

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

PRINTED: 08/04/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2023	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Nursing Home Complaints IN00409243 and IN00409334. This visit included the Investigation of Residential Complaints IN00411764 and IN00411793. Complaint IN00409243 - No deficiencies related to the allegations are cited. Complaint IN00409334 - No deficiencies related to the allegations are cited. Complaint IN00411764 - No deficiencies related to the allegations are cited. Complaint IN00411793 - No deficiencies related to the allegations are cited. Survey dates: August 1 and 2, 2023 Facility number: 013452 Provider number: 155835 AIM number: 201299290 Census Bed Type: SNF/NF: 5 SNF: 55 Residential: 29 Total: 89 Census Payor Type: Medicare: 31 Medicaid: 3 Other: 26 Total: 60 Symphony of Crown Point was found to be in compliance with 42 CFR Part 483 Subpart B and			F 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2023
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 000	Continued From page 1 410 IAC 16.2-3.1 in regard to the Investigation of Nursing Home Complaints IN00409243 and IN00409334. Quality review completed on 8/3/23.	F 000			