STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00385996 and IN00388228 completed on August 25, 2022. Complaint IN00385996 - Corrected. Complaint IN00388228 - Not Corrected. Survey dates: October 3, 4, 5, and 6, 2022. Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 22 Total: 22 Census Payor Type: Medicaid: 17 Other: 5 Total: 22 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/11/22.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RAENITA DUMAS	RNDON	12/02/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure each	F 0550	**F550** **Corrective Action(s) for**	11/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

resident's dignity was maintained related to being exposed in the dining room and dining assistance for dependent residents for 2 of 2 residents reviewed for dignity and for 2 of 6 meals observed. (Residents 4, 1, and 22)

Findings include:

1. On 10/3/22 at 12:54 p.m., Resident 4 was observed in the dining room seated in a chair. The top of his buttocks was exposed and visible from the base of the chair. Staff in the area did not redirect him to pull up his pants.

The record for Resident 4 was reviewed on 10/5/22 at 9:35 a.m. Diagnoses included, but were not limited to, intellectual disability, mood disorder, and brief psychotic disorder.

The Quarterly Minimum Data Set (MDS) assessment, date 8/22/22, was in progress. The resident was moderately impaired for daily decision making and required limited assistance with dressing.

Interview with the Director of Nursing on 10/6/22 at 10:15 a.m., indicated the resident should have been told to pull up his pants by staff. She also indicated the resident needed some more clothes due to a recent weight gain and some of his pants were too small.2. On 10/3/22 at 9:25 a.m., the breakfast meal had started and NA 1 and CNA 1 were observed passing trays to the residents in the main dining room. Resident 1 was observed sitting in a wheelchair at a table with Resident 4. Meal service continued and Resident 1 still had not received his food. All other residents had a beverage to drink as well, however, the resident had nothing to drink. Resident 4 received his food and started eating in front of Resident 1. At

Residents Affected by the Deficient Practice

Resident 4 – unable to correct. Resident’s clothing position is being and has been monitored daily. His care plan has addressed his repetitive behavior of sticking hand in his pants.

Resident 1 – unable to correct. Resident’s meal is being served timely.

Resident 22 – unable to correct. We respectfully request IDR for this citation. See Exhibit 1.

The resident’s request for ice is being and has been honored.

Resident 22 had not received dialysis since Saturday due to malfunctioning of his dialysis access cite. He missed dialysis on
Tuesday and Thursday which was 5 days since dialysis was performed on Resident 22.

Corrective Action(s) for Other Residents Potentially Affected

All residents have the potential to be affected by this deficient practice.

The resident’s right to be treated with dignity and respect is enforced daily through observation and supervision by charge nurses, department managers, the DON and the Administrator.

Measures to Ensure the Deficient Practice Does Not Recur

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	10:36 a.m., Resident 1 received his breakfast and most of the other residents were finished eating. The Director of Nursing sat down to feed him. On 10/3/22 at 2:00 p.m., LPN 1 was observed passing out ice cream to the residents after lunch for dessert. Resident 1 was seated at one of the dining room tables and the LPN passed him up and he did not get any ice cream. At 2:30 p.m., the resident still had not received any ice cream. On 10/4/22 at 12:55 p.m., Resident 1 was brought to the dining room and placed at a table by himself. At 1:49 p.m., the resident received his lunch and NA 1 sat down to feed him. At 2:05 p.m., Dietary Cook 1 came out of the kitchen and passed out cake to all of the residents. Resident 1 did not receive any cake for dessert. On 10/5/22 at 8:50 a.m., LPN 1 started passing coffee to the residents in the dining room. Resident 1 was seated in his wheelchair at a table by himself. The LPN passed out coffee to everyone, however, the resident received nothing. At 9:06 a.m., the LPN passed out bowls of hot and cold cereal to the residents. At 9:12 a.m., the resident started yelling out loud, as he did not get a bowl of cereal. Shortly after, NA 1 brought a bowl of oatmeal to the resident and sat down to feed him. The record for Resident 1 was reviewed on 10/4/22 at 10:52 a.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, aphasia, high blood pressure, and muscle spasms. The Quarterly Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident was totally dependent on staff with 2 person physical		All staff have been in-serviced on the resident’s right to be treated with dignity and respect. They are aware of their responsibility to respond to and/or report any observations of care or service provision that prevents the resident from exercising his or her rights. Department managers are aware of their responsibility to report any staff practice that fails to support the resident’s right to be treated with dignity and respect. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Charge nurses on each shift are responsible for monitoring dignity related to how clothing is positioned to prevent exposure. The monitoring is documented on a daily Nurse Rounds Sheet and will continue on-going. The DON or designee is responsible for reviewing the Nurse Rounds Sheets at least once per week and for follow up to any identified concerns. The DON will prepare a summary of dignity monitoring for review per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/1/22 Exhibit 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	assist for transfers and needed extensive assist with 1 person physical assist for eating. Physician's Orders on the current 10/2022 order statement, indicated the resident was to receive a pureed diet with thickened liquids. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated the resident was not supposed to be in the dining room until he was ready to eat and he should have received the ice cream and cake in pureed form. 3. During a random observation on 10/4/22 at 10:13 a.m., Resident 22 was observed sitting in a straight back chair in the dining room. The resident asked NA 1 for more milk. The NA indicated to the resident he could not have any more milk. The resident then asked for a cup of ice. The NA stated, "Give me one minute." At 10:15 a.m., NA 1 sat down at a table in the dining room and just watched the other residents. No other staff were around. She stood up at 10:17 a.m., and walked over to another table and cleared the dishes and placed them in a tub by the kitchen door. The resident asked NA 1 for ice again and the NA stated, "Give me one minute [resident name]." Another resident asked for an extra cup of orange juice and the NA went into the kitchen and brought out a cup of orange juice and handed it to the resident. Another resident asked her for ice and she walked into the kitchen and brought out a bag of ice for the resident's water cup. Resident 22 continued to ask for a cup of ice and NA 1 continued to state, "Give me one minute [resident name]." At 10:27 a.m., NA 1 left the dining room and asked LPN 1 if the resident could have more to drink. The NA came back into the dining room, walked into the kitchen and brought out a cup of ice for the resident and stated to the		**F550 3.** We respectfully request this citation be struck from the record. Resident 22 had been sent out for dialysis on 10/4/22 but returned without receiving dialysis. According to the progress notes, the dialysis center called the facility at 8:15am informing the nurse that the dialysis could not be performed due to malfunction of the AV fistula access site. NA 1 was informed of this, which was why she did not respond to Resident 22's request for ice. She provided the ice after checking with the charge nurse. The resident has a history of requesting liquids or ice rather than eating the solid foods prepared for him during meals. The care plan for Resident 22 addresses the resident's potential nutritional problem related to End Stage Renal Disease and dietary restrictions. The care plan identifies that the resident becomes easily distracted during meals and prefers soda pop, Kool-Aid or plain ice. An intervention is to attempt to give the resident's tray before or after other residents are served to eliminate excess stimulation for the resident and help him focus on the meal. NA 1 is very familiar with this resident's history, his distraction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident " I had to make sure you could have it." The record for Resident 22 was reviewed on 10/6/22 at 11:40 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and dementia with behaviors. Physician's Orders, dated 6/7/22, indicated the resident was to receive a no added salt diet, regular texture, regular consistency, with no bananas, tomatoes, baked potatoes, or orange juice. Interview with LPN 1 on 10/4/22 at 10:35 a.m., indicated the resident was not on a fluid restriction and could drink whatever he wanted. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated the NA had told her she just wanted to make sure the resident could have something extra to drink, however, she should be aware of the resident's diet and what he could have to eat and drink. 3.1-3(t)		during meals, and his frequent requests for liquids or ice. The charge nurse was completing the morning medication pass at the time the requests were made so NA 1 waited until the nurse was available to answer her question. She did not feel it was emergent enough to distract the nurse from passing medications. The delay in responding to Resident 22's requests for ice was directly related to the fact that NA 1 was aware that the resident had not received dialysis that morning, and she wanted direct instruction from the nurse. The delay in response was not at attempt to restrict the resident's right to a dignified existence.	
F 0638 SS=E Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment timely for 6 of 17 residents whose MDS assessments were reviewed. (Residents 4, 18, 20, 6, 17, and 19)	F 0638	**F638** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 4 – unable to correct. MDS assessments are now in	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: 1. The record for Resident 4 was reviewed on 10/5/22 at 9:35 a.m. There was a Quarterly Minimum Data Set (MDS) assessment, dated 5/22/22 and completed on 6/5/22. The Quarterly MDS assessment, dated 8/22/22, indicated the MDS was in progress and not completed. Interview with the Director of Nursing on 10/5/22 at 3:50 p.m., indicated the Quarterly MDS had not been completed timely and all of the MDS assessments were in the process of being completed and transmitted. 2. The record for Resident 18 was reviewed on 10/4/22 10:38 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 8/17/22, indicated it was still in progress. 3. The record for Resident 20 was reviewed on 10/4/22 at 11:44 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated it was still in progress and not completed. Interview with the Director of Nursing on 10/4/22 at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS assessments. She was aware the MDS assessments were not completed timely.4. The record for Resident 6 was reviewed on 10/5/22 at 11:51 a.m. There was an Admission Minimum Data Set (MDS) assessment completed on 6/1/22.		compliance. Resident 18 – unable to correct. MDS assessments are now in compliance. Resident 20 – unable to correct. MDS assessments are now in compliance. Resident 6 – unable to correct. MDS assessments are now in compliance. Resident 17 – unable to correct. MDS assessments are now in compliance. Resident 19 – unable to correct. MDS assessments are now in compliance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Quarterly MDS assessments have been audited for all current residents and are in compliance with required completion dates. **Measures to Ensure the Deficient Practice Does Not Recur** DON will monitor MDS calendar weekly and address compliance at morning meetings on Wednesday. MDS have been outsourced but they will be done in-house until new MDS Coordinator is hired. MDS will be reviewed by DON and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Quarterly MDS assessment, dated 8/26/22, was still in progress. 5. The record for Resident 17 was reviewed on 10/5/22 at 11:56 a.m. There was a Quarterly Minimum Data Set (MDS) assessment completed on 5/10/22. A Quarterly MDS assessment, dated 8/10/22, was still in progress. Interview with the Director of Nursing on 10/4/22 at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS assessments. She was aware the MDS assessments were not completed timely.6. The record for Resident 19 was reviewed on 10/5/22 at 11:32 a.m. There was a Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22 and completed on 5/17/22. The following Quarterly MDS assessment was dated 8/3/22 and was in progress. Interview with the Director of Nursing on 10/4/22 at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS assessments. She was aware the MDS assessments were not completed timely. 3.1-31(d)(3)		Nurse Consultant weekly to ensure compliance and tracking log will be reviewed with Administrator and Q.A. Committee. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for four weeks, then once every week on-going. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22	
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to successfully export the Minimum Data Set (MDS) assessment in timely manner for 4 of 17 residents whose MDS assessments were reviewed. (Residents 1, 6, 23, and 5) Findings include: 1. The record for Resident 1 was reviewed on 10/4/22 at 10:52 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 7/7/22, indicated it was accepted but not exported. The MDS was completed on 7/21/22. Interview with the Director of Nursing on 10/4/22 at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS assessments. She was aware the MDS assessments had not been exported.2. The record for Resident 6 was reviewed on 10/5/22 at 11:51 a.m. The 5/26/22 Admission Minimum Data Set (MDS) assessment, indicated it had been completed but was not exported or transmitted. 3. The record for Resident 23 was reviewed on	F 0640	**F640** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 1– unable to correct. MDS assessments are now in compliance. Resident 6 – unable to correct. MDS assessments are now in compliance. Resident 23– unable to correct. MDS assessments are now in compliance. Resident 5 – unable to correct. MDS assessments are now in compliance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All MDS assessments have been audited for current residents and have been exported in compliance with required time frames. **Measures to Ensure the**	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	10/5/22 at 11:52 a.m. The 5/18/22 Quarterly Minimum Data Set (MDS) assessment, indicated it had been completed but was not exported or transmitted. 4. The record for Resident 5 was reviewed on 10/5/22 at 12:37 p.m. The 5/20/22 Admission Minimum Data Set (MDS) assessment, indicated it had been completed but was not exported or transmitted.		**Deficient Practice Does Not Recur** DON will monitor MDS calendar weekly and address compliance at morning meetings on Wednesday. MDS have been outsourced but they will be done in-house until new MDS Coordinator is hired. MDS will be reviewed by DON and Nurse Consultant weekly to ensure compliance and tracking log will be reviewed with Administrator and Q.A. Committee. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for four weeks, then once every week on-going. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility	F 0641	**F641**	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antipsychotic medication use and falls with major injury for 2 of 17 MDS assessments reviewed. (Residents B and 20) Findings include: 1. The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked. Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff the resident was on the floor. The resident had a bruise on the upper lip and slight bleeding from the nostril. The lower eyelid was swollen and dark. 911 was notified and the resident was sent to the emergency room. Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated the resident was being transferred to another hospital due to a fracture of the facial bone. Interview with the Director of Nursing (DON) on 10/5/22 at 1:30 p.m., indicated the fracture was not coded on the Significant Change MDS assessment.		**Corrective Action(s) for Residents Affected by the Deficient Practice** Resident B– correction to MDS was completed and assessment is now in compliance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All MDS assessments have been audited for current residents and have been exported in compliance with required time frames. **Measures to Ensure the Deficient Practice Does Not Recur** DON will monitor MDS calendar weekly and address psychotropic drug use compliance at morning meetings on Wednesday. MDS have been outsourced but they will be done in-house until new MDS Coordinator is hired. MDS will be reviewed by DON and Nurse Consultant weekly to ensure compliance and tracking log will be reviewed with Administrator and Q.A. Committee. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2. The record for Resident 20 was reviewed on 10/4/22 at 11:44 a.m. Diagnoses included, but were not limited, to insomnia, anxiety, schizoaffective disorder, post traumatic stress syndrome, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated it was still in progress and not completed. The Annual MDS assessment, dated as being completed on 6/3/22, indicated the resident was cognitively intact. The question regarding the resident being considered by the State Level II PASARR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition was marked "No." In the last 7 days, the resident had received an anti-anxiety and antidepressant medication. Antipsychotic medication was coded with a "0". Physician's Orders, dated 9/18/21, indicated Perphenazine (an antipsychotic medication) tablet 4 milligrams (mg). Give 1 tablet by mouth one time a day for anxiety. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated she was aware the MDS assessment was inaccurately coded. 3.1-31(i)		The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for four weeks, then once every week on-going. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the			

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on record review and interview, the facility failed to ensure a Level II PASARR (Preadmission Screening and Resident Review) was completed for a resident with a mental illness for 1 of 1 residents reviewed for PASARR. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 10/4/22 at 11:44 a.m. Diagnoses included, but were not limited, to insomnia, anxiety, schizoaffective disorder, post traumatic stress syndrome, and major depressive disorder.	F 0645	**F645** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 20 has had a Level II PASARR completed. **Corrective Action(s) for Other Residents Potentially Affected** Any resident with a mental disorder or intellectual disability as defined at §483.20(k)(3) has the potential to be affected by this deficient practice. An audit was	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated it was still in progress and not completed. The Annual MDS assessment, dated as completed on 6/3/22, indicated the resident was cognitively intact. The question regarding the resident being considered by the State Level II PASARR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition was marked "No." In the last 7 days the resident had received an anti-anxiety and antidepressant medication. Antipsychotic medication was coded with a "0". A Level 1 PASARR was completed on 8/2/22 and indicated the resident needed a Level II assessment due to mental illness. Interview with the Social Service Director (SSD) on 10/4/22 at 3:00 p.m., indicated she was unaware the resident needed a Level II assessment and she did not know who to contact for the screening. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated she was unaware the resident needed a PASARR Level II assessment. 3.1-16(d)(1)(B)		completed of Level I PASARR assessments for all current residents, and there are currently no residents who require a Level II PASARR assessment. **Measures to Ensure the Deficient Practice Does Not Recur** Social Worker will refer Resident 20 to agency for Level II assessment **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will complete an audit of all new admissions within one week post admission to ensure that the Level I PASARR assessment does not require a Level II PASARR assessment. The audits will continue following each new admission for three months. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F645** Audits of new admissions will be discontinued when 100% compliance has been achieved for 3 consecutive admissions. will be discontinued when 100% compliance has been achieved for one month. If not achieved, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to shampooing of hair and eating assistance for 3 of 6 residents reviewed for ADL's. (Residents 7, 21, and 2) Findings include: 1. On 10/3/22 at 9:00 a.m. and 1:30 p.m., Resident 7 was seated at a table in the dining room. Her hair was greasy in appearance. On 10/4/22 at 10:30 a.m., 11:25 a.m., and 2:36 p.m., the resident's hair remained greasy in appearance. On 10/5/22 at 8:25 a.m., 9:58 a.m., and 11:08 a.m., the resident's hair remained greasy in appearance. The record for Resident 7 was reviewed on 10/5/22 at 10:52 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, violent behaviors, and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident	F 0677	**F677** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 7. A new shampoo has been trialed for the resident with an improvement in her hair presentation. Resident 21. We respectfully request IDR for this citation. See Exhibit 2. The resident is served liquids and solid foods in accordance with her diet order and care plan interventions. Meal assistance is provided as needed. Resident 2 is in the hospital at this time. **Corrective Action(s) for Other Residents Potentially Affected** All residents who require assistance with ADLs have the potential to be affected by this deficient practice. Residents receive showers with shampoos in	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	was cognitively impaired for daily decision making and she required extensive assistance for bathing. A Care Plan, reviewed on 8/4/22, indicated the resident had an ADL (activities of daily living) self care performance deficit related to decreased mobility. Interventions included, but were not limited to, encourage the resident to participate to the fullest extent possible with each interaction and monitor for any changes, any potential for improvement, reasons for self care deficit, expected course, and decline in function. The October 2022 ADL flow sheet, indicated the resident had received a shower on 10/1, 10/2, 10/3, 10/4, 10/5, and 10/6/22. There was no documentation indicating if the resident's hair had been washed. Interview with the Director of Nursing on 10/6/22 at 10:20 a.m., indicated the resident's hair would be washed. She also indicated they were going to try a different shampoo that wouldn't leave the resident's hair greasy looking. 2. On 10/3/22 at 10:12 a.m., Resident 21 was observed seated at a table in the dining room. She was served her breakfast at that time. The resident had already finished her coffee and juice. She was not served any additional beverages when her tray was delivered. At 10:31 a.m., the resident continued to eat her breakfast and she had not been offered any beverages. On 10/5/22 at 8:54 a.m., the resident was seated in her wheelchair at a table in the dining room. She was drinking coffee at that time. At 9:10 a.m., she received a bowl of cold cereal and she had finished all of her coffee and juice. At 9:51 a.m., she received her breakfast tray and was not		accordance with the planned shower schedule. Beverages are served prior to main entrees, and additional liquids are provided per resident request. Staff are informed of individual resident needs such as assistance with meal set up including cutting meats, cueing and encouragement to eat solid foods, and special body or hair products. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been in-serviced on providing individualized body or hair products, serving liquids and assistance with meals including cutting meat. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Charge nurses on each shift are responsible for monitoring that ADL assistance is provided to dependent residents and that meal assistance is provided when needed. The monitoring is documented on a daily Nurse Rounds Sheet and will continue on-going. The DON or designee is responsible for reviewing the Nurse Rounds Sheets at least once per week and for follow up to any identified concerns. The DON will prepare a summary of ADL and meal assistance monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	provided with any additional fluids. At 1:40 p.m., the resident received her lunch tray. She did not receive anything to drink. At 1:49 p.m., the resident received a glass of orange drink. She immediately picked up the glass and started drinking the beverage. The record for Resident 21 was reviewed on 10/4/22 at 11:47 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident was cognitively impaired for daily decision making and she needed supervision with eating. A Care Plan, dated 9/25/22, indicated the resident was at risk for altered nutrition related to the diagnoses of anorexia and decreased oral consumption. She required supervision with eating due to her short attention span and advanced dementia. Interventions included, but were not limited to, staff were to assist with meals as needed. Interview with the Director of Nursing on 10/5/22 at 4:30 p.m., indicated the resident should have been provided with beverages in a more timely manner. 3. During an observation of breakfast on 10/3/22 at 9:00 a.m., Resident 2 was in a wheelchair at the table. CNA 2 brought a breakfast plate to him at 9:58 a.m. CNA 2 cued the resident, telling him where his food was located on the plate. The resident picked up his orange juice to drink. CNA 2 cued him once more and then left. The resident then set his empty cup on top of his plate, turned his head, and did not eat. The resident was only given a large soup spoon for his eating utensil, his sausage was not cut up and was left in whole		results for review per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 IDR Exhibit 2 **F677 2.** We respectfully request this citation be struck from the record. Resident 21 has extensive cognitive impairments and frequently prefers to drink only liquids rather than consume solid foods. Staff are aware of this and attempt to provide her with adequate hydration while encouraging caloric intake of solid foods. The surveyor noted that the resident's care plan addressed the resident's risk for altered nutrition, and that this plan addresses the short attention span and advanced dementia. The surveyor included in the citation that a planned intervention was that staff were to assist with meals as needed. The surveyor did not mention that meal assistance was not provided. Instead, the citation clearly shows the resident was served liquids before the breakfast meal was served on 10/3/22 at 10:12am as stated "The resident had already finished her coffee and juice". On 10/5/22 at 8:54am the surveyor observed the resident to be drinking coffee at that time. The surveyor further observed that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	patties. At 10:12 a.m., LPN 1 gave the resident his medications and asked CNA 1 to come over and assist him with his meal. Resident 2's record was reviewed on 10/4/22 at 10:08 a.m. Diagnoses included, but were not limited to, schizophrenia, dementia, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was severely impaired for daily decision making. The resident needed setup help only for bed mobility and toilet use. The resident was not assessed for transfers, dressing, eating, personal hygiene, or bathing. A Care Plan, dated 4/3/22, indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to dementia and decreased mobility. Interventions included, but were not limited to, encourage the resident to fully participate, encourage the resident to use the call light for assistance, and monitor for any changes. Interview with the Director of Nursing on 10/5/22 at 3:13 p.m., indicated she had no further information. 3.1-38(a)(2)(D) 3.1-38(a)(3)(B)		resident received a bowl of cold cereal at 9:10am and “she had finished all her coffee and juice”. The surveyor made no observations indicating the resident appeared dehydrated or was requesting additional fluids. The resident does not have a physician’s order for a specific amount of liquids to be provided at meals. The resident’s hydration and nutritional status is monitored by the facility through monthly weights, tracking urinary output through the toileting documentation in the electronic record, and through quarterly Dehydration Risk Screening. The most recent Dehydration Risk Screening was completed 9/6/22 and resulted in a score of 8.0. According to the screening scale, a score of 10 or higher indicates a risk for dehydration. There has been no decrease in the number of incontinent episodes. The resident’s weight is stable. The resident receives Megace twice daily to stimulate appetite and a supplement of Ensure twice daily. Clinically the resident appears well hydrated and nourished. Staff provided the resident with adequate fluids and served her meals in accordance with the diet orders and care plan interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 4 of 4 residents reviewed for activities. (Residents 4, 21, 1, and B) Findings include: 1. On 10/3/22 at 11:30 a.m., Resident 4 was observed seated at a table in the dining room. The television was on but no other activities were taking place. On 10/4/22 at 10:29 a.m., the resident was seated at a table in the dining room. The television was turned on but no other activities were taking place. At 10:32 a.m., the resident was given a coloring book and crayons. The resident did not want them and was given a deck of cards instead. At 11:48 a.m., the resident was observed sorting the cards and placing them on the table in front of him. He continued to do this at 1:20 p.m. and 2:58 p.m. No organized activities were taking place in the dining room.	F 0679	**F679** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 4. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. Resident 21. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. Resident 1. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated.	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 10/5/22 at 8:56 a.m., the resident was seated at a table in the dining room. He was waiting on breakfast and playing with a deck of cards. At 10:19 a.m., the resident remained in the dining room. He continued to play with the deck of cards and a talk show was on the television. No activity calendar was observed to be posted in the dining room. The record for Resident 4 was reviewed on 10/5/22 at 9:35 a.m. Diagnoses included, but were not limited to, intellectual disability, Down Syndrome, and mood disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/22/22, was in progress. The resident was moderately impaired for daily decision making. The resident had no Care Plan related to activity participation. The Activities Quarterly Participation Review, dated 8/21/22, indicated the resident participated in group activities at least once a week and he enjoyed painting, patio outings, snacks and movies, and card games. The last documented activity progress note was dated 4/18/22. Interview with the Director of Nursing on 10/5/22 at 3:50 p.m., indicated the Activity Assistant was also a CNA and he was having to be used on the floor from time to time so activities were lacking. 2. On 10/3/22 at 11:30 a.m., Resident 21 was observed propelling herself up and down the hallway. The television was on in the dining room		Activity progress notes are current. The resident is now positioned in bed so that the TV is in his line of vision. Resident B. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. The resident is now positioned in bed so that the TV is in his line of vision. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Residents have been interviewed and individualized care plans reflecting leisure interests and activity preferences are in place. Activity progress notes and Activities Quarterly Participation Reviews are current for all residents. Monthly Activity Calendars have been updated to reflect the preferred activities and are posted in the dining room. **Measures to Ensure the Deficient Practice Does Not Recur** Activity staff have been in-serviced on job responsibilities related to the facility Activity Program. Supplies have been purchased for the department to ensure that diverse activities can be offered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	but no activities were taking place. On 10/4/22 at 10:27 a.m., the resident was seated in her wheelchair in the dining room. The television was on, but no organized activities were taking place. The resident was propelling herself in and out of the dining room. At 11:08 a.m., the resident left the dining room. At 11:25 a.m., the resident was returned to the dining room by NA 1. At 11:27 a.m., the resident again left the dining room. At 11:45 a.m., she was seated in her wheelchair next to a table in the dining room. Her eyes were closed at the time. At 11:46 a.m., she was woken up by the Administrator and given a ball to hold. At 12:03 p.m., the resident's eyes were closed and the ball remained on the table in front of her. At 1:13 p.m., the resident remained seated in the dining room. The television remained on in the dining room but no organized activities were taking place. The resident received her lunch tray at 1:41 p.m. and at 2:57 p.m., the resident remained in her chair and was sleeping. No activities were taking place. On 10/5/22 at 10:25 a.m., the resident continued to propel herself in and out of the dining room. The television was on but no organized activities were taking place. At 1:04 p.m., the resident was observed on the patio with the other residents and NA 1. The record for Resident 21 was reviewed on 10/4/22 at 11:47 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident was cognitively impaired for daily decision making.		**The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will be responsible for ensuring that planned activities occur on a daily basis Monday through Friday. Charge nurse will be responsible for ensuring that planned activities occur on weekends. Activity audits will be conducted by the Administrator or designee once weekly for two months, then once every two weeks for a month. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F679** Audits of the Activity Program will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further program revisions or corrective actions as well as the frequency and length of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

A Care Plan, reviewed on 9/11/22, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Interventions included, but were not limited to, ensure the activities the resident was attending were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed (such as large print, holders if resident lacked hand strength, and task segmentation), compatible with individual needs and abilities, and age appropriate.

The Activity Quarterly Review, dated 9/11/22, indicated the resident participated in news/coffee, patio outings, music/meditation, and snacks/movie. She had a hard time staying focused during one to one activities as she needed to be redirected. Her favorite activity was watching movies while eating snacks.

The last activity progress note was dated 4/18/22.

Interview with the Director of Nursing on 10/5/22 at 3:50 p.m., indicated the resident had a tendency to wander aimlessly and activities should have been provided. She also indicated the Activity Assistant was a CNA and he was having to be used on the floor from time to time so activities were lacking. 3. On 10/4/22 at 3:00 p.m., Resident 1 was observed in bed with his eyes open and staring at the ceiling. The television was turned on but it was hanging on the wall that was located to the right and behind the resident's head. At 3:30 p.m., the resident started yelling out loud, as another resident was in his room. The television was still on and could not be seen by the resident.

On 10/5/22 at 11:15 a.m., the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

observed lying in bed. His eyes were open and he was staring at the ceiling. The television was turned on, but behind his head and to the right, completely out of view for him to see.

The record for Resident 1 was reviewed on 10/4/22 at 10:52 a.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, and aphasia (difficulty speaking).

The Quarterly Minimum Data Set (MDS) assessment, dated 7/7/22, indicated he was not cognitively intact. The resident was totally dependent on staff with 2 person physical assist for transfers.

There was no Care Plan for activities.

A 9/12/21 Admission Activity Assessment, indicated the resident preferred 1 to 1 visits with staff.

There were no 1 to 1 activity visits documented.

Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated the resident's television was on the wall and he was not able to see it.

4. On 10/3/22 at 11:20 a.m., Resident B was wheeled to his room. At that time, the resident was awake and was positioned by his bed. Staff left him there and did not turn on the television.

On 10/4/22 at 10:40 a.m. to 12:55 p.m., the resident was observed lying in bed. The television was turned on, however, it was located on the night stand behind his head. The resident was not able to see the television.

On 10/4/22 at 3:00 p.m., to 3:30 p.m., the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	was observed lying awake in bed. The television set was turned on, however, it was positioned on the night stand behind his head and completely out of view for him to see. The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, major depressive disorder, psychotic disorder with hallucinations, and glaucoma. The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident liked to listen to music for activities. A Care Plan, revised on 7/7/22, indicated the resident had some limited tolerance for activity programs due to his diagnosis of dementia with behaviors. A Care Plan, revised on 7/7/22, indicated the resident had impaired visual function related to glaucoma. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated the resident's television was behind his head while he was in bed. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to ensure a fall follow up assessment and documentation was completed for 1 of 2 residents reviewed for falls. (Resident B) Finding includes: The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked. A Care Plan, revised on 7/7/22, indicated the resident was at risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was wearing appropriate footwear (non-skid shoes/socks) when ambulating or mobilizing in his wheelchair. Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff the resident was on the floor. The resident had a	F 0684	**F684** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident B. Unable to correct. The resident has had no further falls. **Corrective Action(s) for Other Residents Potentially Affected** All residents with falls have the potential to be affected by this deficient practice. Facility policy related to fall follow-up assessments and documentation is being followed. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed nurses have been in-serviced on facility policy related to fall follow-up assessments and documentation. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for auditing falls and follow-up assessment documentation once weekly for two months, then once every two weeks for a month. Audit results will be reviewed per	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	bruise on the upper lip and slight bleeding from the nostril. The lower eyelid was swollen and dark. 911 was notified and the resident was sent to the emergency room. Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated the resident was being transferred to another hospital due to a fracture of the facial bones. The resident returned on 6/28/22. Nurses' Notes, dated 7/7/22 at 1:37 a.m., indicated the resident was observed on the floor mat next to his bed at 7:00 p.m. The resident was assisted back to the bed and the Director of Nursing (DON) was notified, who instructed the writer to send the resident to the emergency room for an evaluation. 911 was called and the paramedic indicated the hospital was full and there was no bed available. The DON was notified again regarding the hospital status and the resident was left at the facility for close observation. Nurses' Notes, dated 7/7/22 at 7:34 a.m., indicated the resident had a large bowel movement that morning and incontinence care was rendered. The resident refused to be bathed. A full set of vital signs were obtained. A Physician's Progress Note, dated 7/7/22, indicated acute visit for right hip pain and the inability to bear weight. He had a right hip xray done yesterday which was reviewed and was negative. The resident recently returned from the hospital after an evaluation for facial fractures. The resident had pain with range of motion to the right hip. An xray of the knee and CT/MRI of the right hip with and without contrast was ordered. "He is a very complex resident and with the current and multiple comorbidities make him at risk for hospitalization." The resident needed close		the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F684** Audits of falls and follow-up assessments will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

monitoring.

The next documented Nurses' Note, was dated 7/8/22 at 12:47 a.m., which indicated the resident was having difficulty standing. The resident was in bed most of the time except for dinner. The resident tolerated his medication and meals with no distress. Staff will continue to monitor.

The next documented Nurses' Note was 7/8/22 at 2:59 p.m., which indicated the resident had an appointment at the hospital for a Cat Scan (CT) of the right hip.

Nurses' Notes, dated 7/8/22 at 11:57 p.m., indicated the resident was alert with confusion, and tolerated his medications and meals. The resident was still unable to stand and remained in bed most of the time. The resident was pleasant and cooperative with care, with no signs or symptoms of distress. Will continue to monitor.

There was no documentation or an assessment of the resident in Nurses' Notes on 7/9/22.

Nurses' Notes, dated 7/10/22 at 7:06 a.m., indicated the resident had a fair night. He was up in the chair at that time with the call light in reach. The resident's safety was maintained and no distress was noted.

The next documented Nurses' Note was on 7/11/22 at 4:48 p.m., which indicated the resident was alert and verbally responsive. He had continued pain to the right leg and hip and was unable to bear weight. An x-ray was performed which was negative for a fracture, but indicated degenerative changes. The resident had complaints of pain when attempting to bear weight. A CT scan was ordered and performed at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the hospital and results were still pending. Will continue to monitor for any changes. Nurses' Notes, dated 7/11/22 at 7:38 p.m., indicated the Physician had called and indicated the resident had an impacted fracture to the right hip. Naproxen (an anti-inflammatory medication) 500 milligrams (mg) twice a day was ordered for pain. There was no close monitoring with a full set of vital signs after the fall on 7/6/22. There was no follow up assessment of the resident's hip or condition. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated there was no fall follow up assessment or close monitoring of the resident after the fall on 7/6/22. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure post fall interventions were in place for a resident with a history of falls with a fracture related to a floor mat beside the bed and wearing non-skid socks for 1 of 2 residents reviewed for falls. (Resident B)	F 0689	**F689** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident B. The resident was moved to a low bed on 10/6/22.	11/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Finding includes: On 10/3/22 at 9:22 a.m., Resident B was observed sitting in a wheelchair at table by himself in the main dining room. The resident's wheelchair brakes were locked and he started moving the table to the left, right, and forward. The resident was agitated and was speaking nonsensical. He pushed the table forward and the front of his wheelchair popped up leaving him sitting in the chair only on back wheels. He continued to do this until the nurse was summoned immediately into the dining room as there was no other staff around. There were no anti-tippers on the back of his wheelchair to prevent him from tipping backwards. On 10/4/22 at 10:40 a.m. until 12:55 p.m., the resident was observed in bed. He was dressed in street clothes,with no shoes on, and wearing just plain socks to both of his feet. The 1/4 side rail was observed in the upright position. There was no floor mat beside the bed and the bed was not in the lowest position. On 10/4/22 at 3:00 p.m., to 3:30 p.m., the resident was observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. The resident was wearing plain black socks to both feet. The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the		The resident’s wheelchair is now equipped with anti-tipper bars. Staff ensure the resident has non-skid footwear in place when he is in the wheelchair. A motion sensor is at the bedside to alert staff if the resident attempts to exit the low bed. The care plan has been reviewed and updated. **Corrective Action(s) for Other Residents Potentially Affected** All residents at risk of falling have the potential to be affected. Residents are assessed upon admission, quarterly and with significant change for the risk of falling. Individualized fall prevention interventions are implemented as deemed appropriate. Care plans are reviewed and updated as needed after each fall and each assessment. Incident reports will continue to be completed in PCC after any fall has occurred. **Measures to Ensure the Deficient Practice Does Not Recur** Staff have been in-serviced on facility policy related to fall prevention. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Charge nurses on each shift are responsible for monitoring that fall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked. A Care Plan, revised on 7/7/22, indicated the resident was at risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was wearing appropriate footwear (non-skid shoes/socks) when ambulating or mobilizing in the wheelchair. Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff the resident was on the floor. The resident had a bruise on the upper lip and slight bleeding from the nostril. The lower eyelid was swollen and dark. 911 was notified and the resident was sent to the emergency room. A Cat Scan (CT) of the face, neck and head, dated 6/26/22, indicated the resident had an acute left zygomaticomaxillary complex fracture of the left zygomatic arch, left inferior and lateral orbital wall and the left maxillary sinus (this type of fracture was a result from blunt trauma to the periorbital area). Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated the resident was being transferred to another hospital due to a fracture of the facial bones. The resident returned on 6/28/22. Nurses' Notes, dated 7/7/22 at 1:37 a.m., indicated the resident was observed on the floor mat next to his bed at 7:00 p.m. The resident was assisted		prevention interventions are in place as planned. The monitoring is documented on a daily Nurse Rounds Sheet and will continue on-going. The DON or designee will continue to review all Incident/Accident Reports and will investigate any incidents related to falls to determine root causes and potential need for new interventions. The investigation results will be documented and will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE:11/1/22 ADDENDUM **F689** The DON or designee will review incident/accident reports once weekly for two months, then once every two weeks for two months, then at least monthly on-going. The DON or designee will continue to investigate any incidents related to falls to determine root causes and potential need for new interventions. Daily Rounds Sheets will be reviewed at least once per week for two months, then once every two weeks for two months, then at least monthly on-going. Fall investigation results will be documented and reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. The frequency and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	back to the bed and the Director of Nursing (DON) was notified who instructed the writer to send the resident to the emergency room for an evaluation. 911 was called and the paramedic indicated the hospital was full and there was no bed available. The DON was notified again regarding the hospital status and the resident was left at the facility for close observation. A Nurses' Note, dated 7/11/22 at 4:48 p.m., indicated the resident was alert and verbally responsive. He had continued to have pain to the right leg and hip and was unable to bear weight. An x-ray was performed which was negative for a fracture, but indicated degenerative changes. The resident had complaints of pain when attempting to bear weight. A CT scan was ordered and performed at the hospital and results were still pending. Will continue to monitor for any changes. Nurses' Notes, dated 7/11/22 at 7:38 p.m., indicated the Physician had called and indicated the resident had an impacted fracture to the right hip. Naproxen (an anti-inflammatory medication) 500 milligrams (mg) twice a day was ordered for pain. A CT scan of the right hip, dated 7/11/22, indicated an impacted fracture of the femoral neck. Physician's Orders, dated 6/28/22, indicated fall and safety precautions. Place floor mat at bedside when resident was in bed. Alarm sensor in room to alert staff of transfers. Interview with the Director of Nursing (DON) on 10/5/22 at 1:30 p.m., indicated the floor mat should have been on the floor next to the bed at all times and the bed should be in the lowest position.		length of continued reviews will be determined as well.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	They have a low bed in the facility and were going to change out his bed, but that had not been done. 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on record review and interview, the facility failed to assess lung sounds for a resident with pneumonia who was also receiving an antibiotic for 1 of 1 residents reviewed for respiratory infection. (Resident 22) Finding includes: The record for Resident 22 was reviewed on 10/5/22 at 3:30 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and dementia with behaviors. The resident was readmitted to the facility on 9/26/22. The Quarterly Minimum Data Set (MDS) assessment, dated 7/15/22, indicated the resident was cognitively impaired for daily decision making. A Care Plan, dated 9/30/22, indicated the resident	F 0695	**F695** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 22. Unable to correct. The pneumonia has resolved. Daily respiratory status is completed for on-going COVID monitoring. **Corrective Action(s) for Other Residents Potentially Affected** All residents with a respiratory infection have the potential to be affected by this deficient practice. There are currently no residents with a respiratory infection or who require respiratory care. **Measures to Ensure the Deficient Practice Does Not**	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	was receiving antibiotic therapy due to the diagnosis of pneumonia. Interventions included, but were not limited to, administer antibiotics as ordered and auscultate lungs and document findings at least once every 24 hours. A Physician's Order, dated 9/28/22, indicated the resident was to receive Levofloxacin (an antibiotic) 500 milligrams (mg) daily, every other day for pneumonia. The antibiotic was discontinued on 9/30/22. A Physician's Order, dated 9/28/22, indicated the resident was to receive Doxycycline Hyclate (an antibiotic) 100 mg twice a day for pneumonia until 10/5/22. The resident was readmitted to the facility on 9/26/22 at 8:31 p.m. There was no assessment of his lung sounds. There was no assessment of the resident's lung sounds in the nurses' notes dated 9/28, 10/1, 10/2, 10/4, and 10/5/22. Interview with the Director of Nursing on 10/6/22 at 2:30 p.m., indicated the resident's lung sounds should have been assessed while he was being treated for pneumonia. 3.1-47(a)(6)		**Recur** Licensed nurses have been re-educated on standard assessment practices when a resident is being treated for a respiratory infection. A new tool has been developed to assist licensed staff with follow-up assessments and documentation post hospitalization or condition change. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Quality of Care audits for residents with condition changes are being conducted by the Nurse Consultant on a concurrent basis and will continue for three months. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F695** The frequency of Quality of Care audits is directly dependent upon the frequency with which a change of condition occurs. This includes a change in physical or mental health status requiring physician intervention or an incident or accident resulting in injury requiring physician intervention. The Nurse Consultant monitors 24-hour reports in Point Click Care and completes a Quality of Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			audit within five business days when these occurrences are evident. The Nurse Consultant notifies the DON of any concerns when found. The audits will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident who had sustained a fall and had complaints of right hip pain when standing received pain medication for 1 of 1 residents reviewed for pain. (Resident B) Finding includes: The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the	F 0697	**F697** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident B. Unable to correct. The resident continues to receive Naproxen 500mg twice daily. A current Pain Interview assessment has been completed without evidence of pain per verbal or non-verbal expression. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked.

A Care Plan, revised on 7/7/22, indicated the resident was at risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was wearing appropriate footwear (non-skid shoes/socks) when ambulating or mobilizing in wheelchair.

Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff the resident was on the floor. The resident had a bruise on the upper lip and slight bleeding from the nostril. The lower eyelid was swollen and dark. 911 was notified and the resident was sent to the emergency room.

A Cat Scan (CT) of the face, neck and head, dated 6/26/22, indicated the resident had an acute left zygomaticomaxillary complex fracture of the left zygomatic arch, left inferior and lateral orbital wall, and the left maxillary sinus (this type of fracture was a result from blunt trauma to the periorbital area).

Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated the resident was being transferred to another hospital due to a fracture of the facial bones. The resident returned on 6/28/22.

Nurses' Notes, dated 7/7/22 at 1:37 a.m., indicated the resident was observed on the floor mat next to his bed at 7:00 p.m. The resident was assisted

practice. Charge nurses are responsible for responding to verbal or non-verbal expressions of pain. Certified staff are responsible for reporting to charge nurses when aware of verbal or non-verbal expression of pain. The Pain Interview assessment tool is utilized when any new physical condition or injury is apparent. Pain management interventions are planned and implemented with care plans updated as necessary.

Measures to Ensure the Deficient Practice Does Not Recur
Licensed and certified staff have been re-educated on the need to report, monitor and provide interventions for any verbal or non-verbal expressions of pain.

The Monitoring Process to Ensure the Deficient Practice Does Not Recur
Quality of Care audits for residents with condition changes are being conducted by the Nurse Consultant on a concurrent basis and will continue for three months. The audits include monitoring that appropriate interventions are planned and executed for any resident with a new injury or physical condition that could result in pain. Audit results will be reviewed per the QAA Committee with further revisions or actions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	back to the bed and the Director of Nursing (DON) was notified who instructed the writer to send the resident to the emergency room for an evaluation. 911 was called and the paramedic indicated the hospital was full and there was no bed available. The DON was notified again regarding the hospital status and the resident was left at the facility for close observation. A Physician's Progress Note, dated 7/7/22, indicated acute visit for right hip pain and the inability to bear weight. The resident recently returned from the hospital after an evaluation for facial fractures. The resident had pain with range of motion to the right hip. The next documented Nurses' Note, was dated 7/8/22 at 12:47 a.m., which indicated the resident was having difficulty standing. The resident was in bed most of the time except for dinner. The resident tolerated medication and meals with no distress. Will continue to monitor. Nurses' Notes, dated 7/8/22 at 11:57 p.m., indicated the resident was alert with confusion, and he tolerated his medications and meals. The resident was still unable to stand and remained in bed most of the time. The resident was pleasant and cooperative with care, with no signs or symptoms of distress. Will continue to monitor. There was no documentation or an assessment of the resident in Nurses' Notes on 7/9/22. Nurses' Notes, dated 7/11/22 at 4:48 p.m., indicated the resident was alert and verbally responsive. He continued to have pain to the right leg and hip and was unable to bear weight. An x-ray was performed which was negative for a fracture, but indicated degenerative changes. The		implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F697** The frequency of Quality of Care audits is directly dependent upon the frequency with which a change of condition occurs. This includes a change in physical or mental health status requiring physician intervention or an incident or accident resulting in injury requiring physician intervention. The Nurse Consultant monitors 24-hour reports in Point Click Care and completes a Quality of Care audit within five business days when these occurrences are evident. The Nurse Consultant notifies the DON of any concerns when found. The audits will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

resident had complaints of pain when attempting to bear weight. A CT scan was ordered and performed at the hospital and results were still pending. Will continue to monitor for any changes.

Nurses' Notes, dated 7/11/22 at 7:38 p.m., indicated the Physician had called and indicated the resident had an impacted fracture to the right hip. Naproxen (an anti-inflammatory medication) 500 milligrams (mg) twice a day was ordered for pain.

A CT scan of the right hip, dated 7/11/22, indicated an impacted fracture of the femoral neck.

Physician's Orders, dated 7/11/22, indicated Naproxen Tablet 500 mg, give 1 tablet by mouth two times a day for pain.

The Medication Administration Record for 7/2022, indicated the resident received the Naproxen for the first time on 7/12/22 at 9:00 a.m. There was no other pain relief medication ordered or administered to the resident after the fall with the fracture.

The last Pain Assessment, completed on 6/28/22, indicated Tylenol was administered at the hospital for the facial fracture and the resident was unable to tell staff if he had pain.

There was no Pain Assessment completed for the resident after the fall on 7/6/22.

Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated a new pain assessment had not been completed after the most recent fall. There was no monitoring of the resident's pain after the fall or medication given until 7/12/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on record review and interview, the facility failed to ensure a dialysis access site was assessed for 1 of 1 residents reviewed for dialysis. (Resident 8) Finding includes: The record for Resident 8 was reviewed on 10/4/22 at 10:37 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The Annual Minimum Data Set (MDS) assessment, dated 7/17/22, indicated the resident was moderately impaired for daily decision making and she received dialysis. A Care Plan, dated 1/29/22, indicated the resident was at risk for complications related to requiring dialysis. Interventions included, but were not limited to, check for bruit and thrill every shift on the arteriovenous fistula (AVF) to the right upper arm and check for complications to the right AVF every shift. Physician's Orders, dated 11/23/21, indicated to listen for the bruit/thrill, check AV fistula site for signs and symptoms of infection or	F 0698	**F698** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 8. Physician orders to listen for the bruit/thrill and check the AV fistula site for signs and symptoms of infection every shift are being completed as ordered. **Corrective Action(s) for Other Residents Potentially Affected** All residents with a dialysis access site have the potential to be affected by this deficient practice. Physician orders to listen for the bruit/thrill and check the AV fistula site for signs and symptoms of infection every shift are being completed as ordered. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed nurses have been re-educated on the need to complete physician orders and	11/11/2022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	complications every shift for renal dialysis. The August 2022 Treatment Administration Record (TAR), indicated the resident's AV fistula had not been checked for a bruit and thrill or signs and symptoms of infection on the following shifts: 7-3: 8/10 and 8/27/22 3-11: 8/21 and 8/22/22 11-7: 8/21/22 Interview with the Director of Nursing on 10/5/22 at 4:30 p.m., indicated documentation should have been completed related to the resident's fistula. 3.1-37(a)		document the same in PCC. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of residents with dialysis access sites will be completed through Medication Administration Record Audits weekly be the DON or designee for two months, then every two weeks for one month. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F698** Audits of Medication Administration Records will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to post in a timely manner the daily staffing sheet which indicated how many staff were working in the facility and the facility census. This had the potential to affect the 22 residents who resided in the facility.	F 0732	**F732** **Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were cited as affected by this deficient practice.	10/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Finding includes: On 10/3/22 at 8:30 a.m., the daily staffing sheet located in the foyer was dated 9/16 through 9/30/22. The October staffing sheet was not posted. Interview with the Director of Nursing on 10/6/22 at 10:00 a.m., indicated the staffing sheet had not been updated from the weekend.		The posted staff schedule sheets are being updated daily. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. The posted staff schedule sheets are being updated daily. Residents and families/responsible parties will be reminded that this information is posted in the front lobby. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed staff have been re-educated on the need to update the posted staff schedule daily. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for monitoring that the posted staff schedules are updated daily. The monitoring will be documented on an audit form once weekly for two months, then every two weeks for one month. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 10/17/22 ADDENDUM **F732** Audits of posted staff schedules	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure an apical pulse and blood pressures were monitored and cardiac medications were held per blood pressure parameters for 3 of 5 residents reviewed for unnecessary medications.	F 0757	**F757** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 7. Orders to monitor	10/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(Residents 7, 1, and 20) Findings include: 1. The record for Resident 7 was reviewed on 10/5/22 at 10:52 a.m. Diagnoses included, but were not limited to, hypertension and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 1/26/22, indicated the resident was to receive Metoprolol Tartrate (a cardiac medication) 25 milligrams (mg) give 12.5 mg twice a day for hypertension. Hold the medication if the systolic blood pressure (top number) was less than 110 or the heart rate was less than 70. The September 2022 Medication Administration Record (MAR), indicated the resident received the Metoprolol on the following dates and times when her systolic blood pressure was less than 110: - 9/3/22 at 9:00 a.m. and 6:00 p.m., blood pressure 101/85 - 9/8/22 at 9:00 a.m., blood pressure 103/64 - 9/9/22 at 9:00 a.m. and 6:00 p.m., blood pressure 109/75 - 9/10/22 at 6:00 p.m., 108/78 The August 2022 MAR, indicated the resident received the Metoprolol on the following dates and times when her systolic blood pressure was less than 110: - 8/2/22 at 6:00 p.m., blood pressure 100/69 - 8/7/22 at 6:00 p.m., blood pressure 96/66 - 8/10/22 at 6:00 p.m., no blood pressure		apical pulse and blood pressure and hold parameters for antihypertensive medication are now in place. Resident 1. Orders to monitor apical pulse and blood pressure and hold parameters for antihypertensive medication are now in place. Resident 20. Orders to monitor apical pulse and blood pressure and hold parameters for antihypertensive medication are now in place. **Corrective Action(s) for Other Residents Potentially Affected** All residents receiving antihypertensive medications have the potential to be affected by this deficient practice. Antihypertensive medication orders have been reviewed, and orders to monitor apical pulse and blood pressure and to hold the medication based upon specific parameters are in place. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed staff have been re-educated on the need to ensure residents who receive antihypertensive medications have apical pulse, blood pressure, and hold parameter orders in place. **The Monitoring Process to Ensure the Deficient Practice**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	documented. Interview with the Director of Nursing on 10/5/22 at 4:30 p.m., indicated the Metoprolol should have been held as ordered and the parameters needed to be clarified. 2. The record for Resident 1 was reviewed on 10/4/22 at 10:52 a.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, aphasia (difficulty speaking), and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. Physician's Orders, dated 4/16/22, indicated Metoprolol Tartrate (a medication used to lower blood pressure and heart rate) tablet 25 milligrams (mg). Give 1 tablet by mouth two times a day, hold if systolic (top number) blood pressure was less than 100, diastolic (bottom number) blood pressure was less than 60 and heart rate was less than 60. The Medication Administration Record (MAR) for 7/2022, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol. The 8/2022 MAR, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol. The Metoprolol was blank and not signed out as being administered on 8/2 at 8:00 a.m., and 8/10 and 8/16/22 for the 6:00 p.m. dose. The 9/2022 MAR, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol.		**Does Not Recur** Monitoring of residents with antihypertensive hold parameter orders will be completed through Medication Administration Record Audits weekly be the DON or designee for two months, then every two weeks for one month. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 10/10/22 ADDENDUM **F757** Audits of Medication Administration Records will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

The 10/2022 MAR, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol.

The last documented heart rate in the Vital Sign section was on 3/22/21.

Interview with the Director of Nursing on 10/5/22, indicated the heart rate was not documented prior to the administration of the Metoprolol.

3. The record for Resident 20 was reviewed on 10/4/22 at 11:44 a.m. Diagnoses included, but were not limited, to high blood pressure and angina.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated it was still in progress and not completed.

The Annual MDS assessment, dated as completed on 6/3/22, indicated the resident was cognitively intact.

Physician's Orders, dated 4/16/22, indicated Metoprolol Tartrate (a medication used to lower blood pressure and heart rate) tablet 25 milligrams (mg). Give 1 tablet by mouth two times a day, hold if systolic (top number) blood pressure was less than 100, diastolic (bottom number) blood pressure was less than 60 and heart rate was less than 60.

The Medication Administration Records (MAR) for 7/2022, 8/2022, 9/2022, and 10/2022, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated the pulse was not documented prior to the administration of the Metoprolol. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure gradual dose reductions (GDR) for antipsychotic medications were attempted for 2 of 5 residents reviewed for unnecessary medications. (Residents 7 and 20) Findings include: 1. The record for Resident 7 was reviewed on 10/5/22 at 10:52 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, violent behaviors, and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident was cognitively impaired for daily decision making and she had no behaviors during the assessment reference period. The resident was receiving antipsychotic medications on a routine basis and no gradual dose reduction (GDR) had been attempted.	F 0758	**F758** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 7. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents has evaluated the resident's behavior history through record review and interviews with staff. A Progress note is available. Resident 20. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents has evaluated the resident's behavior history through record review and interviews with staff. A Progress note is available. **Corrective Action(s) for Other Residents Potentially Affected** All residents receiving antipsychotic medications have	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

A Care Plan, dated 3/2/22 and reviewed 8/4/22, indicated the resident received psychotropic medications related to the diagnoses of psychotic disorder, depression, insomnia, and anxiety. Interventions included, but were not limited to, consult with the Pharmacy and Physician to consider a dosage reduction when clinically appropriate and at least quarterly.

A Physician's Order, dated 1/26/22, indicated the resident was to receive Zyprexa (an antipsychotic medication) 10 milligrams (mg) twice a day for psychosis.

A Physician's Order, dated 1/26/22, indicated the following behaviors were to be monitored each shift: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care.

The August 2022 Medication Administration Record (MAR), indicated the resident had no documented behaviors for the month.

The September 2022 MAR, indicated the resident had behaviors on 9/12/22 on the 11-7 shift and on 9/21/22 on the 3-11 shift. Which type of behavior was not specified on the MAR. There was no documentation in the nursing progress notes on 9/12 and 9/21/22.

The Psychiatric Nurse Practitioner (NP) progress note, dated 9/15/22, indicated the resident had a history of intermittent behaviors of yelling, screaming, throwing herself on the floor, and inappropriate language to staff. The staff reported the intermittent behaviors were less frequent. Nonpharmacological interventions were

the potential to be affected by this deficient practice. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents continues to evaluate resident behavior history through record review and interviews with staff to determine the effective of current antipsychotic dose. GDRs will continue to be attempted unless contraindicated. Behavior frequency and type will continue to be monitored and documented in the electronic record.

Measures to Ensure the Deficient Practice Does Not Recur
Licensed staff have been re-educated on the need to monitor and document the type and frequency of behaviors for all residents receiving psychotherapeutic medications. They have been reminded of the need to attempt nonpharmacological interventions when behaviors are observed and document the outcomes.

The Monitoring Process to Ensure the Deficient Practice Does Not Recur
The DON and Nurse Consultant have developed a calendar which identifies dates that GDR reviews must be completed by the consultant pharmacist and/or the Psychiatric Nurse Practitioner. They will monitor compliance at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	effective at times. No GDR at this time due to instability. There was no documentation of prior GDR attempts. Interview with the Director of Nursing on 10/5/22 at 4:30 p.m., indicated behavior charting on the MAR should match what was in the nurses' notes for GDR purposes. 2. The record for Resident 20 was reviewed on 10/4/22 at 11:44 a.m. Diagnoses included, but were not limited, insomnia, anxiety, schizoaffective disorder, post traumatic stress syndrome (PTSD), and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated it was still in progress and not completed. The Annual MDS assessment, dated as completed on 6/3/22, indicated the resident was cognitively intact. In the last 7 days the resident had received an anti-anxiety and antidepressant medication. Antipsychotic medication was coded with a "0". The Care Plan, revised on 8/2022, indicated the resident used psychotropic medications related to the diagnosis of schizoaffective disorder and PTSD. Physician's Orders, dated 9/18/21, indicated Perphenazine (an antipsychotic medication) tablet 4 milligrams (mg). Give 1 tablet by mouth one time a day for anxiety. Physician's Orders, dated 3/29/21,indicated monitor behaviors for the following (specify) itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking,		least once per month for three months and document the results. Results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F758** Compliance monitors of GDR documentation will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	spitting, cursing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care. A Nurse Practitioner (NP) Psychiatry Progress Note, dated 8/25/22, indicated the resident was seen today for follow-up visit due to concerns for adjustment with multiple chronic illnesses including major depression, PTSD, schizoaffective disorder, anxiety, and insomnia. Staff reported no changes in behaviors. The resident had shown continued intermittent mild breakthrough behaviors while receiving medication management treatment. Her behaviors would be much worse without medication management. She had periods of refusal of care including hygiene, staff report non-pharmacological interventions were ineffective. She had presented with unstable mood with periods of agitation and uncooperative at times. No GDR (Gradual Dose Reduction) at this time. This provider had reviewed the resident's medical record and consulted with nursing at the facility. Continue current medications and current plan of care including nursing assessment and documentation of daily mood. There was no documented behaviors in Nurses' Notes for the months of 6/2022, 7/2022, and 8/2022 to support the documented progress note for no recommended GDR of the antipsychotic medication. Interview with the Director of Nursing on 10/5/22 at 1:30 p.m., indicated there was no continued documentation of behaviors for the GDR. 3.1-48(b)(2)			
F 0773 SS=D	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	§483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure lab results were obtained in a timely manner and the Physician was notified for 1 of 4 residents reviewed for hospitalization. (Resident 19) Finding includes: The record for Resident 19 was reviewed on 10/6/22 at 10:25 a.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, stroke, non-Alzheimer's dementia, and schizophrenia. Physician's Orders, dated 9/2/22, indicated the following laboratory tests were to be collected: - Complete blood count (CBC) with differential every 3 months starting on the 12th. - Hemoglobin A1C (a test for monitoring blood sugar averages) every month starting on the 23rd. - Valproic acid (a test to measure anticonvulsant medication) every 3 months. - Thyroid stimulating hormone (TSH) every month starting on the 12th related to hypothyroidism (low thyroid). - Metabolic 14 panel (a test to evaluate liver, electrolyte, and kidney function) every 3 months	F 0773	**F773** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 19. The resident received treatment for hypernatremia in the hospital and returned to the facility on 10/12/22. He remains in stable condition. **Corrective Action(s) for Other Residents Potentially Affected** All residents with orders for laboratory monitoring have the potential to be affected by this deficient practice. The lab has provided results of all laboratory tests completed in September. No new laboratory orders have been received. **Measures to Ensure the Deficient Practice Does Not Recur** The DON has obtained a direct contract with the laboratory which	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	starting on the 12th. - Urinalysis (UA) without microscopic test every 3 months starting on the 12th. The labs were drawn on 9/19/22. The laboratory results were faxed to the Physician by the lab on 9/30/22. The facility received the lab results from the Physician on 10/5/22. There was no documentation of follow up with the lab for results by the facility. The lab results indicated the resident had anemia (low blood count), decreased kidney function, elevated TSH levels, decreased valproic acid levels, and a possible urinary tract infection (UTI). During an interview with LPN 1 on 10/5/22 at 2:00 p.m., she indicated the resident was admitted to the hospital for hypernatremia (an elevated sodium level). Interview with the Director of Nursing (DON) on 10/6/22 at 10:24 a.m., indicated the lab they were using was new to the facility and the lab never sent results to the facility, but rather directly to the Physician. The DON also indicated the facility did not have access to online lab results. She could not produce a copy of the contract with the lab and she indicated the contract may be held by the Physician. 3.1-49(f)(2)		includes the requirement that lab results be transmitted to the facility as soon as the results are available. Licensed nurses have been in-serviced on the laboratory arrangement. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will complete laboratory testing audits monthly. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22	
F 0867 SS=F Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of action to correct identified quality deficiencies; Based on observation, record review, and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the number of deficiencies cited involving quality of care for transmitting Minimum Data Set (MDS) assessments, pressure ulcers, pain, unnecessary medications, and infection control. This deficient practice affected 22 of 22 residents residing in the facility. Findings include: Interview with the Director of Nursing on 10/6/22 at 1:34 p.m., indicated the Quality Assessment and Assurance (QAA) Committee met at least quarterly and the committee consisted of the Medical Director, the Administrator, the DON, Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Dietitian, the Food Sanitation Supervisor, the Pharmacist, and Maintenance. The Quality Assurance and Performance Improvement (QAPI) plan requested at the Entrance Conference, was provided during the survey by the DON. The plan was a general outline of how to set up a QAPI committee and what the committee should do. Chapters Four and Five of the plan indicated how to implement performance improvement projects (PIP) as part of the QAPI program and implementing the QAPI program planning and processes. 1. The following deficiencies were cited on this survey at an isolated scope with potential for	F 0867	**F867** **Corrective Action(s) for Residents Affected by the Deficient Practice** No specific residents were identified as affected by the deficient practice. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Corrective actions will be taken for deficient practices involving transmitting Minimum Data Set assessments, pressure ulcers, pain, unnecessary medications, and infection control as submitted in this report. **Measures to Ensure the Deficient Practice Does Not Recur** The Quality Assurance and Performance Improvement committee will continue to meet at least quarterly to review quality performance measured through a variety of audits. Performance improvement projects will be developed and implemented when deemed necessary or appropriate. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring will occur through all audits identified in this report.	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	more than minimal harm and had been cited previously as follows: - F684 Quality of Care was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F686 Pressure Ulcers was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F698 Dialysis was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F757 Unnecessary Medications was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F758 Unnecessary Psychotropic Medications was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F880 Infection Control was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. 2. The following deficiency was cited on this survey at a pattern scope with no actual harm with potential for no more than minimal harm. - F640 Transmitting of Minimum Data Set (MDS) assessments was previously cited on Recertification surveys dated 4/21/22 and 10/29/21. There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Interview with the DON on 10/6/22 at 1:45 p.m., indicated she and the Nurse Consultant were addressing the issue of transmitting the MDS assessments and updating the Care Plans. She		Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F867** QAA Committee to meet quarterly, and available upon request and be actively involved in making systemic changes to prevent deficiency reoccurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	also indicated this had been an ongoing issue. The DON was also aware the above concerns were repeat deficiencies and she indicated some of the areas had been identified and ongoing systems needed to be put into place to prevent recurrence. 3.1-52(b)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to mask use and hand hygiene during random observations of infection control and 1 of 1 treatments observed. (Residents 5 and 2) Findings include: 1. During a random observation on 10/4/22 at 2:05 p.m., Dietary Cook 1 entered the dining room with her mask pulled down below her nose and mouth. She was serving cake to the residents at that time. She briefly pulled up her mask, however, it was positioned beneath her nose. At 2:07 p.m., she proceeded to enter the kitchen and came back to the dining room with another cake. Again, the Cook's mask was positioned beneath her nose. Interview with the Director of Nursing on 10/6/22 at 10:20 a.m., indicated the Cook should have had her mask pulled up when she was serving cake to the residents. 2. During a random observation on 10/5/22 at 9:53 a.m., Physician 1 entered the dining room with his mask pulled down below his nose and mouth. He proceeded to the table where Resident 5 was seated. He pulled up his mask and it was positioned below his nose. Physician 1 started talking to the resident. When the resident indicated he couldn't hear him, he pulled down his mask and it rested below his chin. After speaking with the resident, Physician 1 proceeded to listen to the resident's heart with his mask pulled down. After he was done speaking	F 0880	**F880** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 5. Physician 1 wears a mask when visiting the resident. Resident 2. The resident remains in the hospital. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All staff are required to wear masks in proper positions while in direct resident contact and to use proper hand hygiene while providing care to residents. **Measures to Ensure the Deficient Practice Does Not Recur** All staff have been re-educated on the proper position and method of donning a mask and the proper hand hygiene techniques. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Surveillance of mask and handwashing compliance will be documented on Mask and Handwashing Compliance audit	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with the resident, he pulled up his mask but it was positioned below his nose. He shook hands with the resident and walked out of the dining room. He did not use hand sanitizer prior to leaving the dining room. Interview with the Director of Nursing on 10/6/22 at 10:20 a.m., indicated Physician 1 should have had his mask pulled up and he should have used hand sanitizer prior to leaving the dining room. 3. During an observation of Resident 2's wound treatment with LPN 1 on 10/4/22 at 2:46 p.m., the LPN washed her hands with soap and water, then removed the old dressings. She removed her gloves, sanitized her hands, and cleaned the wound. The LPN did not perform hand hygiene again after cleaning the wound, prior to the application of MediHoney gel and a clean dressing. Interview with LPN 1 at that time, indicated she was aware she should have performed hand hygiene prior to applying a clean dressing. Interview with the Director of Nursing on 10/5/22 at 3:13 p.m., indicated she would be in-servicing staff related to hand hygiene during treatments. The Centers for Disease Control and Prevention, "Hand Hygiene in Healthcare Settings," last reviewed on 1/30/20, indicated " ...Hand Hygiene Guidance ...Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications ...after contact with blood, body fluids, or contaminated surfaces ..." 3.1-18(b)		forms at least once per week for two months, then once every two weeks for four months by D.O.N./ Designee Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. DATE: 11/1/22	
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to loose faucets and toilet seats, dirty baseboards and toilet bases, and a missing cord for the bathroom call light for 2 of 2 halls throughout the facility. (The East and West Halls) Finding includes: During the Environmental tour on 10/6/22 at 10:00 a.m., the following was observed: East Hall a. Room 105 - The toilet seat was observed to be loose and there was no cord for the bathroom call light. Two residents resided in the room and two residents shared the bathroom. b. Room 113 - The sink faucet was observed to be loose. Two residents resided in the room and four residents shared the bathroom. West Hall a. Room 108 - The toilet seat was observed to be dirty and there was adhered dirt along the baseboard in the bathroom and around the base of the toilet. Two residents resided in the room and four residents shared the bathroom. When interviewed on 10/6/22 at 10:13 a.m., the Director of Nursing indicated the above areas should have been cleaned and/or repaired.	F 0921	**F921** **Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were identified as affected by the deficient practice. Room 105 – the toilet seat has been secured and a cord for the bathroom room call light is in place. Room 113 – the sink faucet has been secured to the wall. Room 108 – The toilet seat has been cleaned. The baseboard in this bathroom and the base of the toilet have been cleaned. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. A facility-wide environmental evaluation has been completed to identify any loose toilet seats, loose sinks, and that any areas of adhered dirt have been cleaned. Call lights cords are in place, and any identified areas in need of repair have been repaired. **Measures to Ensure the Deficient Practice Does Not Recur** Maintenance staff have been re-educated on the need to	11/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-19(f)		monitor the safety of resident equipment and the cleanliness of the environment on a regular basis. They are aware of their responsibility to submit requests for any needed supplies or repair parts in a timely manner. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will complete an environmental assessment of equipment, halls, resident rooms, and common areas once per week for two months, then once every two weeks for one month. Assessment results will be documented and submitted to the QAA Committee for review with further revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM **F921** Environmental assessments will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	