PRINTED:	11/05/2021
FORM AP	PROVED
OMB NO. (	)938-0391

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION     IDENTIFICATION NUMBER: 156845     A. BUILING WING     00     COM 08/0       NAME OF PROVIDER OR SUPPLIER     STREET ADDRUSS, CITY, STATE, ZIP CODE TO E 21ST AVE GARY, IN 46407     STREET ADDRUSS, CITY, STATE, ZIP CODE TO E 21ST AVE GARY, IN 46407     STREET ADDRUSS, CITY, STATE, ZIP CODE TO E 21ST AVE GARY, IN 46407     STREET ADDRUSS, CITY, STATE, ZIP CODE TO E 21ST AVE GARY, IN 46407       (X4) ID PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES RECULATORY OR LSC IDENTIFYING INFORMATION     ID PROVIDER OR SUMMER AND COMBINING PRETX TAG     PROVIDER OR SUPPLIER TAG     ID PROVIDER OR SUPPLIER TAG     PROVIDER OR SUPPLIER DEFINITION PRETX TAG     PROVIDER OR SUPPLIER TAG	ENTERS FOR M	MEDICARE & MEDIC	CAID SERVICES			(	OMB NO. 0938-0391	
155845     B. WING     2000       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE TOO E 21ST AVE GARY, IN 46407       (X9 ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     ID PREFIX       F0000     Bidg, 00     This visit was for the Investigation of Complaint IN00359414.     F0000       Complaint IN00359414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F626.     F0000       Survey date: August 9, 2021     Facility number: 100275220       Census bed type: SNFNE 21 Total: 21     Census payor type: Medicare: 1 Medicare: 1	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA'	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SIMMONS LOVING CARE HEALTH FACILITY     700 E 21ST AVE CARY, IN 46407       (X4) ID PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY IPUL. TAG     IP       BIdg.00     This visit was for the Investigation of Complaint IN00359414.     IP       Complaint IN00359414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F626.     F 0000       Survey date: August 9, 2021     Facility number: 100275220       Census bed type: SNF/MF: 21 Total: 21     Census bed type: Medicate: 1 Medicate: 1 Medicate	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COM	COMPLETED		
NAME OF PROVIDER OF SUPLER     700 E 21ST AVE GARY, IN 46407       IX41ID     SUMMARY STATEMENT OF DEFICIENCIES       IX41     D       PREFIX     D       REGULATORY OR LSC IDENTIFYING INFORMATION     TAG       BIdg.00     This visit was for the Investigation of Complaint IN00359414.     F 0000       Complaint IN00359414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F626.     F 0000       Survey date: August 9, 2021     Facility number: 000368 Provider number: 155845 AIM number: 100275220       Census bed type: Medicare: 1 Medicare: 1 Medicaid: 18 Other: 2 Total: 21     Census payor type: Medicare: 1 Medicaid: 18 Other: 2 Total: 21       F 0026     483.15(e)(1)(2)       F 0027     SS=D Permitting Residents to Return to Facility S483.15(e)(1)(2)       F 0276     483.15(e)(1)(2)       F 0276     Formitting residents to return to facility. Afacility must establish and follow a written policy on permitting residents to return to facility. A facility must establish and follow a written			155845	B. WING		08/0	09/2021	
PREIX TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION     PREFIX TAG     Component of the appropriate cooss-septements of the appropriate participation       Bldg. 00     This visit was for the Investigation of Complaint IN00359414.     F 0000     F 0000       Complaint IN00359414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F626.     F 0000       Survey date: August 9, 2021     Facility number: 100275220       Census bed type: SNF/NF: 21 Total: 21     Census bed type: SNF/NF: 21 Total: 21       Census payor type: Medicate: 1 Medicate: 18 Other: 2 Total: 21     This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.       Quality review completed on 8/11/21.     F 0626 SS=D Bidg. 00       F 0626 Bidg. 00       F 0626 Bidg. 00	SIMMONS	LOVING CARE H	HEALTH FACILITY	700 E 2 GARY,	21ST AVE	DDE	(X5)	
TAG     TAG     CROSS-REPRESENT TO THE JAPACPRATE       F 0000     This visit was for the Investigation of Complaint IN00359414.     F 0000       Bidg. 00     This visit was for the Investigation of Complaint IN00359414.     F 0000       Complaint IN00359414.     Substantiated. Federal/State deficiencies related to the allegations are cited at F626.     F 0000       Survey date: August 9, 2021     Facility number: 000368 Provider number: 155845 AIM number: 100275220     F 0000       Census bed type: SNF/NF: 21 Total: 21     Census payor type: Medicare: 1 Medicaid: 18 Other: 2 Total: 21     F 0000       F 0026     Hestienery reflects State Findings cited in accordance with 410 IAC 16,2-3.1.     F 0000       F 0826     483.15(e)(1)(2) Permitting Residents to Return to Facility BIdg. 00     Hacility must establish and follow a written policy on permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the     In the stablish and follow a written							COMPLETION	
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Bidg. 00This visit was for the Investigation of Complaint IN00359414.F 0000Complaint IN00359414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F626.FSurvey date: August 9, 2021FFacility number: 000368 Provider number: 155845 AIM number: 100275220FCensus bed type: SNF/NF: 21 Total: 21Census bed type: SNF/NF: 21 Total: 21Census payor type: Medicate: 1 Medicati: 8 Other: 2 Total: 21FDistrict Census payor type: Medicate: 1 Medicate: 1 Medicate: 18 Other: 2 Total: 21This deficiency reflects State Findings cited in accordance with 410 1AC 16.2-3.1.Quality review completed on 8/11/21.F 0626 SS=D Bldg. 00Bldg. 00Premitting Residents to Return to Facility S483.15(e)(1) Permitting residents to return to facility S483.15(e)(1) Permitting residents to return to the policy on permitting residents to return to the		REGULATORY OF	R LSC IDENTIFTING INFORMATION	IAG			DATE	
policy on permitting residents to return to the	Bldg. 00 0626 SS=D Bldg. 00	IN00359414. Complaint IN00359 Federal/State defici allegations are cited Survey date: Augus Facility number: 00 Provider number: 1 AIM number: 1002 Census bed type: SNF/NF: 21 Total: 21 Census payor type: Medicare: 1 Medicaid: 18 Other: 2 Total: 21 This deficiency refi accordance with 41 Quality review con 483.15(e)(1)(2) Permitting Reside §483.15(e)(1) Per	9414 - Substantiated. iencies related to the d at F626. st 9, 2021 00368 55845 275220 lects State Findings cited in 0 IAC 16.2-3.1. npleted on 8/11/21. ents to Return to Facility	F 0000				
Inacliny after they are nospitalized or placed         on therapeutic leave. The policy must         provide for the following.         LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		policy on permittir facility after they a on therapeutic lea	ng residents to return to the are hospitalized or placed ave. The policy must				(X6) DATE	

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

TITLE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 08/09/2021		
	PROVIDER OR SUPPLI	ER HEALTH FACILITY	700 E	T ADDRESS, CITY, STATE, ZIP 21ST AVE 7, IN 46407	CODE	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	therapeutic leave period under the facility to their pr immediately upo bed in a semi-pri (A) Requires the facility; and (B) Is eligible for facility services of nursing facility services (ii) If the facility tr resident who wa expectation of re return to the faci with the requirent they apply to dis §483.15(e)(2) Re distinct part. Wh resident returns (as defined in § 4 permitted to retur particular locatio part in which he a bed is not avait time of return, th option to return to availability of a b Based on record re failed to allow a re after a hospitaliza 1 of 3 residents re discharge. (Resid Finding includes: The closed record on 8/9/2021. Diag limited to, trauma	e exceeds the bed-hold State plan, returns to the evious room if available or in the first availability of a ivate room if the resident- services provided by the Medicare skilled nursing or Medicaid ervices. hat determines that a s transferred with an eturning to the facility, cannot lity, the facility must comply nents of paragraph (c) as charges. eadmission to a composite nen the facility to which a is a composite distinct part 483.5), the resident must be rn to an available bed in the n of the composite distinct or she resided previously. If lable in that location at the e resident must be given the to that location upon the first bed there. eview and interview, the facility tion for a change in condition for viewed for admission/ transfer/	F 0626	<b>F626</b> 1. What corrective at will be accomplished residents found to ha affected by the defici practice. Simmons Loving Car Facility has a policy	l for those ave been ent re Health	10/22/202

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 08/09/2021	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE 21ST AVE	
SIMMON	IS LOVING CARE	HEALTH FACILITY		, IN 46407	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	A Minimum Data	Set Quarterly assessment was		residents in which they can	
		2021. The resident's Cognitive		provide the proper care to meet their optimal needs. Th	
	-	making were intact. No		Q.A. Committee reviewed the	
		ypnotics or Opioid medication		admission policy, notice of	)
		Antipsychotic medications had		transfer/discharge policy whi	ich
		ent D voiced no complaints of		states the following:	
	pain.			Not Permitting Residents to	
	I			<i>Return</i> Not permitting a resider	nt to
	Nurse Practitioner	Medical Visit Notes indicated		return following hospitalization	
	the following:			therapeutic leave requires a	
		orted behavior issues had		facility to meet the requiremen	ts
	-	cidal or homicidal ideations.		for a facility-initiated discharge	as
	Staff reported agit	ation. Resident was alert and		outlined in §483.15(c)(1)(ii). A	
	orientated to perso	on, place and situation.		facility must not discharge a	
	6/23/21 - Residen	t D's behaviors had worsened		resident unless:1. The	
	and he had been agitated and verbally aggressive			discharge or transfer is necessary for the resident's	
	at times. Also disp	played abusive behaviors. Staff		welfare and the facility cannot	
	_	dent was having more agitation.		meet the resident's needs.2.	
		poke with Franciscan Hospital		The resident's health has	
		ity refusal to accept Resident D		improved sufficiently so that th	e
		rgency Room Visit. No		resident no longer needs the	
	changes.			services of the facility.3. The	
				resident's clinical or behaviora	
		hold form or 30 day notice in		status endangers the safety of	
	the resident's recor	ra.		individuals in the facility.4.	The
	When interviewed	on 8/0/21 at 11:20 cm. DN 1		status endangers the health of	
		l on 8/9/21 at 11:30 a.m., RN 1 lent was sent out to a			The
		al. She was informed he was		resident has failed to pay for (	
	·	al. She was informed he was id threatening. The nurse had		have paid under Medicare or	
		blice. The resident had not		Medicaid) his or her stay at the	
	-	ility at this time. Management		facility.6. The facility ceases	; to
		yould not be coming back. RN 1		operate. As noted at	
		ity did not send a 30 day notice		483.15(c)(2)(i)(B), when the	
		h the resident, but did have the		facility transfers or discharges	
	forms available in			resident for the resident's welf or because the resident's need	
		2		cannot be met in the facility, th	
	When interviewed	l on 8/9/21 at 10:00 a.m., the		medical record must contain	č

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	3) DATE SURVEY COMPLETED 08/09/2021
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	700 E 2	address, city, state, zip code 21ST AVE IN 46407	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O Administrative Sta sent to the hospita and aggressive. T was called when th Resident D was re The DON and Ada during survey for Telephone intervia Manager on 08/09 Resident D was ac The resident was a Case Manager ind behaviors on the u discharge back to had contacted the discharge and the Resident D back to	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION aff #1 indicated the resident was I because he was yelling loudly the Director of Nursing (DON) the hospital called here to report turning. ministrator were not available interview. ww with the hospital Case /2021 at 9:50 a.m., indicated limited to their psychiatric unit. evaluated and treated. The icated he had no further nit and was cleared for the facility. The Case Manager facility related to the resident's facility had refused to accept	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) documentation of the specific resident needs that cannot be met, facility attempts to meet those needs, and the service available at the receiving facility meet the needs. Resident decisions to refuse care should not be considered a basis for transfer or discharge unless the refusal poses a risk to the resident's or other individuals' health and/or safety. In situation where a resident's choice to refuse care or treatment poses a risk to the resident's or others' health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and effort by the interdisciplinary team to educate the resident and the representative, as appropriate (See F656, 483.21(b)(1)(ii), Comprehensive Care Plans.)- If unable to resolve situations where a resident's refusal for ca poses a risk to the resident's or others' health or safety, the facil administration, nursing and medical director may wish to convene an ethics meeting, whi includes legal consultation, in order to determine if the facility can meet the resident's needs, of if the resident should be	to DATE

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	MEDICARE & MEDIC					
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	<u>00</u>	COMPLETED	
		155845	B. WING		08/09/2021	
NAME OF P	ROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP CODE		
VAME OF I	KOVIDEK OK SOTTELE	IX.		21ST AVE		
SIMMON	S LOVING CARE	HEALTH FACILITY	GARY,	IN 46407		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOLL D RE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
				facility was able to care for th		
				resident prior to therapeutic l		
				documentation related to the		
				basis for discharge must clea	arly	
				show why the facility can no		
				<i>longer care for the resident.</i> 2. How other residents having	a the	
				potential to be affected by the		
				same deficient practice will b		
				identified and what corrective		
				action will be taken.		
				Residents are admitted and		
				readmitted according to the		
				facility being able to meet the	eir	
				needs.		
				3. What measures will be put		
				place or what systemic change		
				will be made to ensure that the deficient practice does not re		
				dencient practice does not re		
				Residents will be readmitted		
				according to the medical dire	ctor	
				and psy NP recommendation	IS.	
				Local Ombudsman will be		
				consulted for all transfers to		
				ensure proper placement is o		
				and to ensure all rights of the residents are considered.		
				4. Describe who will be the		
				person(s) responsible for		
				implementing and monitoring		
				plan for future compliance wi	th	
				the regulations.		
				The medical director and Ps N.P. will review all applicable	•	
				documentation on residents		
				behavioral issues to ensure t		
				are of no danger to themselv	•	
				other residents and staff prior		
				readmission.		
			1	Medical director and Psy N.F		

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

Event ID: 1WJY11 Facility ID: 000368

If continuation sheet Page 5 of 6

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	F OF HEALTH AND HU R MEDICARE & MEDIC		_			TED: 11/05/2021 RM APPROVED B NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE S COMPL 08/09/	ETED
	PROVIDER OR SUPPLIEF		700 E 2	address, city, state, zip code 21ST AVE IN 46407	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
				review and ensure resident is stable and able to return after behavioral crisis is exhibited. D.O.N. will monitor residents of behavior upon each incident to ensure resident is safe for the facility environment. Charge Nurses will document behaviors with residents and notify D.O.N., Medical Director and NP if behavior crisis occur so that proper treatment can be obtained. All residents will be allowed to re-admitted when deemed suitable for the facility. Q.A. Committee along with Ombudsman will review each case as it occurs so that prop- placement and transfer mainta the rights of each resident. 5. 10/22/21	a with o all r s b b b b b e r	

1WJY11 Facility ID:

Facility ID: 000368

If continuation sheet Pag

Page 6 of 6