STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/04/2023	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		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: 05/04/23 Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73		E 00	000			
	the survey, the cens						
E 0006 SS=F Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a) 483.475(a)(1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2), §418.113(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2), §485.625(a)(1)-(2), §485.625(a)(1)-(2), (2), (2), (2), (2), (2), (2), (2),	npleted on 05/08/23 , 416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2), , 483.73(a)(1)-(2), 484.102(a))(1)-(2), 485.68(a)(1)-(2), , 485.920(a)(1)-(2), , 491.12(a)(1)-(2), 494.62(a) I Hazards Risk Assessment), §416.54(a)(1)-(2),), §441.184(a)(1)-(2), , §483.475(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),), §486.360(a)(1)-(2),					

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

TITLE (X6) DATE

Kathy Jones Interim Administrator 06/21/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155845	B. W	ING		05/04/	/2023
	PROVIDER OR SUPPLIER S LOVING CARE H			700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	§491.12(a)(1)-(2),	§494.62(a)(1)-(2)					
	[(a) Emergency Pl develop and main preparedness plan and updated at lea must do the follow (1) Be based on a facility-based and assessment, utiliz approach.* (2) Include strategemergency events assessment. * [For Hospices at Plan. The Hospices maintain an emergency every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategements.	lan. The [facility] must tain an emergency in that must be reviewed, ast every 2 years. The plan ving:] and include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk at §418.113(a):] Emergency is must develop and gency preparedness plan ewed, and updated at least is plan must do the and include a documented, community-based risk					
	assessment, inclu	ding the management of					
	· ·	s of power failures, natural er emergencies that would					
	· ·	's ability to provide care.					
	develop and main preparedness plar	s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. The plan must					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI B. WING	ING		COMPL	
		155845	B. WING			05/04/	12023
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD 1ST AVE		
SIMMON	IS LOVING CARE H	HEALTH FACILITY			N 46407		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION and include a documented,	17	AG	DEFICIENCE		DATE
	` '	community-based risk					
	assessment, utiliz						
	approach, including missing residents.						
		gies for addressing					
	emergency events	s identified by the risk					
	assessment.						
	*[For ICF/IIDs at §	3483.475(a):] Emergency					
		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 a	nd include a documented,					
	facility-based and	community-based risk					
	assessment, utiliz	ing an all-hazards					
	approach, includir	-					
		gies for addressing					
		s identified by the risk					
	assessment.		F 0006		4 10/1-4	911 1	06/02/2022
		view and interview, the facility n Emergency Preparedness	E 0006	'	What corrective action(s) with a second		06/23/2023
		s (1) based on and includes a			accomplished for those reside found to have been affected b		
	1 1	y-based and community-based			deficient practice;	y u i C	
		lizing an all-hazards approach,			No residents were found to b	e e	
		esidents and (2) included			affected by the deficient	-	
		ssing emergency events			practice; however, all reside	nts	
		k assessment in accordance			had the potential to be		
	with 42 CFR 483.73	3(a) (1) and 42 CFR 483.73(a) (2).			affected. The risk assessme	nt	
	This deficient pract	ice could affect all occupants.			was completed by the QA	_	
	Findings include:				committee on 6/21/2023 usin the Indiana LTC form "hazard	-	
	-				vulnerability".	-	
		eview with the Director of			2. how other residents having		
		05/04/23 between 09:18 a.m.			potential to be affected by the		
		documentation could be found			same deficient practice will be		
		ented facility-based and			identified and what corrective		
		isk assessment utilizing an			action(s) will be taken;		
I	I all-hazards approac	h. Based on interview at the	1		All residents were identified	as	I

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	OF CORRECTION	IDENTIFICATION NUMBER 155845	A. BUILDING B. WING	JNSTRUCTION 	COMP	LETED 1/2023
	ROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP 21ST AVE IN 46407	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	time of record revie has a documented ri Emergency Prepared be located at the time	w, the DON stated the facility ask assessment that is with the dness Plan, but was unable to be of the survey.	TAG	being potentially affethe deficient practice. Hazard Vulnerability Assessment was platemergency prepared binder and reviewed team on 6/21/2023. 3. what measures wiplace and what syste will be made to ensur deficient practice doe The custodians and administration were by the interim adminincluding the placen risk assessment as need to update it with changes or at least of years. The administror designee will ensure the Hazard Vulnerab Assessment is locate emergency prepared binder at the nurse's 4. how the corrective be monitored to ensure deficient practice will i.e., what quality assure program will be put in The Administrator of will conduct a month for 6 months to ensure Risk Assessment could be located in the empreparedness binder nurse's station. The Administrator will preparedness will preparedness binder the station of the station. The Administrator will preparedness binder the station of the station of the station of the station of the station. The Administrator will preparedness binder the station of	ected by e. The Risk aced in the dness I by the QA Ill be put into mic changes re that the es not recur; educated histrator ment of the well as the th any every 2 crator and ure that hillity Risk red in the dness s station e action(s) will re the not recur, urance hto place; and r designee hly audit ure that the entinues to ergency r at the	DATE
				findings to the QA c	ommittee	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUILDING COM			SURVEY LETED J/2023		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	403.748(b)(4), 416 441.184(b)(4), 485 483.73(b)(4), 485 485.727(b)(2), 486 494.62(b)(3) Policies/Procedure §403.748(b)(4), §4 (i), §441.184(b)(4) (4), §483.73(b)(4), (2), §485.625(b)(4) §485.920(b)(3), §4 (b) Policies and primust develop and preparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and unique and preparedness polition in the policible reviewed and unique and preparedness polition. The policible reviewed and unique and preparedness polition. The policible reviewed and unique and preparedness polition. The politic be reviewed and unique and preparedness polition. The politic beautiful properties and preparedness politic paragraph (a)(1) of communication plasection. The politic beautiful properties and preparedness politic paragraph (a)(1) of communication plasection. The politic paragraph (a)(1) of communication plasection plas	6.54(b)(3), 418.113(b)(6)(i), 2.15(b)(4), 483.475(b)(4), 625(b)(4), 485.68(b)(2), 5.920(b)(3), 491.12(b)(2), es for Sheltering in Place 416.54(b)(3), §418.113(b)(6) 6, §460.84(b)(5), §482.15(b) 6, §483.475(b)(4), §485.68(b) 6), §485.727(b)(2), 491.12(b)(2), §494.62(b)(3). Focedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at 6f this section, and the ean at paragraph (c) of this sies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must ring:]			each month to ensure continued compliance.	ROPRIATE	
	Policies and proce (6) The following a for hospice-operat only. The policies address the follow	are additional requirements red inpatient care facilities and procedures must					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUILDING B. WING			COMPLETED 05/04/2023	
	PROVIDER OR SUPPLIER S LOVING CARE H			700 E 2	ADDRESS, CITY, STATE, ZIP COD 11ST AVE IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACCROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	hospice employee hospice. Based on record revisited to ensure that documented in eme accordance to 42 Cl practice could impa Findings include: Based on record revisited (DON) on and 11:32 a.m., the place policy designs preparedness plans. time of record revie aforementioned documented to be located.	riew and interview, the facility shelter in place policies were regency preparedness plans in FR 483.475(b)(4). This deficient ct all occupants.	E 00		1. what corrective action(s) wi accomplished for those reside found to have been affected by deficient practice; No residents were found to be affected by the deficient practice; however, all resider had the potential to be affected. The shelter in Place Policy and procedures were reviewed by the QA committed on 6/21/2023 and placed in the emergency preparedness binder at the nurses station. 2. how other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were found to be affected by the deficient practice; however, all resident had the potential to be affected. The shelter in Place Policy and procedures were reviewed by the QA committed on 6/21/2023 and placed in the emergency preparedness binder at the nurses station 3. what measures will be put it place and what systemic chan will be made to ensure that the deficient practice does not recommitted that the deficient practice does not recommitted to the maintenance/custodial staff were educated on the requirement to ensure the	nts y the e nts	06/23/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 1/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE		
				facility has a Shelter In Policy and Procedure their emergency prepared binder by the interim administrator on 6/21/24. how the corrective as be monitored to ensure deficient practice will not i.e., what quality assurate program will be put into the administrator or dwill conduct monthly a 6 months as part of the environmental rounds ensure the Shelter In Policy and Procedures continue to be placed emergency prepared binder. The Administrator present the findings or rounds to the QA commonthly to ensure corcompliance.	as part of aredness 2023. action(s) will the ot recur, ance o place; and designee audits for e monthly to Place s in the ess rator will f the mittee			
K 0000								
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/04 Facility Number: 0 Provider Number: 100 At this Life Safety 6	00368 155845	K 0000					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(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 APPROPRIATE			
	with Requirements and Medicaid, 42 Cl Safety from Fire an National Fire Protect Life Safety Code (I Health Care Occupation This one-story facil built in 1967, was described to the construction and was facility has a monitor smoke detection in to the corridor. The power protection. The power protection. The provided with batter The facility has the census of 20 at the total All areas accessible providing facility seems.	for Participation in Medicare FR Subpart 483.90(a), Life d the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. ity with a partial basement, etermined to be of Type II (111) as fully sprinklered. The ored fire alarm system with the corridors and spaces open facility has no emergency wenty resident rooms were ry operated smoke detectors. capacity for 46 and had a					
K 0291 SS=F Bldg. 01		ng g of at least 1-1/2-hour ed automatically in					
	1. Based on records facility failed to enslights were tested mequires functional monthly, with a min maximum of 5 weethan 30 seconds and inspections and test for inspection by the	review and interview, the sure 10 of 10 battery backup nonthly. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less d (5) Written records of visual s shall be kept by the owner e authority having efficient practice could affect all	K 0291	what corrective action(s) will accomplished for those resident found to have been affected by the deficient practice; No residents were affected by this deficient practice. The 2 defective battery-operated emergency lights were replaced by 5/11/2023. April documentation was noted on	nts y		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED
		155845	B. Wl	inG		05/04/2023
NAME OF F	PROVIDER OR SUPPLIER	``````````````````````````````````````			ADDRESS, CITY, STATE, ZIP COD	
					21ST AVE	
SIMMON	S LOVING CARE F	HEALTH FACILITY		GARY,	IN 46407	
(X4) ID		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)	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
		when work is needed in the n during a power outage.			the inspection logs immediately when the	
	transfer switch foor	if during a power outage.			Maintenance Director was	
	Findings include:				notified.	
		view during a tour of the			2. how other residents having	g the
	facility with the Director of Nursing (DON) on				potential to be affected by the	
		9:18 a.m., documentation of a			same deficient practice will be	
		test for the battery powered			identified and what corrective	
		s provided, but there was no			action(s) will be taken;	
		ed that indicated a monthly			All residents had the potenti	
	30-second inspection for April 2023 was conducted. Based on an interview at the time of				to be affected by the deficien	
	record review, the DON stated they were in touch				practice; however, none wer affected. The 2	e
	· · · · · · · · · · · · · · · · · · ·	ersonnel and was told the			battery-operated emergency	,
		one, but did not get signed off			lights were replaced by	
	on the inspection lo				5/11/2023.	
	_					
	_	viewed with the DON during			3. what measures will be put	
	the exit conference.				place and what systemic char	_
	2110(1)				will be made to ensure that t	
	3.1-19(b)				deficient practice does not rec	cur;
	2 Rosed on observe	ation and interview, the facility			Maintenance/custodial staff were educated by the interin	
		f 10 battery powered			administrator on 6/21/2023	'
		ere maintained in accordance			related to monthly	
		C 7.9.2.6 states battery operated			documentation of all	
		nall use only reliable types of			battery-operated emergency	,
	1	ies provided with suitable			lighting that must be routine	
		ining them in properly charged			checked per the NFPA 101	
		s used in such lights or units			regulations. The education	
		or their intended use and shall			includes proper documentat	
		70 National Electric Code. LSC			and record keeping to ensur	e
		nergency lighting system shall			life safety documentation is	
		sly in operation or shall be			available upon request.	
		automatic operation without			4 how the earnestive settler /-	N will
		n. This deficient practice could y 20 residents and staff.			4. how the corrective action(s be monitored to ensure the	s) will
	arrect approximater	y 20 residents and start.			deficient practice will not recu	r
	Findings include:				i e what quality assurance	1,

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155845	B. WI	NG		05/04/	/2023
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
CINANAONI		IFALTILEACH ITV		l	21ST AVE		
SIMIMON	S LOVING CARE H	IEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY S	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
					program will be put into place		
	Based on observation	on with the Director of			The administrator or designe	e	
	Nursing (DON) on 05/04/23 between 11:50 a.m.				will audit the life safety binde	∍r	
and 12:55 p.m., the battery-operated emergency				documentation monthly for 6	;		
	lights in the dining	area next to the kitchen			months to ensure the routine	;	
	entrance/exit doors	did not work when tested.			monthly inspections of the 1	0	
	Based on interview	at the time of the			battery-operated Emergency	ļ	
	observations, the Do	ON agreed the			lighting are documented time	∍ly	
		ergency lights failed to			and accurately. The	ļ	
function when its respective test button was pushed and stated the emergency lights will be replaced later this week.				administrator will present			
				findings of these audits to th	е		
				QA committee monthly to			
				ensure continued compliance	е		
	The findings were reviewed with the DON during				for at least 6 months.		
	the exit conference.						
	2.1.10(1-)						
	3.1-19(b)						
K 0300	NFPA 101						
SS=C	Protection - Other						
Bldg. 01	Protection - Other						
	List in the REMAR	RKS section any LSC					
	Section 18.3 and	19.3 Protection					
	requirements that	are not addressed by the					
	provided K-tags, b	out are deficient. This				ļ	
	information, along	with the applicable Life					
	Safety Code or NF	PA standard citation,					
	should be included	d on Form CMS-2567.					
	Based on record rev	riew, interview, and	K 0	300	1. what corrective action(s) wil	l be	06/23/2023
	observation, the fac	ility failed to ensure			accomplished for those reside	nts	
		he preventative maintenance			found to have been affected by	y the	
	-	operated smoke alarms in			deficient practice;	ļ	
		complete. NFPA 101 in			No residents were found to I	be	
		ing life safety features obvious			affected by the deficient	ļ	
		required by the Code, shall be			practice; however, all	ļ	
		72, 29.10 Maintenance and			residents, staff and visitors h	nad	
Tests. Fire-warning equipment shall be maintained					the potential to be affected.	ļ	
		ance with the manufacturer's			The smoke detectors were	ļ	
	published instructio	ns and per the requirements			retested in May and logged	ļ	
	of Chapter 14, NFP	A 72. 14.2.1.1.1 Inspection.	1		accordingly on the log sheet	9	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/04/2023 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE testing, and maintenance programs shall satisfy in addition to the April 2023 the requirements of this Code and conform to the documentation by 5/11/2023 by equipment manufacturer's published instructions. the maintenance director when This deficient practice could affect all residents, made aware. staff, and visitors. 2. how other residents having the Findings include: potential to be affected by the same deficient practice will be Based on records review with the Director of identified and what corrective Nursing (DON) on 05/04/23 between 09:18 a.m. action(s) will be taken; and 11:32 a.m., documentation for monthly No residents were found to be inspections for all battery-operated smoke affected by the deficient detectors was able to be presented during the practice; however, all survey, but a monthly inspection for April 2023 residents, staff and visitors had was not documented. Based on interview at the the potential to be affected. time of review, the DON stated she was able The smoke detectors were contact maintenance personnel who stated the retested in May and logged checks were done, but did not document the accordingly on the log sheets checks on the monthly inspection sheets. in addition to the April 2023 documentation by 5/11/2023 by Findings were discussed with the DON at the exit the maintenance director when conference. made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the

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deficient practice will not recur, i.e., what quality assurance

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COM	e survey pleted 4/2023	
	ROVIDER OR SUPPLIER S LOVING CARE H		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(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 (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire extii accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas t REMARKS. 19.3.2.1, 19.3.5.9 Area	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of hat are deficient in		program will be put The administrator will audit the life sa documentation mo months to ensure t monthly testing of battery-operated sa detectors are docu timely. The admini present findings of to the QA committe to ensure continue compliance for at I 6 months.	or designee afety binder anthly for 6 the routine all moke mented istrator will f these audits ee monthly		
	Separation	N/A					

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPI		
		155845	B. W	ING		05/04	/2023	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
	Г						T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION -Fired Heater Rooms		TAG	DEFICIENC!)		DATE	
	b. Laundries (larger than 100 square feet)c. Repair, Maintenance, and Paint Shopsd. Soiled Linen Rooms (exceeding 64							
	gallons)	Joins (exceeding 04						
	e. Trash Collectio	n Rooms						
	(exceeding 64 gal							
		orage Rooms/Spaces						
	(over 50 square fe							
		classified as Severe						
	Hazard - see K32							
	Based on observation	on and interview, the facility	K 0	321	1. what corrective action(s) w	ill be	06/23/2023	
	failed to ensure the	corridor doors to 1 of 4			accomplished for those reside	nts		
	hazardous rooms w	ere provided with a			found to have been affected b	y the		
	_	which would cause the door to			deficient practice;			
		and latch into the door frame.			No residents were found to	be		
	_	ice could affect approximately			affected by the deficient			
	5 staff and an unkn	own amount of residents.			practice; however, all reside	nts		
					could have been affected.			
	Findings include:				New spring hinges were			
	D 1 1 4	1			purchased and installed by			
		ons during a tour of the facility f Nursing (DON) on 05/04/23			6/5/2023 to ensure the storag	je		
		and 12:55 p.m., the corridor			room corridor door met the			
		room in the basement across			hazardous area Enclosure guidelines.			
		ry room did not self-close. The			2. how other residents having	ı the		
		proximately 60 square feet, had			potential to be affected by the			
		boxes of PPE and patient care			same deficient practice will be			
		erview at the time of			identified and what corrective			
		ON acknowledged the amount			action(s) will be taken;			
		erial within the room; that room			A round of all potential area	s	1	
	was larger 50 squar	re feet; and the door did not			needing self closure		1	
	self close				mechanism was conducted b	ру		
					the interim administrator on			
		viewed with the DON during			6/21/2023 and list given to			
	the exit conference.				ownership in QA meeting.			
					More spring hinges will be			
	3.1-19(b)				ordered for other doors			
					needing a self-closure			
					mechanism to be installed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 05/04/2023	
	ROVIDER OR SUPPLIER S LOVING CARE H		700 E 2	21ST AVE IN 46407		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	upon delivery. 3. what measures will be put in place and what systemic channels will be made to ensure that the deficient practice does not reconstructed. Administration and maintenance/custodial staff were educated on 6/21/2023 regarding the use of self closure mechanisms in hazardous areas. New maintenance staff will be educated as well upon hire during emergency preparedness rounds with administrator or designee. 4. how the corrective action(so be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The maintenance director or designee will conduct monthe checks on doors leading to hazardous areas and supply storage closets and document according. The administration or designee will check monthed documentation to ensure it is completed timely for 6 monther Findings will be presented to the QA committee monthly to ensure continued compliance.	nges e e e e e ur;) will f, nt or hly s hs. o o	
K 0353 SS=F Bldg. 01	Sprinkler System	- Maintenance and Testing - Maintenance and Testing er and standpipe systems				

are inspected, tested, and maintained in

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL			LETED
155845 B		B. W	B. WING 05/04/2023			/2023	
				CERTE	ADDRESS SITU STATE TIP SOP		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
CIMMONIO I OVINIO CARE LIEALTI LEACULITY				700 E 21ST AVE			
SIMIMON	SIMMONS LOVING CARE HEALTH FACILITY			GARY,	IN 46407		
(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 APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with I	NFPA 25, Standard for the					
	Inspection, Testin	g, and Maintaining of					
	Water-based Fire	Protection Systems.					
	Records of syster	n design, maintenance,					
	inspection and tes	sting are maintained in a					
	secure location ar	nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	l system test					
	<u></u>						
	c) Water system	supply source					
	Provide in PEMAI	PKS information on					
	Provide in REMARKS information on coverage for any non-required or partial						
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8	-					
		view and interview, the facility	K 0	353	1. what corrective action(s) w	ill he	06/23/2023
		ritten documentation or other	K U	333	accomplished for those reside		00/23/2023
	_	eler system components had			found to have been affected b		
	_	tested for 1 of 4 quarters. LSC			deficient practice;	y iiio	
	_	ny device, equipment or system			No resident found to be		
	_	ance with this Code be			affected; The quarterly		
		rdance with applicable NFPA			sprinkler test was conducted	lon	
		nkler systems shall be properly			5/1/2023 and is scheduled to		
		rdance with NFPA 25, Standard			conducted again before the		
		Testing, and Maintenance of			end of June for quarter 2.		
	-	Protection Systems. NFPA 25,			2. how other residents having	the	
		rds shall be made for all			potential to be affected by the		
	_	nd maintenance of the system			same deficient practice will be		
	_	all be made available to the			identified and what corrective		
	_	risdiction upon request. 4.3.2			action(s) will be taken;		
	, ,	s shall indicate the procedure			All residents were potentiall	V	
	_	spection, test, or maintenance),			affected. The quarterly	•	
		at performed the work, the			sprinkler test was conducted	l on	
	_	e. NFPA 25, 5.2.5 requires that			5/1/2023 with no abnormal		
		evices shall be inspected			findings and is scheduled to	be	
		they are free of physical			conducted again by the end		
		5.3.3.1 requires the mechanical			June to stay on schedule for		
		evices including, but not limited			Q2.		
		ngs, shall be tested quarterly.			3. what measures will be put	into	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/04/2023
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
	S LOVING CARE F SUMMARY S (EACH DEFICIEN REGULATORY OR 5.3.3.2 requires van switch-type waterfle tested semiannually affect all residents, facility. Findings include: Based on review of inspection records v (DON) on 05/04/23 a.m., there was no q inspection report av (January, February si interview at the time acknowledged there documentation avai system had been ins of 2023 and stated t company did not do quarter and was goi inspections during s missed inspection.	BEALTH FACILITY STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION e-type and pressure ow alarm devices shall be . This deficient practice could staff, and visitors in the the quarterly sprinkler system with the Director of Nursing between 09:18 a.m. and 11:32 quarterly sprinkler system ailable for the first quarter and March) of 2023. During an e of record review, the DON	STREET 700 E 2	21ST AVE	(X5) COMPLETION DATE Inges ne cur; nd o or etor e of pon ed ng s. nese s. s) will ur, e; and he at e QA
				as well. Quarterly inspection to be audited for completion monthly for 6 months to incuration June through December inspections. Administrator present findings of monthly audits to the QA committee	n lude will

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			ONIB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	A. BUILDING B. WING		COMPLETED 05/04/2023	
NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD		
		HEALTH FACILITY		21ST AVE . IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROUDENG N. AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				ensure continued compliance through the remainder of the year.		
K 0500	NFPA 101					
SS=C	Building Services	- Other				
Bldg. 01	Building Services					
J		RKS section any LSC				
		19.5 Building Services				
	requirements that	are not addressed by the				
	provided K-tags, I	but are deficient. This				
	information, along with the applicable Life Safety Code or NFPA standard citation,					
		ed on Form CMS-2567.				
		view, observation, and	K 0500	1. what corrective action(s) will b	e 06/23/2023	
		ity failed to ensure 1 of 1 water		accomplished for those residents		
		inspection certificates to eaters were in safe operating		found to have been affected by the	e	
		101, Section 19.1.1.3.1 requires		deficient practice; No residents were found to be		
		to be designed constructed,		affected by the deficient		
		erated to minimize the		practice; The facility is working		
	_	emergency requiring the		with the insurance company		
		pants. This deficient practice		and other appropriate parties		
	could affect approximately 10 staff and an unknown number of residents.			to schedule the inspections and		
				gain the certificates as soon as		
				inspected. Insurance company		
	Findings include:			was contacted and they will		
		2.7.2.1		make arrangements for the		
		on during a tour of the facility		boiler inspections then		
		f Nursing (DON) on 05/04/23		ownership can renew the		
		and 12:55 p.m., one water basement did not have a		certification online.		
		n the water heater. Based on		how other residents having the		
	•	veen 09:18 a.m. and 11:32 a.m., a		potential to be affected by the	'	
		etion certificate was available		same deficient practice will be		
	•	expiration date was dated		identified and what corrective		
		interview at the time of record		action(s) will be taken;		
		ation, the DON stated that the		No residents were found to be		

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insurance company used to do inspections, but

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affected by the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			· /	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUILDING <u>01</u> COMPLETED B. WING 05/04/2023			COMPLETED 05/04/2023		
		100040				03/04/2023	
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
SIMMON	IS LOVING CARE H	ΙΕΔΙ ΤΗ ΕΔΟΙΙ ΙΤΥ			1ST AVE IN 46407		
	1	-			II		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG		ed inspections and was unable	<u>'</u>	IAG	practice; however, all resider		
		cheduled before the indicated			had the potential to be		
	expiration date.				affected. The facility is		
					working with the insurance		
	_	ewed with the DON at exit			company and other		
	conference.				appropriate parties to sched		
	3.1-19(b)				the inspections and gain the certificates as soon as		
	3.1-17(0)				inspected. Insurance compa	inv	
					was contacted and they will		
					make arrangements for the		
					boiler inspections then		
					ownership can renew the		
					certification online.		
					3. what measures will be put i	into	
					place and what systemic chan		
					will be made to ensure that the	~	
					deficient practice does not rec	ur;	
					Owner and maintenance sta	ff	
					educated on the process for		
					water heater/boiler inspectio on or before 6/21/2023 by the		
					interim administrator. The		
					owner will continue to be in		
					contact with the insurance		
					company daily with follow up)	
					requested by interim		
					administrator to ensure scheduling of the inspection		
					occurs as soon as possible.		
					4. how the corrective action(s) will	
					be monitored to ensure the		
					deficient practice will not recur	,	
					i.e., what quality assurance		
					program will be put into place	at	
					Administrator will follow up least weekly ongoing until	αι	
					inspection completed and		

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	PROVIDER OR SUPPLIE	R HEALTH FACILITY	700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				certificates placed in life safe binder. Once the inspection completed, the administrator will include the water heater inspections documentation of the monthly environmental round audit form. The administrator will present findings to the QA committed monthly for 6 months to ensist compliance. The inspection due date will be placed also the inspection log tool notify the maintenance director whe each inspection is due next.	is r on e ure n on ving en
K 0511 SS=D Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided 18.5.1.1, 19.5.1.1 Based on observati failed to ensure ele Closet was protecte Article 406.5 (F) E shall be enclosed se	d Electric gas or related gas piping PA 54, National Fuel Gas wiring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 on and interview, the facility actrical wiring in 1 of 1 Janitor's ed. NFPA 70, 2011 Edition. Exposed Terminals, Receptacles to that live wiring terminals are tact. This deficient practice	K 0511	1. what corrective action(s) we accomplished for those reside found to have been affected by deficient practice; No residents were found to be affected by the deficient practice. A new light fixture was purchased and installed immediately on or before 5/1	ents by the De 1
	with the Director o 11:50 a.m. and 12:	on during a tour of the facility of Nursing on 05/04/23 between 55 p.m., in the Janitor closet next No had a broken light fixture.		 by the maintenance director. how other residents having potential to be affected by the same deficient practice will be 	; the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUIL	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/04/2023	
	PROVIDER OR SUPPLIE	R HEALTH FACILITY		700 E 2	DDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407	•	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	The light bulb was wiring exposed with the mount used to time of observation unaware of the def process to repair the	hanging off of the wall and had ring coming from the wall where be. Based on interview at the 1, the DON stated they were iciency and would start the		IAU	identified and what corrective action(s) will be taken; No residents were found to be affected by the deficient practice; An audit of the faci was conducted on 6/22/2023 maintenance and interim administrator looking for exposed wiring and other electrical hazards. 3. what measures will be put place and what systemic chan will be made to ensure that the deficient practice does not recommend to ensure all areas are safe if staff and residents. All staff will be educated by 6/23/2023 to ensure work orders are available for all staff to fill ou and communicate the need if an item to be fixed timely. Maintenance Director will monitor exposed wiring monthly during environment rounds. 4. how the corrective action(see the monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. Administrator or designee we conduct monthly audits of the required documentation in liting afety binder for 6 months to the conduct for the conduct monthly audits of the required documentation in liting afety binder for 6 months to	into ages e cur; ne ing or 3 at for ill ne fe	DATE

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/04/2023
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700	ET ADDRESS, CITY, STATE, ZIP COD E 21ST AVE Y, IN 46407	
(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
				include work orders and time completion especially when causing a risk to residents a staff. Work orders will be discussed with owners daily as needed. Administrator widiscuss findings in QA meet monthly for 6 months to ens continued compliance.	nd or ill ing

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