PRINTED: 09/23/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	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			
		155835	B. W	B. WING			09/07/2022		
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER					MAIN STREET				
SYMPLIONY OF CROWN POINT LLC									
SYMPHONY OF CROWN POINT LLC				CROWN POINT, IN 46307					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
F 0000									
Bldg. 00									
		he Investigation of Nursing	F 00	000	Symphony of Crown Point Ple	ase			
	_	N00384855. This visit included			accept the following as the				
	_	f Residential Complaints			facility's credible allegation of				
	IN00388844 and II	N00389557.			compliance. This plan of				
					correction does not constitute	an			
		4855 - Unsubstantiated due to			admission of guilt or liability by	/ the			
	lack of evidence.				facility and is submitted only ir	1			
					response to the regulatory				
	-	8844 - Substantiated. No			requirement.				
	deficiencies related	d to the allegations are cited.							
	Complaint IN00389557 - Substantiated. No deficiencies related to the allegations are cited.								
	Unrelated deficient	cy is cited.							
	Survey dates: September 6 & 7, 2022								
	Facility number: 0								
	Provider number:								
	AIM number: 201	299290							
	G D 1 T								
	Census Bed Type:								
SNF/NF: 4 SNF: 54 Residential: 25 Total: 83									
	Total: 83								
	C D T								
	Census Payor Type: Medicare: 47 Medicaid: 4								
	Other: 7								
	Total: 58								
	10tai: 38								
	This deficiency	Jaata Stata Findings sited in							
		lects State Findings cited in							
	accordance with 41	IU IAC 10.2-3.1.							

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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: SNES11 Facility ID: 013452 If continuation sheet Page 1 of 6

PRINTED: 09/23/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	JLTIPLE CC ILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155835		B. WING 09/07/20				
	PROVIDER OR SUPPLIER			1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
F 0610 SS=D Bldg. 00	§483.12(c) In resp abuse, neglect, ex the facility must: §483.12(c)(2) Hav violations are thore §483.12(c)(3) Preveneglect, exploitation the investigation is §483.12(c)(4) Rep investigations to the investigations to the redesignated reposition of the secondary officials in accordary including to the St 5 working days of alleged violation is corrective action in Based on record reversided to thoroughly misappropriation of a resident's missing medication for 1 of allegation of misapper Finding includes: A facility reported indicated Resident 2 was unable to be located for the follow up to the 6/23/22, indicated of the follow up to the follows up to the	nt/Correct Alleged Violation conse to allegations of exploitation, or mistreatment, are evidence that all alleged coughly investigated. Went further potential abuse, con, or mistreatment while in progress. For the results of all the administrator or his or coresentative and to other concernic with State law, attended to the concernic with State law, attended to	F 06	10	Symphony of Crown Point Ple accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement. F610 Investigate/Prevent/Corr Alleged Violation What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? • Guest 2 is no longer in the facility.	an y the n rect oe nts	09/20/2022	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SNES11 Facility ID: 013452

If continuation sheet Page 2 of 6

PRINTED: 09/23/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DINTIFICATION NUMBER 155835 NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC (X9) ID SUMMARY STATEMENT OF DEFICUENCIES PRECISE OF SYMPHONY OF CROWN POINT LLC (X9) ID Ala given it to the nurse. The nurse placed the Percocet butle in the locked box on the Medication Cart. When the resident was being discharged from the facility, the bottle of Percocet was unable to be located. Resident 2's record was reviewed on 9/6/22 at 4.36 p.m. The diagnoses included, but were not limited to, a left hip replacement. The resident was admitted into the facility on 6/17/22. The facility investigation of the missing Percocet was started on 6/17/22 and indicated the following: A telephone interview, dated 6/17/22 and indicated the following: A telephone interview, dated 6/17/22 and indicated the following: A telephone interview, dated 6/17/22 and indicated the form the resident's family. A Narcotic Count Record was initiated so the Percocet and another non-narcotic medication was received from the resident's family. A Narcotic Count Record was initiated as other of Percocet was last seen by her on 6/10/22 at the end of her shift. (Scheduled for day and evening shift). She had notified the resident's family and asked them to come to the facility to sign some consents and to also pick the medication up. She was informed by the family they would visit the facility, "in the next few days".	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835 NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC IDENTIFICATION NUMBER OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC IDENTIFICATION OF CROWN POINT LLC IDENTIFICATION OF PROVIDER OR SUPPLIER TAG SUMMARY STATEMENT OF DEFICIENCIE PRECILI ATORY OR LSC IDENTIFYING INFORMATION In Addition Cart. When the resident was being discharged from the facility, the bottle of Percocet was unable to be located. Resident 2's record was reviewed on 9/6/22 at 4:36 p.m. The diagnoses included, but were not limited to, a left hip replacement. The resident was admitted into the facility on 6/17/22. The facility investigation of the missing Percocet was started on 6/17/22 and discharged from the facility on 6/17/22. The facility investigation of the missing Percocet was started on 6/17/22 and discharged from the resident's family. A Narcotic Count Record was initiated so the Percocet and another non-narcotic medication was received from the resident's family. A Narcotic Count Record was initiated so the Percocet pills would be counted each shift. A hand-written and signed statement from Nurse 3, dated 6/17/22, indicated the bottle of Percocet was last seen by her on 6/10/22 at the end of her shift, (Scheduled for day and evening shift). She had notified the resident's family and asked them to come to the facility to sign some consents and to also pick the medication up. She was informed by the family they would visit the facility, "in the ID PROVIDER INT. TATE TO CROWN POINT, IN 483037 ID PROVIDER IN 48307 ID PROVIDER IN 48307 ID PROVIDER IN 48307	CENTERS FOI	TERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE TAG REGULATORY OR LSE DIENTEPHYIN INFORMATION I blad given it to the nurse. The nurse placed the Percocet bottle in the locked box on the Medication Cart. When the resident was being discharged from the facility, the bottle of Percocet was unable to be located. Resident 2's record was reviewed on 9/6/22 at 4:36 p.m. The diagnoses included, but were not limited to, a left hip replacement. The resident was admitted into the facility on 6/17/22 and discharged from the facility on 6/17/22 and indicated the following: The facility investigation of the missing Percocet was started on 6/17/22 and indicated the following: A telephone interview, dated 6/17/22 at 5:10 p.m. with Nurse 1 indicated a bottle of Percocet and another non-narrotic medication was received from the resident's family. A Narcotic Count Record was initiated so the Percocet pills would be counted each shift. A hand-written and signed statement from Nurse 3, dated 6/17/22, indicated the bottle of Percocet was last seen by her on 6/10/22 at the end of her shift. (Scheduled for day and evening shift). She had notified the resident's family and asked them to come to the facility to sign some consents and to also pick the medication up. She was informed by the family they would visit the facility, "in the next few days". SURJ PREFIX TAG DRESES, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307 SAINING SAINING STREET CROWN POINT, IN 46307 TAG SURJ PROVIDERS PLANOT CERRIFOTO TO THE PROPAGEMATE CROWN POINT, IN 46307 COMPLETION TAG PREFIX TAG ID PREFIX TAG PREFI	NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC (X5) ID SWING WINDARY STATEMENT OF DEFICIENCIE (REGULATORY OR LSC IDESTIFYING INTOMATION had given it to the nurse. The nurse placed the Percocet bottle in the locked box on the Medication Cart. When the resident was being discharged from the facility, the bottle of Percocet was unable to be located. Resident 2's record was reviewed on 9/6/22 at 4:36 p.m. The diagnoses included, but were not limited to, a left hip replacement. The resident was admitted into the facility on 6/17/22 and discharged from the facility on 6/17/22 and discharged from the facility on 6/17/22 and indicated the following: A telephone interview, dated 6/17/22 at 5:10 p.m. with Nurse 1 indicated a bottle of Percocet was last seen by her on 6/10/22 at the end of her shift. (Schedulade for day and exening shift). She had notified the resident's family and asked them to come to the facility to sign some consents and to also pick the medication up. She was informed by the family they would visit the facility, in the next few days." A telephone interview with Nurse 2 on 6/17/22 at 5:28 p.m., indicated she had worked the night shift (11 p.m. to 7 a.m.) on 6/11/22 and only the Xarelto (blood thinner) was in the lock box. She had	STATEMEN	CATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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SYMPHONY OF CROWN POINT LLC (X3) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG PROVIDERS PLANOT CORRECTION COMPLETION DATE **NURSE 4, 5, and 6 were interviewed with no findings. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All Guests in the facility have the potential to be affected by the same alleged deficient practice. All State Reportable Incidents reported since June were reviewed to ensure investigations were complete. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Education was provided to DON and Assistant Administrator to ensure all steps of investigations are completed. COMPLETION DATE **OMPLETION DATE **OMPLETION DATE **OMPLETION DATE **OMPLETION DATE **OMPLETION DATE **Nurse 4, 5, and 6 were interviewed with no findings. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - All Guests in the facility have the potential to be affected by the same alleged deficient practice. All State Reportable Incidents reported since June were reviewed to ensure investigations were complete. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Education was provided to DON and Assistant Administrator to ensure all steps of investigations are completed according to policy. Administrator will audit all monthly State Reportable nonemer the resident's family. A Narcotic Count and the reviewed with no findings. How will you identify ther residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - All State Reportable incients reported since June will be taken.	CROWN POINT, IN 46307 CROWN POINT LLC	NAME OF I	PROVIDER OR SUPPLIER	₹						
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	(11 p.m. to 7 a.m.) on 6/11/22 and only the Xarelto (blood thinner) was in the lock box. She had by the Quality Assurance committee that further monitoring		-					ned		
	(blood thinner) was in the lock box. She had committee that further monitoring		-	_						
				-				ring		
								-		
	narcotic lock box on the Medication Cart. The Date of compliance: Sept 20, 2022		-							

bottle of Percocet was not in the lock box.

PRINTED: 09/23/2022 FORM APPROVED OMB NO. 0938-039

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	
155835		155835	B. W	B. WING 09/07/2022			/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			MAIN STREET		
SAMDHU	NY OF CROWN P	OINT LLC			N POINT, IN 46307		
STIVIFITO	- CROWN P	OINT LLO	_	CINOWI			
(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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		signed statement from Nurse 7					
		y and evening shift), dated					
		he resident's family had been in					
		uested the medication from the					
	I	e unable to locate the Percocet.					
		ged there were prescription					
		oox, though was unable to					
	recall if those were	the resident's medications.					
	D						
		sing Schedules for 6/10/22 and					
		Nurse 4, Nurse 5, and Nurse 6					
		C-Unit from 11 p.m. on 6/10/22					
	through 11 p.m. on	6/11/22.					
	D ((1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
	Drug testing had been completed as part of the investigation. Nurse 4 and Nurse 6 had not had a drug test completed.						
	drug test completed	ı.					
	A Police Report da	ated 6/17/22, indicated the					
	_	n able to determine where the					
	1	cord for the Percocet was and					
		from the Narcotic Count Log.					
		Ale 1 marsure Count Dog.					
	During an interviev	v on 9/7/22 at 10:10 a.m., the					
	_	g indicated Nurses 4, 5, and 6					
		iewed. She indicated she					
		nurses who had been					
		dication Cart in which the					
	1 -	en stored, though the					
		have left the keys with the					
		ed on the C-Unit when they					
	left the floor on bre						
	A facility narcotic	policy, dated 3/2022 and					
		Assistant Administrator as					
	current, indicated th	ne narcotics were to be					
	counted at the begin	nning and end of each shift by					
		o nurses were to be the					
		oing nurses. If a discrepancy					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SNES11 Facility ID: 013452

If continuation sheet Page 4 of 6

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

PRINTED: 09/23/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 09/07/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	A facility abuse polifrom the Assistant A indicated misappropwas to be reported to immediately. The appropriate the control of	icy, dated 9/2016, and received Administrator as current, oriation of a resident's property to the Administrator oppointed investigator would the may have had direct						
R 0000	3.1-28(d)							
Bldg. 00	Complaints IN0038 included the Investig Complaint IN00384 Complaint IN00388 deficiencies related Complaint IN00389 deficiencies related Complaint IN00384 lack of evidence. Survey dates: Septer Facility number: 01 Residential Census: Symphony of Crown	844 - Substantiated. No to the allegations are cited. 557 - Substantiated. No to the allegations are cited. 855 - Unsubstantiated due to mber 6 & 7, 2022 3452 25 In Point was found to be in 0 IAC 16.2-5 in regard to the idential Complaints	R 0000	Symphony of Crown Point Pleaccept the following as the facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only it response to the regulatory requirement.	an y the			

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

PRINTED: 09/23/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(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 COMPL CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review com	pleted on 9/8/22.					

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