 6 On 10/5/23 at 1:15 p.m., LPN 2 entered Resident 6's related to alleged deficient room to administer his intravenous (IV) antibiotic. practice. The LPN gathered her supplies, donned a gown NP, resident, and family and gloves, and began to set up the IV pump for were immediately made aware of the medication administration. The IV pump infusing time. No new orders were displayed a warning to reset the machine. Four received from NP. separate attempts were made to reset the machine. How will you identify other The LPN retrieved a Dial-A-Flo IV tubing set residents having the potential (manual flow regulator or IV flow regulator). The to be affected by the same LPN connected the Dial-A-Flo IV tubing to deficient practice and what Resident 6's PICC line (Peripherally Inserted corrective action will be taken?

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All residents have the

receiving IV medication to ensure

the infusing time is completed

potential to be affected by this

alleged deficient practice. A full house audit was

completed on all residents

Dial-A-Flo tubing.

Central Catheter). The LPN began to administer

the IV medication via the PICC line, using the

On 10/5/23 at 1:45 p.m., LPN 2 attempted to

remove Resident 6's IV antibiotic. There was

medication remaining in the IV bag so the LPN

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155844	B. WI	NG		10/11	/2023
		.000	Ш	_	-		
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SOLI EIEN			2775 V	ILLAGE POINT		
SYMPHO	ONY OF CHESTER	TON LLC		CHESTERTON, IN 46304			
ava ib	CID D (1 DV)	CT A TEN CENTE OF DEFICIENCIE	-	TD.	T		975
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	continued to let the	medication infuse.			according to the physician's or	der.	
					What measure will be put into	0	
	On 10/5/23 at 3:07	p.m., LPN 2 informed the			place or what systemic		
	Director of Nursing	(DON), that the resident had			changes you will make to		
	_	emaining in the bag. The DON			ensure that the deficient		
		I notify the Nurse Practitioner			practice does not recur?		
		hat the resident would not			Nursing staff educated or	n	
		e of the IV medication and to			ensuring that infusion of	•	
		PN 2 went back to the			Intravenous (IV) medication ru	ın	
					times are completed according		
	resident's room and the medication had completely infused. The infusion time was 1 hour				the physician's order.		
	and 52 minutes via the Dial-A-Flo. The label on				1	How will the corrective	
	the IV bag indicated the medication was to infuse				action(s) be monitored to		
	_	the medication was to infuse			1 ''		
	over 30 minutes.				ensure the deficient practice		
		1 10/5/00			will not recur, ie., what qualit	-	
		dent 6 was reviewed on 10/5/23			assurance program will be p	ut	
		oses included, but were not			into place?		
		disease, acute osteomyelitis			DON/Designee will Audit		
	(bone infection) rig	ht ankle and foot, acquired			IV medication administrations	on	
	absence of other rig	ht toe, and diabetes mellitus.			random residents/days/shifts t	0	
					ensure that infusing time is		
	A Physician's Order	c, dated 9/16/23, indicated the			completed according to the		
	resident was to rece	ive IV Pipericillin (an			physician's order.		
	antibiotic) 3.375 mi	lligrams (mg) per 100 milliliters			DON/Designee will prese	nt	
	(ml) over 30 minute	es every 8 hours via his PICC			summaries of the audit to the		
	line.	•			Quality Assurance Committee		
					monthly for six months.		
	Interview with the I	OON on 10/5/23 at 3:20 p.m.,			Thereafter, if determined by		
		np was ordered for the resident.			Quality Assurance Committee	that	
		hey didn't like using the			further monitoring is needed,	anat	
		because it doesn't always give			audits will continue.		
	_	amount of the IV medication.			audits will continue.		
	uic resident the full	amount of the IV medication.					
	2.1.47(-)(2)				D-tf		
	3.1-47(a)(2)				Date of compliance: 10-26-23		
F 0759	483.45(f)(1)						
SS=D	` ' ' '	n Error Rts 5 Prcnt or More					
Bldg. 00	§483.45(f) Medica						
l .	The facility must e	ngure that its-			1		1

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Event ID:

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Facility ID: 013688

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155844	B. W	ING		10/11/2023	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R					
SAMDHU	ONY OF CHESTER	TONLLC		2775 VILLAGE POINT CHESTERTON, IN 46304			
STIVIFTIC	JNT OF CHESTER	TON LLC		CHEST			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	§483.45(f)(1) Medication error rates are not 5						
	percent or greate						
	Based on observation, record review, and		F 0'	759	POC for F759 Free of	10/26/2023	
	interview, the facili	ity failed to ensure a medication			Medication Error Rights 5		
	error rate of less that	an 5% for 2 of 6 residents			Percent or More		
	observed during me	edication pass. Two errors			What corrective action(s) wi	II	
	were observed duri	ng 31 opportunities for errors			be accomplished for those		
		administration. This resulted in			resident(s) found to have be	en	
	a medication error	rate of 6.45%. (Residents 5 and			affected by the deficient		
	6)				practice?		
					No harm came to Reside	ent 5	
	Findings include:				or Resident 6 related to allege	∍d	
					deficient practice.		
	During observation				Resident 5 was assesse	d to	
	administration on 1	.0/5/23 at 4:30 p.m., RN 1			have no signs of symptoms of	f	
	handed Resident 5	a Ventolin HFA inhaler. The			respiratory distress, wheezing	J	
	resident administer	ed his own inhaler with no			and/or congestion.		
		N 1 on how to properly			Resident 6 picc line rema	ains	
		ication. The resident quickly			patent.		
	pushed down on the	e inhaler twice for two puffs			How will you identify other		
		apped the inhaler and handed it			residents having the potenti	al	
		I put the inhaler in the cart and			to be affected by the same		
	locked it.				deficient practice and what		
					corrective action will be take	n?	
		ident 5 was reviewed on 10/5/23			All residents have the		
	at 4:40 p.m.				potential to be affected by this	;	
					alleged deficient practice.		
		Physician's Order Summary			A full house audit was		
	` ′	e resident was to receive his			completed on all residents wit		
	Ventolin HFA Inha	aler, 2 puffs, 4 times per day.			inhalers to ensure the specific		
					time between puffs is perform	ed.	
		1 on 10/5/23 at 4:45 p.m.,			A full house audit was		
		ent initiated the puffs too			completed on all residents wit	.h IV	
	quickly, and he did	not wait in between puffs.			access to ensure flushes are		
					being completed according to		
		olicy, titled "Specific			orders.		
		istration Procedures: Oral			What measure will be put int	:o	
		stration", indicated, "press			place or what systemic		
		ice to release medication as			changes you will make to		
resident starts to breathe in slowly through the				ensure that the deficient			

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DEPARTMEN' CENTERS FOI		RM APPROVED B NO. 0938-039				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED 10/11/2023	
	PROVIDER OR SUPPLIED		2775 V	ADDRESS, CITY, STATE, ZIP COD /ILLAGE POINT TERTON, IN 46304		
(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)	ATE	(X5) COMPLETION DATE
	than one puff at a to same or different m least 1-2 minutes b	econds". Do not spray more ime" "If another puff of the nedication is required, wait at etween, or per manufacturer repeat procedures above"		practice does not recur? Nursing staff educated o giving proper instructions whil residents are self-administerir medications including but not limited to waiting proper perio time between puffs while using	e ng d of	
	observed preparing intravenous (IV) ar gown and gloves at She flushed the res Inserted Central Ca disconnecting the a	ion of medication 0/5/23 at 3:07 p.m., LPN 2 was to remove Resident 6's tibiotic. The LPN donned a nd entered the resident's room. ident's PICC line (Peripherally theter) with normal saline after ntibiotic. No heparin was used to flush the PICC		inhaled medications that requimore than one puff. Nursing staff educated or proper flushing of an IV access according to the type of IV devices. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what qualities assurance program will be printo place?	ire n ss vice.	
	at 1:45 p.m. Diagn limited to, vascular (bone infection) rig absence of other rig A Physician's Orderesident's PICC limited interview with LPN indicated that she in	oses included, but were not disease, acute osteomyelitis that and foot, acquired the toe, and diabetes mellitus. Tr., dated 9/16/23, indicated the e was to be flushed with 10 ormal saline before and after ten flush with 5 ml of heparin. N 2 on 10/5/23 at 3:39 p.m., ever used heparin to flush the didn't know that she was		DON/Designee will rando check 5 medication passes per week that include inhalers to ensure proper instructions are giving while residents are self-administering medications including but not limited to ward proper period of time between puffs while using inhaled medications that require more than one puff. DON/Designee will rando check 5 medication passes per week that include IV flushes to ensure that IV accesses are beflushed according to the type of the week to the self-according to the type of the week to the self-according to the type of the self-according to the self-accor	er s iting n omly er o eing	

3.1-48(c)(1)

Interview with the Director of Nursing on 10/5/23

at 3:41 p.m., indicated they didn't use heparin, but

she would call and clarify the order to flush with

saline after medication administration.

D93U11

device.

DON/Designee will present

summaries of the audit to the

Quality Assurance Committee monthly for six months.

Thereafter, if determined by

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/11/2023	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CHESTERTON LLC			2775 V	ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT ERTON, IN 46304			
(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
					Quality Assurance Committee further monitoring is needed, audits will continue.	that	
					Date of compliance: 10-26-23		
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted professing the appropriate accepted instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper temporate in the storage of the storage	s and Biologicals ing of Drugs and Biologicals cals used in the facility in accordance with currently conal principles, and include cessory and cautionary the expiration date when ge of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments cerature controls, and dized personnel to have					
	separately locked compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the f package drug dist	e facility must provide permanently affixed storage of controlled drugs Il of the Comprehensive ention and Control Act of ugs subject to abuse, acility uses single unit ribution systems in which d is minimal and a missing ly detected.					
	Based on observation interview, the facility	on, record review, and ty failed to ensure medications y for 1 of 3 medication carts	F 0'	761	POC for F761 Label/store Dru and Biologicals What corrective action(s) wil		10/26/2023

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observed. (C hallway, Cart 2).

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be accomplished for those

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10/30/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/11/2023 155844 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT CHESTERTON, IN 46304 SYMPHONY OF CHESTERTON LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident(s) found to have been Finding includes: affected by the deficient practice? On 10/6/23 at 9:37 a.m., LPN 3 was observed at the No residents were identified medication cart preparing to pass medications to have been effected. from Cart 2 on the C hallway. The cart was found How will you identify other to have 12 loose pills, varying in size, shape, and residents having the potential color. The pills were found in the bottom 3 to be affected by the same drawers of the medication cart. The LPN removed deficient practice and what the pills from the cart and disposed of them in the corrective action will be taken? sharps container. All residents have the potential to be affected by this Interview with LPN 3 on 10/6/23 at 9:37 a.m., alleged deficient practice. indicated she always cleaned her med cart and she A full house audit was completed on all medication carts knew the loose pills should not have been in the to ensure all carts are free of loose medications and medications are

Interview with the Director of Nursing on 10/6/23 at 10:03 a.m., indicated the loose pills should not

A current facility policy, titled " Medication Storage in the Facility: Storage of Medications", indicated... "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..."

3.1-25(m)

have been in the cart.

stored properly, safely, and securely.

What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Nursing staff were educated on proper, safe, and secure storage of medications and keeping carts clean and free of loose, unlabeled pills. How will the corrective

action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?

DON/Designee will perform an audit twice a week (different day/shift) on all medication carts to ensure medications are stored properly, safely, securely, and free

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM		COMPL	ETED	
		155844	B. WI	NG		10/11/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT				
SAMDILO	NY OF CHESTER	FON LL C					
STIVIFIC	INT OF CHESTER	TON LLC	CHESTERTON, IN 46304		ERTON, IN 40304		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(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'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					of loose, unlabeled pills.		
					DON/Designee will prese	nt	
					summaries of the audit to the		
					Quality Assurance Committee		
					monthly for six months.		
					Thereafter, if determined by		
					Quality Assurance Committee	that	
					further monitoring is needed,		
					audits will continue.		
					Date of compliance: 10-26-23		
R 0000							
K 0000							
Bldg. 00							
Diug. 00	This visit was for a	State Residential Licensure	D 00	000	This plan of correction shall se	r. (O	
		icluded a Recertification and	R 00)00	as this facilities' credible allega		
	-	vey and the Investigation of			of compliance Preparation,	alion	
		aplaints IN00411671,			submission, and implementation	n .	
	-	117763, and IN00418635.			of the plan of corrections does		
	11100414057, 111004	117703, and 11400410033.			constitute an admission of or	TIOL	
	Complaint IN00411	671 - No deficiencies related to			agreement with the facts and		
	the allegations are c				conclusions set forth in this su	rvev	
	the unegations are e	neu.			report Our plan of correction is	•	
	Complaint IN00414	039 - No deficiencies related to			prepared and executed as a	•	
	the allegations are c				means to continuously improve	ے	
					the quality of care and to comp		
	Complaint IN00417	763 - No deficiencies related to			with all applicable state and	. · · ·	
	the allegations are c				federal regulatory requirement	S.	
					The facility respectfully reques		
	Complaint IN00418	635 - No deficiencies related to			paper compliance Thank you f		
	the allegations are c				your consideration,	•	
					,		
	Survey dates: Octo	ber 3, 4, 5, 6, 10, and 11, 2023			Respectfully,		
	-				, , , , , , , , , , , , , , , , , , ,		
	Facility number: 01	3688					
	-						
	Residential Census:	22			Kevin Mehay		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/11/2023			
	PROVIDER OR SUPPLIER		2775 \	STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304		
(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	
TAU	REGULATORY OR LSC IDENTIFYING INFORMATION These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/13/23.		TAU	Symphony of Chesterton 317-525-3537	DATE	
R 0036 Bldg. 00	resident 's physic legal representation noticed: (1) a significant dephysical, mental, of (2) a need to alter is, a need to discontreatment due to a commence a new Based on record revisited to notify the right with injury for 1 of (Resident 5) Finding includes: The record for Residual for the record for Residual to notify the right at 12:00 p were not limited to, osteoporosis. A Nurses' Note, dat indicated at 4:50 a.r. laying on the floor into state what happer was completed and the right arm. The a saline, steri strips we was used to cover the significant in the saline, steri strips we was used to cover the significant in the saline, steri strips we was used to cover the significant in the saline, steri strips we was used to cover the significant in the saline in the sali	b Deficiency st immediately consult the ian and the resident 's we when the facility has cline in the resident 's or psychosocial status; or treatment significantly, that intinue an existing form of idverse consequences or to	R 0036	POC for R036 Residents' Rights-Deficiency What corrective action(s) will be accomplished for those resident(s) found to have be affected by the deficient practice? No harm came to Reside related to alleged deficient practice. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure notification physician is being performed.	en Int 5 al Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.	

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 9 of 21

PRINTED: 10/30/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155844		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2023	
	PROVIDER OR SUPPLIEF		2775 V	ADDRESS, CITY, STATE, ZIP COD /ILLAGE POINT TERTON, IN 46304	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF There was no docur	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION mentation the Physician was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) to injury resulting from a fall a	5.112
	indicated the Physic resident's fall with in The revised 1/2023 provided by the DC indicated designate and the doctor and the guest's medical in the resident statu	DON on 10/11/23 at 1:00 p.m., cian was not notified of the njury. "Accident/Incident" policy, DN on 10/11/23 at 1:05 p.m., d staff should contact family document as changes occur in record. If no injuries or change is due to an accident or documentation was required		change in condition. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice do not reoccur? Nursing staff were eduction notifying the residents physician of any fall with injurand/or change in condition. How will the corrective action(s) be monitored to ensure the deficient practic will not reoccur, ie., what quality assurance program be put into place? AL Director/Designee w monitor all falls weekly to ensure that physicians are notified o injury resulting from a fall and change in condition. AL Director/Designee w present summaries of the authe Quality Assurance Commmonthly for six months. Thereafter, if determined by Quality Assurance Committe further monitoring is needed, audits will continue.	ated ry e will ill sure f any d/or ill dit to nittee e that
D 0247	440 140 40 0 5 0	-)/4 F)		Date of Compliance: 10-26-2	3
R 0217 Bldg. 00	facility, using appi members, shall id				

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 10 of 21

PRINTED: 10/30/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155844	B. W	ING		10/11/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ILLAGE POINT		
SYMPHO	ONY OF CHESTER	TON LLC		CHESTERTON, IN 46304			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	follows: (1) The services offered to the individual						
	, ,	appropriate to the:					
	(A) scope;	appropriate to the.					
	(B) frequency;						
	(C) need; and						
	(D) preference;						
	of the resident.						
	(2) The services of	offered shall be reviewed and					
		oriate and discussed by the					
	resident and facility as needs or desires						
	change. Either the facility or the resident may						
	request a service plan review.						
		oon service plan shall be					
	_	by the resident, and a copy					
	· ·	n shall be given to the					
	resident upon req						
	, ,	on and documentation of is needed if evaluations					
	•	e initial evaluation indicate					
	no need for a cha						
		on of medications or the					
	, ,	ential nursing services, or					
	1 3	licensed nurse shall be					
		ication and documentation of					
	the services to be	provided.					
	Based on record re-	view and interview, the facility	R 0	217	POC for R217		10/26/2023
		service plan was signed by			Evaluation-Deficiency		
		ey were revised and updated			What corrective action(s) wi	II	
		sident's change in condition for			be accomplished for those		
		iewed for service plans.			resident(s) found to have be	en	
	(Residents 1, 4, and	1 6)			affected by the deficient		
	F: 1:				practice?		
	Findings include:				No harm came to Reside	ent	
	1 The record for D	esident 1 was reviewed on			1, Resident 4, or Resident 6		
		m. Diagnoses included, but were			related to alleged deficient		
	_	essive disorder, dementia with			practice. Resident 1 no longer res	ides	
	_	ice, psychotic disorder, and			in this facility.	iuca	
	anxiety.	ers, payerione amoraer, una			How will you identify other		
	1 ,		1		1 ,		Ī

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 11 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMPI	
		155844	B. W	ING		10/11	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ILLAGE POINT		
SYMPHO	ONY OF CHESTER	TONLIC		CHESTERTON, IN 46304			
	T				T		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. 0/11/02 G : T				residents having the poten	tial	
		iving Evaluation indicated the			to be affected by the same		
		vays oriented to person, place			deficient practice and what		
	and time and requir	ed assistance with orientation.			corrective action will be tal	ken.	
	ADI ST	10/10/20 11.00			All residents have the		
		ated 9/12/23 at 1:06 p.m.,			potential to be affected by the	IIS	
		nt had been having anxiety			alleged deficient practice.		
		ve over little things like pillow			A full house audit was		
	cases, phones, and	other things in his room.			completed to ensure all serv		
	137 137 1	1.0/17/02 + 2.47			plans were signed by reside	nts or	
	A Nurses' Note, dated 9/17/23 at 3:47 p.m.,				their responsible party.		
	indicated the resident appeared anxious and was				A full house audit was		
	observed with heavy breathing. The resident was				completed to ensure all beha		
		different resident rooms and			were addressed in service p		
		l. He was trying to call his			What measure will be put in	nto	
		ing anxiety about finding their			place or what systemic		
	phone numbers.				changes you will make to		
		10/04/00			ensure that the deficient		
		ated 9/21/23 at 2:01 p.m.,			practice do not reoccur?		
		was agitated and was asking			Nursing staff/AL Directo		
	_	over and over again. He was			were educated on updating	service	
		g in the hall and trying to find			plans to address behaviors.		
	his room.				Nursing staff/AL Directo		
		1.10/5/22 2.25			educated on ensuring all ser		
		ated 10/5/23 at 3:37 p.m.,			plans are signed by resident	or	
		jumped out of his chair and			their responsible party.		
		After he had caught up with			How will the corrective		
		gainst the wall. He was trying			action(s) be monitored to		
		k. At 4:44 p.m., the resident's			ensure the deficient practic	ce	
	-	facility. The guest was			will not reoccur, ie., what		
		him, when she stated no she			quality assurance program	WIII	
		p and attempted to push her.			be put into place?	.:11	
		directed to his room, however,			AL Director/Designee v		
	he continued to pac	e and curse.			monitor all behaviors weekly		
	Th. C' Di	-4-10/11/22 1-1			ensure they are addressed of	on	
		ated 8/11/23, had no			service plans.	•••	
		ne resident's physical			AL Director/Designee v		
	behaviors towards l	nis daughter and staff.			monitor all new service plan	S	
					weekly and ensure they are		
	Interview with the	Assisted Living Director on			signed by resident or their		1

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155844	B. W	B. WING 10/11/2023			/2023
				_			
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ILLAGE POINT		
SYMPHO	DNY OF CHESTER	TON LLC		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	10/11/23 at 1:34 p.i	m., indicated the resident's			responsible party.		
		tive behaviors were not			AL Director/Designee wil	l	
	addressed on his Se	ervice Plan.			present summaries of the aud	it to	
					the Quality Assurance Commi	ttee	
	2. The record for R	esident 4 was reviewed on			monthly for six months.		
	10/10/23 at 12:55 p	.m. Diagnoses included, but			Thereafter, if determined by		
	were not limited to,	, major depressive disorder,			Quality Assurance Committee	that	
	anxiety, and COPD	(chronic obstructive			further monitoring is needed,		
	pulmonary disease)	ı .			audits will continue.		
	A Service Plan, dat	ed 8/15/23 was completed,			Date of Compliance: 10-26-23	}	
	however, was not s	igned by the resident or her					
	responsible party.						
	Interview with the	Assisted Living Director on					
	10/11/23 at 1:34 p.i	m., indicated the Service Plan					
	was not signed by t	he resident.					
		d for Resident 6 was reviewed					
		5 a.m. Diagnoses included, but					
		anxiety, stroke, hemiplegia					
	· ·	on one side of the body), and					
	major depressive di	sorder.					
		15/15/00					
		ed 7/17/23 was completed,					
		igned by the resident or her					
	responsible party.						
	Interview with the	Assisted Living Director on					
		m., indicated the Service Plan					
	_	he resident or her responsible					
	party.	ne resident of her responsible					
	puity.						
R 0295	410 IAC 16.2-5-6(′a)					
	1	ervices - Noncompliance					
Bldg. 00		self-medicate may keep					
	1 ' '	on and nonprescription					
		eir unit as long as they keep					
	them secured from	- · · · · · · · · · · · · · · · · · · ·					
		on, record review, and	R_0	295	POC for R295-Pharmaceutica	al	10/26/2023
ı	1	•	1 0		l		1 - 0 0 0-0

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 13 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPLETED	
155844		155844			10/11/2023		
				CTPEET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME O	F PROVIDER OR SUPPLIE	R			ILLAGE POINT		
SAMDI	HONY OF CHESTER	TONLLC			ERTON, IN 46304		
O I WIFT	- CHESTER	TON LLO	_	GILGI			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	4	TAG	DEFICIENCY)	DATE	
	· ·	ity failed to ensure medications			Services-Noncompliance		
		sident rooms for those who self			What corrective action(s) wi	ill	
		own medications for 1 of 2			be accomplished for those		
		for self administration of			resident(s) found to have be	en	
	medication. (Resid	lent 8)			affected by the deficient		
					practice?		
	Finding includes:				No harm came to Reside		
		11			or any other resident related	to	
		ident 8 on 10/10/23 at 11:13			alleged deficient practice.		
	· ·	self administered his own					
		dicated his medications were in			How will you identify other		
	1	ounter. At that time, the drawer			residents having the potenti	ial	
	was not locked, it easily opened, and all of his				to be affected by the same		
		observed inside in containers.			deficient practice and what		
		ted he never locked his room			corrective action will be take	en.	
	_	pointed to the keys which			All residents have the		
	where secured arou	and the arm of his wheelchair.			potential to be affected by this	S	
	0 10/11/02 . 0 0				alleged deficient practice.		
		3 a.m., the resident was			A full house audit was		
	_	s wheelchair in the hallway			completed to ensure that		
		dining room. At that time, his			medications were secured in		
	•	le open and the drawer that			resident rooms for those who		
	housed his medicat	ions was uniocked.			self-administered their own		
	The man and face D	idant 0 maa namiama 1			medications.	40	
		ident 8 was reviewed on			What measure will be put in	το	
	_	m. Diagnoses included, but , type 2 diabetes, COPD			place or what systemic		
		• •			changes you will make to		
		e pulmonary disease), and high			ensure that the deficient		
	blood pressure.				practice do not reoccur?	r	
	Δ Self Administrat	ion of Medication Assessment,			Nursing staff/AL Director were educated on ensuring the		
		ated the resident was			residents that self-administer		
	· ·	aily decision making and was			own medications ensure their		
	_	ninister his own medications.			medications are secure in the		
		s were to be kept in his room.			rooms.	ZII	
	7 th the medications	s were to be kept in his foom.			How will the corrective		
	Interview with I DN	N 1 on 10/11/23 at 8:30 a.m.,			action(s) be monitored to		
		ent was to have all of his			ensure the deficient practice		
		I in the drawer inside his room.			will not reoccur, ie., what	-	
		I drawer with a lock on it for			quality assurance program	will	
	THEIR Was a specia	i diamei willi a ioek oli il ioi	1		I quality assurance proutain	VV I I	

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PRINTED: 10/30/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/11/2023				
	PROVIDER OR SUPPLIER		2775 \	STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304				
(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			
R 0349 Bldg. 00	residents who self a The current 4/2004, Medications and Tr the Assisted Living p.m., indicated med administration were drawer/box in the re 410 IAC 16.2-5-8. Clinical Records - (a) The facility mu	dminister their medication. "Self Administration of eatment" policy, provided by Director on 10/11/23 at 1:34 ications and treatments for self to be kept in a locked esident's room.	TAU	be put into place? AL Director/Designee will monitor 10 residents weekly (different day/shift) that self-administer their own medications to ensure their medications are secured in the rooms. AL Director/Designee will present summaries of the aud the Quality Assurance Commitmonthly for six months. Thereafter, if determined by Quality Assurance Committee further monitoring is needed, audits will continue. Date of Compliance: 10-26-23	eir I it to ttee that			
	maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc. (3) Readily access (4) Systematically Based on record revialled to ensure clin accurately documer assessment and doc injury or change in needed (PRN) medinon-pharmacological	the supervision of an acility designated with that records must be as umented.	R 0349	POC for R349- Clinical Records-Noncompliance What corrective action(s) wil be accomplished for those resident(s) found to have be affected by the deficient practice? No harm came to Reside	en			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	f 1			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLET	COMPLETED	
155844		B. WING 10/11/2023			023			
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	t .			ILLAGE POINT			
SYMPHO	NY OF CHESTER	TON LLC			ERTON, IN 46304			
_						ı		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	· ·	residents reviewed for clinical			1, Resident 2, Resident 4 or			
	records. (Residents	1, 2, 4, and 5)			Resident 5 related to alleged			
	TO 11 1 1 1 1				deficient practice.			
	Findings include:				Resident 1 no longer resi	ides		
	1 701 10 5				in the facility.			
		esident 1 was reviewed on			Resident 2 was assessed	a,		
	-	m. Diagnoses included, but were			stop date obtain for antibiotic			
	_	essive disorder, dementia with			ointment.			
		ce, psychotic disorder, and			Resident 4 no longer resi	ides		
	anxiety.				in Assistant Living.			
	A 0/11/22 C : 3				Resident 5 no longer resi	ides		
		Living Evaluation, indicated the			in the facility.			
		vays oriented to person, place						
	and time and requir	ed assistance with orientation.			How will you identify other			
	m · · · · o ·	1 . 10/20/22			residents having the potentia	al		
	Physician's Orders,				to be affected by the same			
		7/23, indicated Seroquel (an			deficient practice and what			
		cation) 25 milligrams (mg)			corrective action will be take	en.		
	every 8 hours as ne	eded for agitation.			All residents have the			
	DI '' LOI	1 4 10/21/22 : 1: 4 1			potential to be affected by this	;		
	-	dated 9/21/23, indicated			alleged deficient practice.			
		ery 8 hours as needed for			A full house audit was			
	agitation.				completed to ensure	iono		
	The 0/2022 1 10/	2022 Madigation			nonpharmacological interventi	ions		
	The 9/2023 and 10/				are attempted first before	giaal		
		ord (MAR) indicated the as			administering prn pharmacolo	gicai		
		as signed out as being at 12:21 p.m., 9/9 at 11:55 a.m.,			interventions. A full house audit was			
	10/6 at 11:14 a.m.,	-						
	10/6 at 11:14 a.m., a 10/10/23 at 2:50 p.r				completed to ensure follow-up assessments and documentate			
	10/10/23 at 2.30 p.1	11.				I		
	An eMAD Adminio	stration note, dated 9/4/23 at			are completed for residents when the properties of the state of the st	IIO		
		ed "Guest family came and he			have infections following administration of antibiotics.			
	•	t then it was the cabinet. Gave			A full house audit was			
	•	uest went up front to visit with						
		uest went up front to visit with ue to monitor." (sic)			completed to ensure follow-up assessments and documentate			
	i aminy, win contint	ie to monitor. (sic)						
	An aMAD Adminia	stration note dated 0/0/22 at			are completed following fall wi			
		tration note, dated 9/9/23 at			injury or change in the resider	IL		
		ed "resident complained of			condition.			
	anxiety. administere	eu per nurse." (sic)	1		A full house audit was			

State Form Event ID: D93U11 Facility ID: 013688 If continuation sheet Page 16 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
		155844	B. WI	NG		10/11/	2023
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
CVMDLIC	NIV OF CHECTED	TONILLO			ILLAGE POINT		
SYMPHO	ONY OF CHESTER	ION LLC		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					completed to ensure that orde	ers	
		tration note, dated 10/6/23 at			are obtained and documented	l for	
		ed the Seroquel 25 mg			first aide treatments.		
	medication was adn	ninistered for agitation.			What measure will be put int	0	
					place or what systemic		
		stration note, dated 10/10/23 at			changes you will make to		
	_	l "Medication gave when guest			ensure that the deficient		
	~	n coat on. Very agitated,			practice do not reoccur?		
		going to SNF [Skilled Nursing			Nursing staff/AL Director		
	Facility] unit. Will	continue to monitor." (sic)			were educated that		
					non-pharmacological interven		
	Interview with LPN 1 on 10/11/23 at 8:45 a.m.,				should be attempted first befo	re	
	indicated before administering the as needed				administering any prn		
	-	ng she did try to do other			pharmacological medications.		
		ne resident remained agitated,			Nursing staff/AL Director		
	· ·	ot document what she had			were educated on ensuring th	at	
	done.				follow-up assessments and		
					documentation are completed		
		Director of Nursing on 10/11/23			following administration of		
		ted nurses were to try non-			antibiotics, falls with injury and	d	
		terventions first before			change in status of resident.		
	administering the as	s needed Seroquel.			Nursing staff/AL Directo		
	0 TI 10 D				were educated on ensuring or	ders	
		esident 2 was reviewed on			are documented for first aide		
		m. Diagnoses included, but were			treatments.		
	· ·	fibrillation, glaucoma,					
	pacemaker.	blood pressure, and cardiac					
	pacemaker.				How will the corrective		
	Numanal Matas, data	d 9/18/23 at 9:28 a.m., indicated			action(s) be monitored to		
	· · · · · · · · · · · · · · · · · · ·	was red with discharge. The			ensure the deficient practice	,	
		C			will not reoccur, ie., what	vill	
	hospice nurse contacted the doctor. Nursing would continue to monitor.			quality assurance program will		VIII	
	would commue to h	monto.			be put into place? AL Director/Designee wil	ı	
	Physician's Orders	dated 9/18/23, indicated			randomly monitor 5 residents	'	
	-	in-Polymyxin external eye			weekly that receive prn medic	ation	
		nin ribbon to the right eye two			to ensure nonpharmacologica		
	times a day.	1.23011 to the right eye two			interventions are attempted fir		
	annes a day.				before pharmacological	J.	
	There was no furthe	er assessment or			interventions.		
	There was no further assessment or				into vondons.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155844				10/11/	/2023
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
CVMDLIC	NIV OF CHECTED	TONILLO			ILLAGE POINT		
SYMPHO	ONY OF CHESTER	TON LLC		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documentation rega	rding the right eye redness or			AL Director/Designee will		
	drainage in nursing	progress notes.			randomly monitor 10 residents	;	
					weekly that are on antibiotics,		
	Hospice Nurse visit	notes, dated 10/2, 10/4, 10/6,			change in status or fall with inj	ury	
	and 10/9/23, indicat				to ensure that follow-up		
	documentation or a	n assessment of the right eye			reassessments and		
	for redness or drain	age.			documentations are completed	d.	
					AL Director/Designee will		
		Director of Nursing on 10/11/23			monitor all first aide treatment	S	
		ted there was no other			that are rendered to ensure the	at	
		eted by nursing staff of the			orders are in place.		
	right eye redness and discharge.				AL Director/Designee will		
					present summaries of the aud		
		LPN 1 on 10/11/23 at 8:45 a.m.,			the Quality Assurance Commi	ttee	
	_	ce Nurse visited the facility			monthly for six months.		
		k to change the resident's			Thereafter, if determined by		
	pressure ulcer band	ages.			Quality Assurance Committee	that	
					further monitoring is needed,		
		esident 4 was reviewed on			audits will continue.		
	_	.m. Diagnoses included, but					
		major depressive disorder,					
	I	(chronic obstructive			Date of Compliance: 10-26-23		
	pulmonary disease)						
		- /20/20					
		7/28/23 at 1:13 p.m., indicated					
		lost her balance, and fell to					
		m. The resident had complaints					
	_	on both feet, however, nothing					
		r as swelling, redness or					
	warmth.						
	There was no deau	montation of fall fallow up or					
	There was no documentation of fall follow up or an assessment after the fall.						
	an assessment after	uic iail.					
	Interview with the I	Director of Nursing on 10/11/23					
		ted a follow up assessment and					
	_	to be completed after a fall if					
		There was no follow up					
	1	_					
	documentation of the resident after the complaints						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				COMPLETED	
	155844		B. W	ING		10/11/	/2023	
NAME OF B	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
					LLAGE POINT			
SYMPHO	NY OF CHESTER	TON LLC		CHEST	ERTON, IN 46304			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	4 The record for R	esident 5 was reviewed on						
		.m. Diagnoses included, but						
		hypothyroidism and						
	osteoporosis.	any posity to to to the control of t						
		scharged to the hospital on						
	9/26/23 and was cu	rrently not in the facility.						
	A Nurses' Note, dat	eed 9/15/23 at 6:37 a.m.,						
	indicated at 4:50 a.r	m., the guest was observed						
	laying on the floor	next to the bed and was unable						
	to state what happen	ned. A nursing assessment						
	_	a skin tear was observed to						
		rea was cleansed with normal						
	-	vere applied and a dry dressing						
		he area. The Director of						
	Nursing (DON) and	Administrator were notified.						
	There was no follow	w up assessment or						
		r the resident's fall with injury.						
	There were no Phys	sician's Orders for the steri						
	strips for the treatm							
	Nurses! Notes data	d 9/25/23 at 10:07 a.m.,						
	-	had a change in behavior. She						
	_	nad a change in behavior. She						
		esident's daughter was worried						
		hydrated, so the physician						
	was notified and a r							
		<i>6</i> - ·····						
	Nurses' Notes, dated	d 9/25/23 at 12:51 p.m.,						
	indicated the guest	refused to get up for lunch						
	and she was asked if she wanted to go to the							
	Emergency Room (ER) and she refused that as						
	well. The daughter	was informed she had been						
	trying to reach the d	loctor, however, she only able						
	to leave messages.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/11/2023				
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CHESTERTON LLC		2775 V	STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
140	Nurses' Notes, date	d 9/25/23 at 4:24 p.m., nt's son had arrived to	TAG		DAIL			
	indicated the guest and an antibiotic wa urinary tract infection	ed 9/26/23 at 8:33 a.m., had gone to the ER last night as ordered for symptoms of a on. The writer called and spoke arse regarding the resident's						
	nursing progress no	er documentation in the tes regarding the resident's e she had been transferred out						
	at 8:45 a.m., indicate ER with family on 9 family a scrip for an urinary tract infection and they could not antibiotic medication family were informed nothing for their monthing for their months assessment of the resident to anothe evaluated on 9/26/2 admitted. There was assessment of the refamily to go to the Physician's Order for Interview with the I indicated a follow undocumentation was there was an injury assessment of the refamily to go to the refamily to go to the I indicated a follow undocumentation was there was an injury assessment of the refamily assessment of the refami	DON on 10/11/23 at 1:02 p.m., up assessment and to be completed after a fall if There was no follow up esident after her fall.						
		"Accident/Incident" policy, N on 10/11/23 at 1:05 p.m.,						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/11/2023	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CHESTERTON LLC			STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	and the doctor and coccurred in the gues injuries or change in	d staff should contact family document as changes st's medical record. If no nother resident status due to an nother than the record.					

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