STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUILDING B. WING				
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP ( 21ST AVE IN 46407	COD	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Bldg. 00  F 0550 SS=D Bldg. 00	Licensure Survey.  This visit was in cornection Revisit (PSR) to the IN00385996 and In 25, 2022.  Complaint IN0038  Complaint IN0038  Survey dates: Octor Facility number: Operating number: AIM number: 1002  Census Bed Type: SNF/NF: 22  Total: 22  Census Payor Typ Medicaid: 17  Other: 5  Total: 22  These deficiencies accordance with 4  Quality review conductive with 4  Quality review conductive with 4  Quality review conductive with 4  Resident Rights// §483.10(a) (Resident Rights// §483.10(a) Resident Ri	reflect State Findings cited in 10 IAC 16.2-3.1. mpleted on 10/11/22.  0)(1)(2) Exercise of Rights lent Rights. a right to a dignified	F 0000			
LABORATOR	I RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE		(X6) DATE

RAENITA DUMAS RNDON 12/02/2022

Any definency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CWMF11 Facility ID: 000368 If continuation sheet Page 1 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	(X3) DATE SURVEY  COMPLETED  10/06/2022		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
1.20	communication wand services inside including those speaks \$483.10(a)(1) A faresident with respeach resident in a environment that enhancement of hacility must prote the resident.  §483.10(a)(2) The access to quality diagnosis, severit source. A facility maintain identical regarding transfer provision of servicall residents regarding transfer provision of servical resident has her rights as a respective or register or resident can exist without interference or reprisal from the \$483.10(b)(2) The free of interference and reprisal from	ith and access to persons le and outside the facility, pecified in this section.  acility must treat each ect and dignity and care for manner and in an promotes maintenance or his or her quality of life, resident's individuality. The ct and promote the rights of  a facility must provide equal care regardless of y of condition, or payment must establish and policies and practices r, discharge, and the rese under the State plan for redless of payment source.  se of Rights. The right to exercise his or hident of the facility and as not of the United States.  a facility must ensure that exercise his or her rights on, coercion, discrimination,				DATE	
	required under thi	cise of his or her rights as s subpart. on, record review and	F 0550	F550		11/01/2022	

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

interview, the facility failed to ensure each

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

Corrective Action(s) for

If continuation sheet Page 2 of 62

12/07/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident's dignity was maintained related to being Residents Affected by the exposed in the dining room and dining assistance **Deficient Practice** for dependent residents for 2 of 2 residents Resident 4 – unable to correct. reviewed for dignity and for 2 of 6 meals Resident's clothing position is observed. (Residents 4, 1, and 22) being and has been monitored daily. His care plan has Findings include: addressed his repetitive behavior of sticking hand in his pants. 1. On 10/3/22 at 12:54 p.m., Resident 4 was Resident 1 – unable to correct. observed in the dining room seated in a chair. Resident's meal is being served The top of his buttocks was exposed and visible timely. from the base of the chair. Staff in the area did not Resident 22 – unable to correct. redirect him to pull up his pants. We respectfully request IDR for this citation. See Exhibit 1. The record for Resident 4 was reviewed on 10/5/22 The resident's request for ice is at 9:35 a.m. Diagnoses included, but were not being and has been honored. limited to, intellectual disability, mood disorder, Resident 22 had not received and brief psychotic disorder. dialysis since Saturday due to malfunctioning of his dialysis The Quarterly Minimum Data Set (MDS) access cite. He missed dialysis assessment, date 8/22/22, was in progress. The resident was moderately impaired for daily Tuesday and Thursday which was decision making and required limited assistance 5 days since dialysis was with dressing. performed on Resident 22. Interview with the Director of Nursing on 10/6/22 Corrective Action(s) for Other at 10:15 a.m., indicated the resident should have Residents Potentially Affected been told to pull up his pants by staff. She also All residents have the potential to indicated the resident needed some more clothes be affected by this deficient due to a recent weight gain and some of his pants practice. were too small.2. On 10/3/22 at 9:25 a.m., the The resident's right to be treated breakfast meal had started and NA 1 and CNA 1 with dignity and respect is were observed passing trays to the residents in enforced daily through observation the main dining room. Resident 1 was observed and supervision by charge nurses, sitting in a wheelchair at a table with Resident 4. department managers, the DON Meal service continued and Resident 1 still had and the Administrator. not received his food. All other residents had a beverage to drink as well, however, the resident Measures to Ensure the had nothing to drink. Resident 4 received his **Deficient Practice Does Not** food and started eating in front of Resident 1. At Recur

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155845	B. WI	B. WING			10/06/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITT, STATE, ZIF COD			
SIMMON	S LOVING CARE L	IENI TH ENCILITY			IN 46407			
SIMMONS LOVING CARE HEALTH FACILITY				GAINT,	III 40407			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	10:36 a.m., Residen	t 1 received his breakfast and			All staff have been in-serviced	on		
	most of the other re	sidents were finished eating.			the resident's right to be treate	ed		
	The Director of Nu	rsing sat down to feed him.			with dignity and respect. They	are		
					aware of their responsibility to			
	On 10/3/22 at 2:00 p.m., LPN 1 was observed				respond to and/or report any			
	passing out ice crea	m to the residents after lunch			observations of care or service	•		
	for dessert. Resider	nt 1 was seated at one of the			provision that prevents the res	ident		
	dining room tables	and the LPN passed him up			from exercising his or her right			
	and he did not get a	ny ice cream. At 2:30 p.m., the			Department managers are awa			
	resident still had no	t received any ice cream.			of their responsibility to report	any		
					staff practice that fails to suppo	ort		
	On 10/4/22 at 12:55 p.m., Resident 1 was brought				the resident's right to be treate			
	to the dining room a	and placed at a table by			with dignity and respect.			
	himself. At 1:49 p.m., the resident received his				Disciplinary actions will be take	en		
	lunch and NA 1 sat	down to feed him. At 2:05			per facility policy if repeated			
	p.m., Dietary Cook	1 came out of the kitchen and			infractions are identified.			
	passed out cake to a	all of the residents. Resident 1						
	did not receive any	cake for dessert.			The Monitoring Process to			
					Ensure the Deficient Practice	•		
	On 10/5/22 at 8:50	a.m., LPN 1 started passing			Does Not Recur			
		nts in the dining room.			Charge nurses on each shift a	re		
		ed in his wheelchair at a table			responsible for monitoring digr			
	by himself. The LP	N passed out coffee to			related to how clothing is	,		
	-	the resident received nothing.			positioned to prevent exposure	€.		
	-	PN passed out bowls of hot and			The monitoring is documented			
		sidents. At 9:12 a.m., the			a daily Nurse Rounds Sheet a			
		ing out loud, as he did not get			will continue on-going. The DC			
		hortly after, NA 1 brought a			designee is responsible for			
		the resident and sat down to			reviewing the Nurse Rounds			
	feed him.				Sheets at least once per week			
					and for follow up to any identif			
	The record for Resi	dent 1 was reviewed on 10/4/22			concerns. The DON will prepa			
		noses included, but were not			summary of dignity monitoring			
	-	al disabilities, cerebral palsy,			review per the QAA Committee			
		pressure, and muscle spasms.			with further revisions or actions			
	1, 3 51504	,			implemented as deemed	-		
	The Ouarterly Mini	mum Data Set (MDS)			necessary.			
		/7/22, indicated the resident						
		intact. The resident was			DATE: 11/1/22			
		n staff with 2 person physical			Exhibit 1			
		Person Prijsteat						

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assist for transfers and needed extensive assist with 1 person physical assist for eating. We respectfully request this citation be struck from the record. Physician's Orders on the current 10/2022 order statement, indicated the resident was to receive a Resident 22 had been sent out for pureed diet with thickened liquids. dialysis on 10/4/22 but returned without receiving dialysis. Interview with the Director of Nursing on 10/5/22 According to the progress notes, at 1:30 p.m., indicated the resident was not the dialysis center called the supposed to be in the dining room until he was facility at 8:15am informing the ready to eat and he should have received the ice nurse that the dialysis could not cream and cake in pureed form. be performed due to malfunction of the AV fistula access site. NA 1 3. During a random observation on 10/4/22 at was informed of this, which was 10:13 a.m., Resident 22 was observed sitting in a why she did not respond to straight back chair in the dining room. The Resident 22's request for ice. She resident asked NA 1 for more milk. The NA provided the ice after checking indicated to the resident he could not have any with the charge nurse. The more milk. The resident then asked for a cup of resident has a history of ice. The NA stated, "Give me one minute." At requesting liquids or ice rather 10:15 a.m., NA 1 sat down at a table in the dining than eating the solid foods room and just watched the other residents. No prepared for him during meals. other staff were around. She stood up at 10:17 The care plan for Resident 22 a.m., and walked over to another table and cleared addresses the resident's potential the dishes and placed them in a tub by the kitchen nutritional problem related to End door. The resident asked NA 1 for ice again and Stage Renal Disease and dietary the NA stated, "Give me one minute [resident restrictions. The care plan name]." Another resident asked for an extra cup identifies that the resident of orange juice and the NA went into the kitchen becomes easily distracted during and brought out a cup of orange juice and handed meals and prefers soda pop, it to the resident. Another resident asked her for Kool-Aid or plain ice. An ice and she walked into the kitchen and brought intervention is to attempt to give out a bag of ice for the resident's water cup. the resident's tray before or after Resident 22 continued to ask for a cup of ice and other residents are served to NA 1 continued to state, "Give me one minute eliminate excess stimulation for [resident name]." At 10:27 a.m., NA 1 left the the resident and help him focus on

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

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

Event ID:

CWMF11 Facility ID: 000368

NA 1 is very familiar with this

resident's history, his distraction

the meal.

If continuation sheet

Page 5 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155845	B. W	ING		10/06/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION
TAG	``			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			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)  483.20(c)  Qrtly Assessment at Least Every 3 Months				during meals, and his frequent requests for liquids or ice. The charge nurse was completing morning medication pass at the time the requests were made. NA 1 waited until the nurse was available to answer her questi. She did not feel it was emerge enough to distract the nurse frequesting medications. The delay 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 she wanted direct instruction for the nurse. The delay in resport was not at attempt to restrict the resident's right to a dignified existence.	the e so as on. ent om ay in  as ot , and rom ase	
F 0638 SS=E Bldg. 00			F 00	638	F638 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 4 – unable to correct MDS assessments are now in		11/11/2022

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 6 of 62

12/07/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: compliance. Resident 18 - unable to correct. 1. The record for Resident 4 was reviewed on MDS assessments are now in 10/5/22 at 9:35 a.m. compliance. Resident 20 – unable to correct. There was a Quarterly Minimum Data Set (MDS) MDS assessments are now in assessment, dated 5/22/22 and completed on compliance. 6/5/22. The Quarterly MDS assessment, dated Resident 6 – unable to correct. 8/22/22, indicated the MDS was in progress and MDS assessments are now in not completed. compliance. Resident 17 – unable to correct. Interview with the Director of Nursing on 10/5/22 MDS assessments are now in at 3:50 p.m., indicated the Quarterly MDS had not compliance. been completed timely and all of the MDS Resident 19 – unable to correct. MDS assessments are now in assessments were in the process of being completed and transmitted. 2. The record for compliance. Resident 18 was reviewed on 10/4/22 10:38 a.m. Corrective Action(s) for Other The Quarterly Minimum Data Set (MDS) **Residents Potentially Affected** assessment, dated 8/17/22, indicated it was still in All residents have the potential to progress. be affected by this deficient practice. 3. The record for Resident 20 was reviewed on Quarterly MDS assessments have 10/4/22 at 11:44 a.m. been audited for all current residents and are in compliance The Quarterly Minimum Data Set (MDS) with required completion dates. assessment, dated 8/20/22, indicated it was still in progress and not completed. Measures to Ensure the **Deficient Practice Does Not** Interview with the Director of Nursing on 10/4/22 Recur at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS DON will monitor MDS calendar assessments. She was aware the MDS weekly and address compliance at assessments were not completed timely.4. The morning meetings on record for Resident 6 was reviewed on 10/5/22 at Wednesday. MDS have been 11:51 a.m. outsourced but they will be done in-house until new MDS There was an Admission Minimum Data Set Coordinator is hired. (MDS) assessment completed on 6/1/22. MDS will be reviewed by DON and

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 7 of 62

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/06/2022	
	PROVIDER OR SUPPLIER		700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	A Quarterly MDS a still in progress.	ssessment, dated 8/26/22, was esident 17 was reviewed on n.	TAG	Nurse Consultant weekly to ensure compliance and tracki log will be reviewed with Administrator and Q.A. Committee.	ng DATE
	A Quarterly MDS a still in progress.  Interview with the I at 2:00 p.m., indicat	Sissessment, dated 8/10/22, was Director of Nursing on 10/4/22 and the Nurse Consultant and		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 for	our
	assessments. She wassessments were no record for Resident 11:32 a.m.	ng on correcting all of the MDS was aware the MDS of completed timely.6. The 19 was reviewed on 10/5/22 at only Minimum Data Set (MDS)		weeks, then once every week on-going. Audit results will be reviewed per the QAA Comm with further revisions or action implemented as deemed necessary.	ittee
	assessment, dated 5 5/17/22.	/3/22 and completed on		DATE: 11/11/22	
	The following Quar dated 8/3/22 and wa	terly MDS assessment was as in progress.			
	at 2:00 p.m., indicate herself were working assessments. She w	Director of Nursing on 10/4/22 and the Nurse Consultant and ag on correcting all of the MDS was aware the MDS of completed timely.			
	3.1-31(d)(3)				
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmi Assessments §483.20(f) Automa	itting Resident ated data processing			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION  00	COM	(X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI		(X5) COMPLETION	
TAG	§483.20(f)(1) End after a facility con assessment, a far following informat facility:  (i) Admission ass (ii) Annual assess (iii) Significant chassessments.  (iv) Quarterly revi (v) A subset of ite transfer, reentry, (vi) Background (there is no admission assessment, a factransmitting to the for each resident format that confol layouts and data passes standardizand the State.  §483.20(f)(3) Transmitting to the format that confol layouts and data passes standardizand the State.  §483.20(f)(3) Transmitting to the format that confol layouts and data passes standardizand the State.	ew assessments.  ew assessments.  ems upon a resident's discharge, and death. face-sheet) information, if sion assessment.  esmitting data. Within 7 ety completes a resident's cility must be capable of e CMS System information contained in the MDS in a ems to standard record dictionaries, and that ed edits defined by CMS  ensmittal requirements. eter a facility must esmit encoded, accurate, es data to the CMS System, wing: essment. enge in status assessment. errection of prior quarterly	TAG	DEFICIENCY)		DATE	

(vii) A subset of items upon a resident's

PRINTED: 12/07/2022

DEPARTMEN CENTERS FOI		FORM APPROVED OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/06/2022		
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	700	ET ADDRESS, CITY, STATE, ZIP COL E 21ST AVE RY, IN 46407	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	(viii) Background an initial transmis resident that does assessment.  §483.20(f)(4) Dat transmit data in the or, for a State where approved by CMS the State and app Based on record refailed to successful Set (MDS) assessments whose M reviewed. (Residents whose M reviewed. (Residents whose M reviewed. (Residents whose M reviewed.)  1. The record for F 10/4/22 at 10:52 a.  The Quarterly Min assessment, dated accepted but not excompleted on 7/21/2. Interview with the at 2:00 p.m., indicates herself were working assessments. She wassessments had not for Resident 6 was a.m.  The 5/26/22 Admissional control of the support of the suppo	view and interview, the facility ly export the Minimum Data ment in timely manner for 4 of 17 DS assessments were ints 1, 6, 23, and 5)  Resident 1 was reviewed on m.  imum Data Set (MDS) 7/7/22, indicated it was exported. The MDS was	F 0640	F640 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 1— unable to compliance. Resident 6— unable to compliance. Resident 23— unable to compliance. Resident 23— unable to compliance. Resident 5— unable to compliance. Corrective Action(s) for Residents Potentially Action Residents Potentially Residents Potentially Action Residents Potentially Residents Potentially Residents P	he  orrect. ow in  orrect. ow in  correct. ow in  orrect. ow in  Other ffected  tential to ent  ave been ents and	11/11/2022

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

was not exported or transmitted.

3. The record for Resident 23 was reviewed on

Event ID:

CWMF11 Facility ID: 000368

with required time frames.

Measures to Ensure the

If continuation sheet

Page 10 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/06/2022		
	PROVIDER OR SUPPLIE	R HEALTH FACILITY		700 E 2	ADDRESS, CITY, STATE, ZIP COD PAST AVE IN 46407	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
F 0641	10/5/22 at 11:52 a  The 5/18/22 Quart assessment, indica was not exported of 4. The record for I 10/5/22 at 12:37 p  The 5/20/22 Admi assessment, indica was not exported of a second control of the cont	rerly Minimum Data Set (MDS) ted it had been completed but or transmitted.  Resident 5 was reviewed on .m.  ssion Minimum Data Set (MDS) ted it had been completed but		TAG	Deficient Practice Does Not Recur  DON will monitor MDS calend weekly and address compliant morning meetings on Wednesday. MDS have beer outsourced but they will be do in-house until new MDS Coordinator is hired.  MDS will be reviewed by DON Nurse Consultant weekly to ensure compliance and trackil 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 foweeks, then once every week on-going. Audit results will be reviewed per the QAA Comm with further revisions or action implemented as deemed necessary.  DATE: 11/11/22	ce at none N and ng	DATE
SS=A Bldg. 00	The assessment resident's status.	racy of Assessments. must accurately reflect the	F 064	41	F641		11/11/2022

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

STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SUR	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE		COMPLETE	D	
		155845	B. W	NG _		10/06/202	22
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			1ST AVE		
SIMMON	IS LOVING CARE H	JEALTH EACH ITY			IN 46407		
SIIVIIVIOIN	IS LOVING CARE F	TEALTH FACILITY		GART,	IN 40407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re CC	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to ensure the	Minimum Data Set (MDS)			Corrective Action(s) for		
	comprehensive assessment was accurately				Residents Affected by the		
	completed related to	o antipsychotic medication use			Deficient Practice		
	and falls with major	r injury for 2 of 17 MDS			Resident B- correction to MDS	6	
	assessments review	ed. (Residents B and 20)			was completed and assessme	nt	
					is now in compliance.		
	Findings include:						
					Corrective Action(s) for Othe	r	
	1. The record for Resident B was reviewed on				Residents Potentially Affecte	d	
	10/5/22 at 8:46 a.m. Diagnoses included, but were						
	not limited to, chronic kidney disease, dementia				All residents have the potentia	l to	
	with behaviors, glaucoma, anxiety, major				be affected by this deficient		
	depressive disorder, psychotic disorder with				practice.		
	hallucinations, and insomnia.				All MDS assessments have be	en	
					audited for current residents a	nd	
	The Modified Signi	ficant Change Minimum Data			have been exported in complia	nce	
	Set (MDS) assessm	ent, dated 7/7/22, indicated the			with required time frames.		
	resident was not co	gnitively intact. The resident					
	needed supervision	with 1 person physical assist			Measures to Ensure the		
	for bed mobility and	d 1 person physical assist for			Deficient Practice Does Not		
	transfers. The resid	lent had 1 fall with injury			Recur		
	(except major) since	e the last assessment. A					
	fracture had not bee	en checked.			DON will monitor MDS calenda	ar	
					weekly and address psychotro	pic	
	Nurses' Notes, date	d 6/26/22 at 6:20 a.m., indicated			drug use compliance at mornir	-	
	at 4:30 a.m., the res	ident's roommate alerted staff			meetings on Wednesday. MD	-	
		the floor. The resident had a			have been outsourced but the		
	bruise on the upper	lip and slight bleeding from			be done in-house until new MI		
	the nostril. The low	ver eyelid was swollen and			Coordinator is hired.		
	dark. 911 was notif	ied and the resident was sent to					
	the emergency room	n.			MDS will be reviewed by DON	and	
					Nurse Consultant weekly to		
	Nurses' Notes, date	d 6/26/22 at 8:42 a.m., indicated			ensure compliance and trackir	ıg	
	the resident was bei	ing transferred to another			log will be reviewed with		
		acture of the facial bone.			Administrator and Q.A.		
					Committee.		
	Interview with the I	Director of Nursing (DON) on					
		., indicated the fracture was not			The Monitoring Process to		
	coded on the Signif				Ensure the Deficient Practice		
	assessment.	-			Does Not Recur		
					-		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		155845	B. WI	ING		10/06	/2022
				CTD FET	ADDRESS OF A STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CINANACNI					1ST AVE		
SIMMONS LOVING CARE HEALTH FACILITY				GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					The Director of Nursing or		
	2. The record for l	Resident 20 was reviewed on			designee will audit MDS		
	10/4/22 at 11:44 a.	m. Diagnoses included, but			assessments for timely		
	were not limited, to	o insomnia, anxiety,			completion twice a week for fo	our	
	schizoaffective dis	order, post traumatic stress			weeks, then once every week		
	syndrome, and maj	jor depressive disorder.			on-going. Audit results will be		
					reviewed per the QAA Commi	ttee	
	The Quarterly Min	imum Data Set (MDS)			with further revisions or action	s	
	assessment, dated	8/20/22, indicated it was still in			implemented as deemed		
	progress and not co	ompleted.			necessary.		
	The Annual MDS assessment, dated as being				DATE: 11/11/22		
	completed on 6/3/22, indicated the resident was						
		The question regarding the					
	_	sidered by the State Level II					
	· ·	ission Screening and Resident					
		have serious mental illness					
		disability or a related condition					
		In the last 7 days, the resident					
		ti-anxiety and antidepressant					
	_	sychotic medication was coded					
	with a "0".						
		, dated 9/18/21, indicated					
		antipsychotic medication) tablet					
		Give 1 tablet by mouth one time					
	a day for anxiety.						
		Director of Nursing on 10/5/22					
	_	ated she was aware the MDS					
	assessment was ina	accurately coded.					
	2.1.21(1)						
	3.1-31(i)						
F 0645	402 20(1/3/4) (2)						
SS=D	483.20(k)(1)-(3)	ing for MD 9 ID					
Bldg. 00	PASARR Screen	_					
Diag. 00	- ' '	Imission Screening for mental disorder and					
	i individuals with ir	ntellectual disability.					

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 13 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155845	B. W	ING		10/06/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			1ST AVE		
CIMMMON	S I OVING CADE L	JEALTH EACH ITV			IN 46407		
SIIVIIVIOIN	MMONS LOVING CARE HEALTH FACILITY			GART,			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.20(k)(1) A n	ursing facility must not					
	admit, on or after	January 1, 1989, any new					
	residents with:						
	* *	r as defined in paragraph (k)					
	, , , ,	on, unless the State mental					
	-	as determined, based on an					
		ical and mental evaluation					
		erson or entity other than					
		nealth 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; an						
	, ,	al requires such level of					
		the individual requires					
	specialized servic						
	, ,	ability, as defined in					
		i) of this section, unless the					
		disability or developmental					
	admission-	has determined prior to					
		of the physical and mental					
	, ,	dividual, the individual					
		of services provided by a					
	nursing facility; an						
		al requires such level of					
	• •	the individual requires					
		es for intellectual disability.					
	opoolanzoa ool vio	oo for intellectual dicubility.					
	\$483.20(k)(2) Exc	ceptions. For purposes of					
	this section-						
		on screening program under					
		f this section need not					
	. •	ninations in the case of the					
	readmission to a nursing facility of an						
		ter being admitted to the					
		as transferred for care in a					
	hospital.						
		choose not to apply the					

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 14 of 62

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155845	B. WI	NG		10/06/	2022
	PROVIDER OR SUPPLIER			700 E 2	DDRESS, CITY, STATE, ZIP COD		
SIMMON	S LOVING CARE F	IEALTH FACILITY		GARY, I	IN 46407		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	paragraph (k)(1) of admission to a nurindividual- (A) Who is admitted from a hospital after care at the hospital (B) Who requires in the condition for we care in the hospital (C) Whose attending before admission individual is likely days of nursing faction- (i) An individual is mental disorder if mental disorder definity and individual is definitely and individual is defined and individual individual is defined and individual individual is defined and individual individua	ed to the facility directly er receiving acute inpatient al, nursing facility services for which the individual received al, and ing physician has certified, to the facility that the to require less than 30 cility services.  Inition. For purposes of this considered to have a the individual has a serious efined in 483.102(b)(1).					
	§483.102(b)(3) or condition as descr chapter. Based on record rev	r is a person with a related cribed in 435.1010 of this eview and interview, the facility		45	F645		11/11/2022
	Screening and Resident with a residents reviewed for a resident reviewed for the residents reviewed for the resident with a resident with a resident with a resident reviewed for the reviewed for the resident reviewed for the reviewed	evel II PASARR (Preadmission dent Review) was completed mental illness for 1 of 1 for PASARR. (Resident 20)			Corrective Action(s) for Residents Affected by the Deficient Practice Resident 20 has had a Level II PASARR completed.		
	10/4/22 at 11:44 a.n were not limited, to schizoaffective diso	dent 20 was reviewed on n. Diagnoses included, but insomnia, anxiety, order, post traumatic stress or depressive disorder.			Corrective Action(s) for Othe Residents Potentially Affecte Any resident with a mental disorder or intellectual disabilit defined at §483.20(k)(3) has t potential to be affected by this deficient practice. An audit was	<b>d</b> y as he	

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

Event ID: CWMF11 Facility ID: 000368

If continuation sheet

Page 15 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED	
		155845	B. W	ING		10/06/2	2022
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
CINANACNI	IC LOVING GADE I	IEAL THEA ON ITY			21ST AVE		
SIMMON	S LOVING CARE H	1EALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The Quarterly Mini	mum Data Set (MDS)			completed of Level I PASARR	₹	
	assessment, dated 8	/20/22, indicated it was still in			assessments for all current		
	progress and not co	mpleted.			residents, and there are curre	ntly	
					no residents who require a Le	vel II	
	The Annual MDS	assessment, dated as			PASARR assessment.		
	completed on 6/3/22, indicated the resident was				Measures to Ensure the		
	_	The question regarding the			Deficient Practice Does Not		
	resident being considered by the State Level II				Recur		
	PASARR (Preadmission Screening and Resident						
	Review) process to have serious mental illness				Social Worker will refer Reside	ent	
	and/or intellectual disability or a related condition				20 to agency for Level II		
	was marked "No." In the last 7 days the resident				assessment		
	had received an anti-anxiety and antidepressant						
	medication. Antipsychotic medication was coded				The Monitoring Process to		
	with a "0".				Ensure the Deficient Practice	e	
					Does Not Recur		
	A Level 1 PASARI	R was completed on 8/2/22 and			The DON or designee will		
	indicated the reside	nt needed a Level II			complete an audit of all new		
	assessment due to n	nental illness.			admissions within one week p	ost	
					admission to ensure that the L	_evel	
	Interview with the S	Social Service Director (SSD)			I PASARR assessment does i	not	
	on 10/4/22 at 3:00 p	o.m., indicated she was unaware			require a Level II PASARR		
	the resident needed	a Level II assessment and she			assessment. The audits will		
	did not know who t	o contact for the screening.			continue following each new		
					admission for three months. A	udit	
	Interview with the I	Director of Nursing on 10/5/22			results will be reviewed per th	e	
	_	ted she was unaware the			QAA Committee with further		
	resident needed a P.	ASARR Level II assessment.			revisions or actions implemen	ted	
					as deemed necessary.		
	3.1-16(d)(1)(B)						
					DATE: 11/11/22		
					ADDENDUM		
					F645		
					Audits of new admissions will	be	
					discontinued when 100%		
					compliance has been achieve	d for	
					3 consecutive admissions. wil	l be	
					discontinued when 100%		
					compliance has been achieve	d for	
					one month. If not achieved, th	е	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER  155845	A. BUILDING 00  B. WING			COMPLETED 10/06/2022	
	ROVIDER OR SUPPLIER S LOVING CARE H				DDRESS, CITY, STATE, ZIP COD IST AVE N 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
					QAA Committee will determine need for further revisions or corrective actions as well as th frequency and length of contin- audits.	e	
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene;	g, and personal and oral					
	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:		F 067	7	Corrective Action(s) for Residents Affected by the Deficient Practice Resident 7. A new shampoo habeen trialed for the resident with an improvement in her hair		11/11/2022
	7 was seated at a tab hair was greasy in a On 10/4/22 at 10:30	200 a.m. and 1:30 p.m., Resident tole in the dining room. Her ppearance.  a.m., 11:25 a.m., and 2:36 p.m., amained greasy in appearance.			presentation. Resident 21. We respectfully request IDR for this citation. Se Exhibit 2. The resident is served liquids a solid foods in accordance with diet order and care plan interventions. Meal assistance	and her	
	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				provided as needed. Resident 2 is in the hospital at this time.		
	limited to, dementia violent behaviors, and delusions.	noses included, but were not with behavior disturbance, and psychotic disorder with			Corrective Action(s) for Other Residents Potentially Affecte All residents who require assistance with ADLs have the potential to be affected by this	d	
		mum Data Set (MDS) /4/22, indicated the resident			deficient practice. Residents receive showers with shampoo	s in	

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

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

If continuation sheet

Page 17 of 62

PRINTED: 12/07/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was cognitively impaired for daily decision making accordance with the planned and she required extensive assistance for bathing. shower schedule. Beverages are served prior to main entrees, and A Care Plan, reviewed on 8/4/22, indicated the additional liquids are provided per resident had an ADL (activities of daily living) self resident request. Staff are care performance deficit related to decreased informed of individual resident mobility. Interventions included, but were not needs such as assistance with limited to, encourage the resident to participate to meal set up including cutting the fullest extent possible with each interaction meats, cueing and encouragement and monitor for any changes, any potential for to eat solid foods, and special improvement, reasons for self care deficit, body or hair products. expected course, and decline in function. Measures to Ensure the The October 2022 ADL flow sheet, indicated the **Deficient Practice Does Not** resident had received a shower on 10/1, 10/2, 10/3, Recur 10/4, 10/5, and 10/6/22. There was no Licensed and certified staff have documentation indicating if the resident's hair had been in-serviced on providing been washed. individualized body or hair products, serving liquids and Interview with the Director of Nursing on 10/6/22 assistance with meals including at 10:20 a.m., indicated the resident's hair would be cutting meat. washed. She also indicated they were going to try a different shampoo that wouldn't leave the The Monitoring Process to resident's hair greasy looking. **Ensure the Deficient Practice Does Not Recur** 2. On 10/3/22 at 10:12 a.m., Resident 21 was Charge nurses on each shift are observed seated at a table in the dining room. She responsible for monitoring that was served her breakfast at that time. The ADL assistance is provided to resident had already finished her coffee and juice. dependent residents and that meal She was not served any additional beverages assistance is provided when when her tray was delivered. At 10:31 a.m., the needed. The monitoring is resident continued to eat her breakfast and she documented on a daily Nurse had not been offered any beverages. Rounds Sheet and will continue on-going. The DON or designee is On 10/5/22 at 8:54 a.m., the resident was seated in responsible for reviewing the Nurse her wheelchair at a table in the dining room. She Rounds Sheets at least once per

was drinking coffee at that time. At 9:10 a.m., she

finished all of her coffee and juice. At 9:51 a.m.,

received a bowl of cold cereal and she had

she received her breakfast tray and was not

week and for follow up to any

identified concerns. The DON will

prepare a summary of ADL and

meal assistance monitoring

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155845	B. W	ING		10/06	/2022
		1		STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
SIMMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
SIIVIIVIOIN	LOVING CARE F	ILALIIII AOILIII		GART,	11N TUTU!		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<del>                                     </del>	TAG	DEFICIENCY)		DATE
	1 -	additional fluids. At 1:40 p.m.,			results for review per the QAA		
		ed her lunch tray. She did not			Committee with further revisio	ns or	
		drink. At 1:49 p.m., the			actions implemented as deem	ed	
		glass of orange drink. She			necessary.		
		d up the glass and started			DATE: 11/11/22		
	drinking the bevera	ige.					
					IDR Exhibit 2		
		ident 21 was reviewed on			F677 2.		
		m. Diagnoses included, but			We respectfully request this		
	were not limited to, dementia with behavioral				citation be struck from the rec	ord.	
	disturbance.						
	The Quarterly Minimum Date Set (MDS)				Resident 21 has extensive		
	The Quarterly Minimum Data Set (MDS)				cognitive impairments and		
		9/11/22, indicated the resident			frequently prefers to drink only		
		paired for daily decision making			liquids rather than consume so		
	and she needed sup	ervision with eating.			foods. Staff are aware of this a	and	
		0/07/00			attempt to provide her with		
		9/25/22, indicated the resident			adequate hydration while		
		red nutrition related to the			encouraging caloric intake of		
	_	xia and decreased oral			foods. The surveyor noted that		
		required supervision with			resident's care plan addressed		
	1 -	nort attention span and			resident's risk for altered nutri		
		. Interventions included, but			and that this plan addresses the		
		, staff were to assist with meals			short attention span and adva		
	as needed.				dementia. The surveyor includ	ied in	
	I	Dinastan af Namaina 10/5/22			the citation that a planned	4 -	
		Director of Nursing on 10/5/22			intervention was that staff wer		
		ted the resident should have			assist with meals as needed.		
		beverages in a more timely			surveyor did not mention that	meai	
	_	an observation of breakfast on			assistance was not provided.	0110	
		., Resident 2 was in a wheelchair			Instead, the citation clearly sh		
		brought a breakfast plate to			the resident was served liquid		
		NA 2 cued the resident, telling			before the breakfast meal was		
	him where his food was located on the plate. The				served on 10/3/22 at 10:12am		
	resident picked up his orange juice to drink. CNA				stated "The resident had alrea	-	
	2 cued him once more and then left. The resident				finished her coffee and juice".		
		cup on top of his plate, turned			10/5/22 at 8:54am the surveyo	or <sup>.</sup>	
		ot eat. The resident was only			observed the resident to be		
		spoon for his eating utensil,			drinking coffee at that time. Th		
1	nis sausage was not	t cut up and was left in whole	1		surveyor further observed that	the	I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155845	B. WI	ING		10/06/	/2022
				CTDPPT :	ADDRESS CITY STATE ZIR COP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CINANACNI		ICALTH CACHITY			IN 46407		
SIMIMON	S LOVING CARE F	IEAL I II FAUILII Y		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	•	DATE
	patties. At 10:12 a.r	n., LPN 1 gave the resident his			resident received a bowl of co	ld	
	medications and asl	xed CNA 1 to come over and			cereal at 9:10am and "she had	b	
	assist him with his 1	meal.			finished all her coffee and juic	e".	
					-		
	Resident 2's record	was reviewed on 10/4/22 at			The surveyor made no		
	10:08 a.m. Diagnos	es included, but were not			observations indicating the		
	limited to, schizoph	renia, dementia, major			resident appeared dehydrated	or	
	depressive disorder	, and anxiety disorder.			was requesting additional fluid		
	The Quarterly Minimum Data Set (MDS)				The resident does not have a		
					physician's order for a specific	;	
	assessment, dated 6	/30/22, indicated the resident			amount of liquids to be provide	ed at	
	was severely impaired for daily decision making.				meals. The resident's hydratio	n	
	The resident needed setup help only for bed				and nutritional status is monito		
	mobility and toilet use. The resident was not				by the facility through monthly		
	assessed for transfe	rs, dressing, eating, personal			weights, tracking urinary outpu	ut	
	hygiene, or bathing				through the toileting		
					documentation in the electroni	ic	
	A Care Plan, dated	4/3/22, indicated the resident			record, and through quarterly		
	had an Activities of	Daily Living (ADL) self-care			Dehydration Risk Screening.	Гһе	
	performance deficit	related to dementia and			most recent Dehydration Risk		
	decreased mobility.	Interventions included, but			Screening was completed 9/6/		
	were not limited to,	encourage the resident to fully			and resulted in a score of 8.0.		
	participate, encoura	ge the resident to use the call			According to the screening sca	ale,	
	light for assistance,	and monitor for any changes.			a score of 10 or higher indicat		
					risk for dehydration. There has		
	Interview with the I	Director of Nursing on 10/5/22			been no decrease in the numb		
		ted she had no further			incontinent episodes. The		
	information.				resident's weight is stable. The	е	
					resident receives Megace twi		
	3.1-38(a)(2)(D)				daily to stimulate appetite and		
	3.1-38(a)(3)(B)				supplement of Ensure twice da		
					Clinically the resident appears	well	
					hydrated and nourished.		
					Staff provided the resident wit	h	
					adequate fluids and served he	er	
					meals in accordance with the	diet	
					orders and care plan		
					interventions.		

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 20 of 62

12/07/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0679 483.24(c)(1) SS=E Activities Meet Interest/Needs Each Resident Bldg. 00 §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 F 0679 F679 11/11/2022 interview, the facility failed to ensure an ongoing Corrective Action(s) for activity program was implemented for cognitively Residents Affected by the impaired and dependent residents for 4 of 4 **Deficient Practice** residents reviewed for activities. (Residents 4, 21, Resident 4. A care plan related to 1, and B) individualized activity programming has been developed and Findings include: implemented. The Activities Quarterly Participation Review has been reviewed and updated. 1. On 10/3/22 at 11:30 a.m., Resident 4 was observed seated at a table in the dining room. Activity progress notes are The television was on but no other activities were current. taking place. Resident 21. A care plan related to individualized activity On 10/4/22 at 10:29 a.m., the resident was seated at programming has been developed a table in the dining room. The television was and implemented. The Activities turned on but no other activities were taking Quarterly Participation Review has place. At 10:32 a.m., the resident was given a been reviewed and updated. coloring book and crayons. The resident did not Activity progress notes are want them and was given a deck of cards instead. current. At 11:48 a.m., the resident was observed sorting Resident 1. A care plan related to

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

the dining room.

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

Event ID:

CWMF11 Facility ID: 000368

individualized activity programming

Quarterly Participation Review has been reviewed and updated.

has been developed and

implemented. The Activities

If continuation sheet Page 21 of 62

PRINTED: 12/07/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155845 B. WING 10/06/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 10/5/22 at 8:56 a.m., the resident was seated at Activity progress notes are a table in the dining room. He was waiting on current. The resident is now breakfast and playing with a deck of cards. At positioned in bed so that the TV is 10:19 a.m., the resident remained in the dining in his line of vision. room. He continued to play with the deck of cards Resident B. A care plan related to and a talk show was on the television. individualized activity programming has been developed and No activity calendar was observed to be posted in implemented. The Activities the dining room. Quarterly Participation Review has been reviewed and updated. The record for Resident 4 was reviewed on 10/5/22 Activity progress notes are at 9:35 a.m. Diagnoses included, but were not current. The resident is now limited to, intellectual disability, Down Syndrome, positioned in bed so that the TV is and mood disorder. in his line of vision. The Quarterly Minimum Data Set (MDS) Corrective Action(s) for Other assessment, dated 8/22/22, was in progress. The **Residents Potentially Affected** resident was moderately impaired for daily All residents have the potential to decision making. be affected by this deficient practice. Residents have been The resident had no Care Plan related to activity interviewed and individualized care participation. plans reflecting leisure interests and activity preferences are in The Activities Quarterly Participation Review, place. Activity progress notes and dated 8/21/22, indicated the resident participated **Activities Quarterly Participation** in group activities at least once a week and he Reviews are current for all enjoyed painting, patio outings, snacks and residents. Monthly Activity movies, and card games. Calendars have been updated to reflect the preferred activities and The last documented activity progress note was are posted in the dining room. dated 4/18/22. Measures to Ensure the Interview with the Director of Nursing on 10/5/22 **Deficient Practice Does Not** at 3:50 p.m., indicated the Activity Assistant was Recur also a CNA and he was having to be used on the Activity staff have been in-serviced floor from time to time so activities were lacking. on job responsibilities related to the facility Activity Program.

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

Supplies have been purchased for

the department to ensure that

diverse activities can be offered.

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155845	B. W	ING		10/06	/2022
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					21ST AVE		
SIMMON	NS LOVING CARE I	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	A T.F.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	but no activities we						
		are tuning place.			The Monitoring Process to		
	On 10/4/22 at 10:2	7 a.m., the resident was seated in			Ensure the Deficient Practic	Δ	
		ne dining room. The television			Does Not Recur	C	
		_				النبد	
	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				The Administrator or designed		
					be responsible for ensuring the		
					planned activities occur on a	-	
	1				basis Monday through Friday		
	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				Charge nurse will be respons		
					for ensuring that planned acti	vities	
					occur on weekends. Activity		
					audits will be conducted by th		
		At 11:46 a.m., she was woken			Administrator or designee one		
		rator and given a ball to hold.			weekly for two months, then of		
	_	resident's eyes were closed and			every two weeks for a month.		
		n the table in front of her. At			Audit results will be reviewed		
	1:13 p.m., the resid	ent remained seated in the			the QAA Committee with furth	ner	
	dining room. The to	elevision remained on in the			revisions or actions implemer	nted	
	dining room but no	organized activities were			as deemed necessary.		
	taking place. The r	resident received her lunch tray					
	at 1:41 p.m. and at	2:57 p.m., the resident remained			DATE: 11/11/22		
		s sleeping. No activities were					
	taking place.				ADDENDUM		
					F679		
	On 10/5/22 at 10:2:	5 a.m., the resident continued to			Audits of the Activity Program	will	
		d out of the dining room. The			be discontinued when 100%		
		ut no organized activities were			compliance has been achieve	ed for	
		04 p.m., the resident was			one month. If not achieved, the		
		tio with the other residents			QAA Committee will determin		
	and NA 1.	no with the other residents					
	allu INA 1.				need for further program revis		
	The mass 1 f D	idant 21 vyga marriar I			or corrective actions as well a		
		ident 21 was reviewed on			frequency and length of conti	nuea	
		m. Diagnoses included, but			audits.		
		, dementia with behavioral					
	disturbance.						
	The Quarterly Mini	imum Data Set (MDS)					
	assessment dated 9/11/22 indicated the resident						

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

making.

was cognitively impaired for daily decision

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 23 of 62

PRINTED: 12/07/2022

DEPARTMENT		FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	l í	JILDING	ONSTRUCTION 00	(x3) date survey  completed  10/06/2022	
	PROVIDER OR SUPPLIE	R HEALTH FACILITY		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	resident was dependent emotional, intellector related to cognitive included, but were activities the reside compatible with photompatible with know adapted as needed resident lacked har segmentation), con and abilities, and a segmentation outings, must snacks/movie. She focused during one needed to be redired watching movies where the segmentation of the last activity properties with the at 3:50 p.m., indicate to wander aimless been provided. She Assistant was a CN used on the floor fill were lacking. 3. On was observed in be staring at the ceiling staring at the ceiling watching into the ceiling at the ceiling staring at the ceiling activities and the segmentation of the segme	terly Review, dated 9/11/22, ent participated in news/coffee, ic/meditation, and thad a hard time staying to one activities as she exted. Her favorite activity was					

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

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 24 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155845	B. WING		10/06/2022
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	•
				21ST AVE	
SIMMON	S LOVING CARE H	HEALTH FACILITY	GARY	, IN 46407	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ed. His eyes were open and he eiling. The television was			
		nd his head and to the right,			
	completely out of v				
	1 2				
		dent 1 was reviewed on 10/4/22			
	_	noses included, but were not			
	limited to, intellectual disabilities, cerebral palsy, and aphasia (difficulty speaking).				
	and apnasia (difficu	шу ърсакину).			
	The Quarterly Mini	mum 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.			
	Δ 9/12/21 Admissia	on Activity Assessment,			
		nt preferred 1 to 1 visits with			
	staff.	•			
	There were no 1 to	1 activity visits documented.			
	There were no 1 to	i activity visits documented.			
	Interview with the I	Director of Nursing on 10/5/22			
	at 1:30 p.m., indica	ted the resident's television was			
	on the wall and he	was not able to see it.			
	1 On 10/2/22 of 11	:20 a.m., Resident B was			
		n. At that time, the resident			
		positioned by his bed. Staff			
		id not turn on the television.			
		a.m. to 12:55 p.m., the resident			
		in bed. The television was			
		, it was located on the night ad. 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			

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 25 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRU	JCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	3 <u>00</u>		COMPL	ETED
		155845	B. WING			10/06/	2022
	PROVIDER OR SUPPLIER		700	EET ADDRES E 21ST A RY, IN 464		•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION  D BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CORRES DEFENDED FOR THE ADDRODULE OF THE		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	was observed lying	awake in bed. The television					
		nowever, it was positioned on					
	I -	nd his head and completely					
	out of view for him	to see.					
	TI ICD.	1 (D : 1					
		dent B was reviewed on  . 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						
	_	with 1 person physical assist					
	I	d 1 person physical assist for					
	activities.	lent liked to listen to music for					
	activities.						
	A Care Plan, revise	d on 7/7/22, indicated the					
		imited tolerance for activity					
	programs due to his	s diagnosis of dementia with					
	behaviors.						
		d on 7/7/22, indicated the					
	1	ed visual function related to					
	glaucoma.						
	Interview with the I	Director of Nursing on 10/5/22					
		ted the resident's television was					
	behind his head wh						
	3.1-33(a)						
F 0004	400.05						
F 0684 SS=D	483.25						
SS=D Bldg. 00	Quality of Care	of care					
ыug. uu	§ 483.25 Quality of	or care a fundamental principle that					
	1	ment and care provided to					
	facility residents.						

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 26 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155845	B. W	ING		10/06	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			21ST AVE		
SIMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
GIIVIIVIOIN	C LOVING OAKET	ILALIII AOILII I		GAITT,	114		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	ssessment of a resident, the					
	· -	re that residents receive					
		e in accordance with					
	professional standards of practice, the						
		erson-centered care plan,					
	and the residents'						
		view and interview, the facility	F 0	684	F684		11/11/2022
		all follow up assessment and			Corrective Action(s) for		
		completed for 1 of 2 residents			Residents Affected by the		
	reviewed for falls.	(Kesident B)			Deficient Practice	<b>-</b> .	
	F: 1: 1 1				Resident B. Unable to correct		
	Finding includes:				resident has had no further fal	IS.	
	The record for Resident B was reviewed on				Corrective Action(s) for Othe	er	
	10/5/22 at 8:46 a.m	. Diagnoses included, but were			Residents Potentially Affects	ed	
	not limited to, demo	entia with behaviors, glaucoma,			All residents with falls have the	е	
		ressive disorder, psychotic			potential to be affected by this	i	
	disorder with hallud	cinations, and insomnia.			deficient practice. Facility police	СУ	
					related to fall follow-up		
		ificant Change Minimum Data			assessments and documentat	ion	
		ent, dated 7/7/22, indicated the			is being followed.		
		gnitively intact. The resident					
		with 1 person physical assist			Measures to Ensure the		
	1	d 1 person physical assist for			Deficient Practice Does Not		
		lent had 1 fall with injury			Recur		
		e the last assessment. A			Licensed nurses have been		
	fracture had not bee	en enecked.			in-serviced on facility policy		
	A Coro Plan maxi	d on 7/7/22 indicated the			related to fall follow-up	ion	
		d on 7/7/22, indicated the			assessments and documentat	ION.	
		for falls related to a history of and balance, impaired			The Menitoring Process to		
	cognition, and the u	-			The Monitoring Process to Ensure the Deficient Practice		
		oproaches were to ensure the			Does Not Recur	7	
	_	ng appropriate footwear			The DON or designee will be		
		cks) when ambulating or			responsible for auditing falls a	nd	
	mobilizing in his w				follow-up assessment	iiu	
	moonizing in ins w				documentation once weekly for	or .	
	Nurses' Notes date	d 6/26/22 at 6:20 a.m., indicated			two months, then once every		
		sident's roommate alerted staff			weeks for a month.		
		the floor. The resident had a			Audit results will be reviewed	ner	
I	I resident was on	1.501. The resident had a	1		, wait loodito will be leviewed	PO1	I

12/07/2022 PRINTED:

	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	X3) DATE SURVEY COMPLETED 10/06/2022	
	PROVIDER OR SUPPLIEI		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407	. (X5)	
PREFIX TAG	pruise on the upper the nostril. The low dark. 911 was notifit the emergency room. Nurses' Notes, date the resident was be hospital due to a fra resident returned or nurses' Notes, date the resident was obhis bed at 7:00 p.m back to the bed and (DON) was notifies send the resident to evaluation. 911 w indicated the hospit bed available. The regarding the hospit left at the facility for Nurses' Notes, date the resident had a lamorning and incontraining and in	Icy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  Ilip and slight bleeding from wer eyelid was swollen and fied and the resident was sent to m.  Id 6/26/22 at 8:42 a.m., indicated ing transferred to another acture of the facial bones. The in 6/28/22.  Id 7/7/22 at 1:37 a.m., indicated served on the floor mat next to increase the Director of Nursing in the Director of Nursing in the Director of Nursing in the matter to be the emergency room for an as called and the paramedic tall was full and there was no DON was notified again tall status and the resident was or close observation.  In a fine dependent of the parametric to the emergency room for an as called and the parametric tall was full and there was no DON was notified again tall status and the resident was or close observation.  In a fine dependent of the parametric tall was full and there was no DON was notified again tall status and the resident was or close observation.	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  the QAA Committee with furth revisions or actions implement as deemed necessary.  DATE: 11/11/22  ADDENDUM  F684  Audits of falls and follow-up assessments will be disconting when 100% compliance has achieved for one month. If not achieved, the QAA Committee determine the need for further revisions or corrective actions well as the frequency and lend continued audits.	nued been ot ee will er s as	COMPLETION DATE
	hospital after an ev	aluation for facial fractures.  in with range of motion to the				

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

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 28 of 62

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/06/2022
	PROVIDER OR SUPPLIE S LOVING CARE H	R HEALTH FACILITY	700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	7/8/22 at 12:47 a.m was having difficul in bed most of the tresident tolerated h no distress. Staff w  The next document 2:59 p.m., which in appointment at the the right hip.  Nurses' Notes, date indicated the reside and tolerated his m resident was still urbed most of the tim and cooperative wir symptoms of distret the resident in Nurses' Notes, date the resident in Nurses' Notes, date the resident had a fichair at that time w resident's safety was anoted.  The next document 7/11/22 at 4:48 p.m was alert and verba continued pain to the unable to bear weig which was negative degenerative change.	ed Nurses' Note, was dated and when attempting to bear was performed ed Nurses' Note was 7/8/22 at adicated the resident had an			
		was ordered and performed at			

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 29 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155845	B. WING	10/06/2022	
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		ults were still pending. Will			
	indicated the Physic the resident had an hip. Naproxen (an	d 7/11/22 at 7:38 p.m., cian had called and indicated impacted fracture to the right anti-inflammatory medication) g) twice a day was ordered for			
	vital signs after the	monitoring with a full set of fall on 7/6/22. There was no nt of the resident's hip or			
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		ents.			
	adequate supervisito prevent accider Based on observation interview, the facili interventions were history of falls with beside the bed and	h resident receives sion and assistance devices nts. on, record review, and ty failed to ensure post fall in place for a resident with a a fracture related to a floor mat wearing non-skid socks for 1 wed 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 10/6/2	

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 158845  NAME OF PROVIDER OR SUPPLIER  SIMMONS LOVING CARE HEALTH FACILITY  (XA) ID  SIMMANS STATIMENT OF DETICIENCE: BREFTX AGAIN DEFICIENCY MINT BE PRECEDED BY PLIL TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  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 diming room. The residents wheelchair brakes were locked and he started moving the table to the left, right, and forward. The resident was agaited and was speaking nonsensical. He pushed the table forward and the front of his wheelchair proper tall pearing him sitting in the chair only on back wheels. He continued to do this until the aurse was summoned immediately into the drining room as there was no other staff around. There were no anti-tippers on the back of his wheelchair proper tall pearing him sitting in 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 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 bed. At a floor mut was placed beside the bed, however, the bed was not in the lowest position. The resident was observed in bed, and not mut 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, anviey, major depressive disorder, psychotic disorder with ballucinations, and insomnia.  The Modified Significant Change Minimum Data Sci (MDS) assessment, dated 7/7/22; indicated the report of the proposal of the propos	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  SIMMONS LOVING CARE HEALTH FACILITY  TAG				A. BUILDING 00			î ´	
SIMMONS LOVING CARE HEALTH FACILITY  IN SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  FINDing in a checkbair at table by himself in the main dining room. The resident's wheelchair brakes were looked 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 propred up leaving him sitting in the chair only on back wheels. He continued to do this until the nurse was summoned immediately into the drining room as there was no other staff around. There were no anti-tippers on the back of his wereholarit 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 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 the upright position. There was no floor mat beside the bed and the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was not now and material prevention interventions are implemented as a 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 Dose Not Recur  The Monitoring Process to Ensure the Deficient Practice Dose Not Rec			155845					
SIMMONS LOVING CARE HEALTH FACILITY  IN SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  FINDing in a checkbair at table by himself in the main dining room. The resident's wheelchair brakes were looked 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 propred up leaving him sitting in the chair only on back wheels. He continued to do this until the nurse was summoned immediately into the drining room as there was no other staff around. There were no anti-tippers on the back of his wereholarit 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 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 the upright position. There was no floor mat beside the bed and the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, now cover, the bed was not in the lowest position. The resident was not now and material prevention interventions are implemented as a 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 Dose Not Recur  The Monitoring Process to Ensure the Deficient Practice Dose Not Rec				<u> </u>	CTD DET	ADDRESS CITY STATE ZIR COR		
SIMMONS LOVING CARE HEALTH FACILITY	NAME OF P	ROVIDER OR SUPPLIE	R					
SUMMARY STATEMENT OF DEFICIENCIE   TAG   SUMMARY STATEMENT OF DEFICIENCIE   TAG   SUMMARY STATEMENT OF DEFICIENCY MUST BE PRICEIDED BY BUILT   TAG   SUMMARY STATEMENT OF DEFICE STATEMENT OF STATEMEN	CINANAONI	8 I OVINC CARE !	JEALTH EACH ITV					
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 opto and backwheels. 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 shose 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, however, 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 observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. 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 observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. 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 observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. 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 observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. The resident was observed in the pright position. There was no floor mat position the position of the po	SIMMONS LOVING CARE HEALTH FACILITY			GARY,	IIN 404U/			
FRETIX TAG  REGULATORY OR I.SC IDENTIFYING INFORMATION  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 oppoped upleaving him sitting in the chair only on back wheels. He continued to do this until the nurse was summoned immediately into the drining 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 bed, a floor mat was placed beside the bed, however, 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. There was no floor mat beside the was not in the lowest position. 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  PREFIX TAG  Toc.  The resident's wheelchair is now equipped with anti-tippers on the he is in the wheelchair, A motion sensor is at the bedside to alert staff if the resident attempts to exit file low bed. The care plan has been reviewed and updated.  Corrective Action(s) for Other Residents at the low bed of falling have the potential to be affec	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
Finding includes:  On 10/3/22 at 9-22 a.m., Resident B was observed sitting in a wheelchair at table by hinself 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 propped 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 hed. 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 hed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was observed in bed, a floor mat was placed beside the hed, however, the bed was not in the lowest position. The resident was defined and the formation of the provided and the bed and the bed was not in the lowest position. T	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
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 he 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 soeks 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, af floor mat was placed beside the bed, however, the bed was not in the lowest position.  The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Disgnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia.  Equipped with anti-tippee when he is in the wheelchair. A motion sensor is at the bedisde to alert staff if the resident attempts to exit fif the resident attempts to exit fif the resident attempts to exit fif the resident attempts to exit the low bed. The care plan has been reviewed and updated.  Corrective Action(s) for Other Residents President and sessessed upon admission, quarterly and with significant change for the risk of falling have the potential to be affected.  Residents Potential to be affected.  Residents Potentially Affected All residents a reseed and updated as needed after each fall and each assessment. Incident reports will continue to be completed in PCC afte	TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	1	TAG			DATE
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  Staff ensure the resident has non-skid footwear in place when he is in the wheelchair. A motion sensor is at the bedside to lelet staff if the resident attempts to exit the lowest position. The care plan has been reviewed and updated.  Corrective Action(s) for Other Residents at saff is the resident attempts to saff the bedside to bed in the lowest position.  Corrective Action(s) for Other Residents at saff is the resident attempts to fall ry the residents at saff is the fixed plane and updated.  All residents at risk of falling have the potential to be affected.  Residents are reviewed and upda								1
On 10/3/22 at 9:22 a.m., Resident B was observed sitting in a wheelchair at table by hinself 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 poped 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 clottes, with no shoes on, and wearing just plain sooks 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. 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.  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		Finding includes:				1		1
sitting in a wheelchair at table by himself in the main dining room. The resident's wheelchair hacks 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  has been reviewed and updated.  Corrective Action(s) for Other Resident 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 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								1
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 poped 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 fect. The 1/4 side rail was observed in the upright position. There was no floor mat beside the bed, however, 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  sensor is at the bedside ttem, the cat the levith the cat then plan has been reviewed and updated.  exit the low west here admit updated.  Corrective Action(s) for Other Residents at risk of falling have the potential to be affected.  All residents a risk of falling have the potential to be affected.  Residents Potentially Affected All residents a risk of falling have the potential to be affected.  Residents Potentially Affected All residents a risk of falling have the potential to be affected.  Residents Potentially Affected All residents a risk of falling have the potential to be affected.  Residents Potentially Affected All residents a risk of falling have the potential valuable.  In c						1 ·		
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 wheelehair popped upleaving 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 wheelehair 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  staff if the resident Ama was earlied thas been reviewed and updated.  Corrective Action(s) for Other Residentd plant packed and updated all prevention are risk of falling, Individualized all prevention interventions are implemented as deemed appropriate. Care plans are reviewed and updated.  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.  Residents are risk of falling have the potential to be affected.  Residents are risk of falling have the potential to be affected.  Residents are risk of falling ha		-						1
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 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  exit the low bed. The care plan has been reviewed and updated.  Corrective Action(s) for Other Residents All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potential to be affected.		_						
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 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  has been reviewed and updated.  Corrective Action(s) for Other Residents of falling have the potential to be affected.  All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Residents Potentially Affected All residents at risk of falling have the potential to be affected.  Reside			<del>-</del>			-		
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 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 insommia.  The Modified Significant Change Minimum Data  Corrective Action(s) for Other Resident All residents at risk of falling have the 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, lowidualized fall preventions 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  The Modified Significant Change Minimum Data		_				-		
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 black socks to both feet.  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 insommia.  Corrective Action(s) for Other Residents was fliling have the potential ty Affected All residents at risk of falling have the potential to be affected.  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 have the potential to be affected.  Residents are assessed upon admission, quarterly and with significant change for the risk of falling have the potential to be affected.  Residents are assessed upon admission, quarterly and with significant change for the risk of falling have the potential to be affected.  Residents are assessed upon admission, quarterly and with significant change for the risk of falling have the potential to be affected.  Residents Po		_				has been reviewed and updat	ed.	
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.  Residents Potentially Affected All residents at risk of falling have the potential to be affected. Residents Potentially Affected All residents at risk of falling have the potential to be affected. Residents Potentially Affected All residents at risk of falling have the potential to be affected. Residents Potentially Affected All residents at risk of falling have the potential to be affected. Residents Potentially affected All residents at risk of falling have the potential to be affected. 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  The Monitoring Process		*						
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.  All residents at risk of falling have the potential to be affected.  Residents are risk of falling have the potential to be affected.  Residents are 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 if repeated infractions are identified.  The Monitoring Process to Ensure the Deficient Practice Does Not Recur  Charge nurses on each shift are								
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 fin 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 observed in bed, a floor mat was placed beside the bed, however, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, however, the bed was not in the lowest position. The resident was observed in bed, as floor mat was placed beside the bed, however, the bed was not in the lowest position. The resident was observed in bed, as 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  The Modified Significant Change Minimum Data  The Modified Significant Change Minimum Data  The poential 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  The Moniforing Process to Ensure the Deficient Practice Does Not Recur						_		
around. There were no anti-tippers on the back of his wheelchair to prevent him from tipping backwards.  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.  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.  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			-			_	nave	
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 fin 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.  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 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  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 if repeated infractions are identified.  The Monitoring Process to Ensure the Deficient Practice Does Not Recur Charge nurses on each shift are						1		
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.  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						1		
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  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		-	revent him from tipping			1		
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 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.  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		backwards.						
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.  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 if repeated infractions are identified.  The Monitoring Process to Ensure the Deficient Practice Does Not Recur Charge nurses on each shift are		0 10/4/22 : 12 1	0 (110.55			-		
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  Treviewed 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			-			1 · · · · · · · · · · · · · · · · · · ·		
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  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						1	ans	
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.  Weasures 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						· · · · · · · · · · · · · · · · · · ·		
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  Continue to be completed in PCC after any fall has occurred.  Measures to Ensure the Deficient Practice Does Not Recur  The Monitoring Process to Ensure the Deficient Practice Does Not Recur  Charge nurses on each shift are		_						
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  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								
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  Measures to Ensure the Deficient Practice Does Not Recur  The Monitoring Process to Ensure the Deficient Practice Does Not Recur  The Modified Significant Change Minimum Data  Charge nurses on each shift are						· ·	CC	
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.  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		in the lowest positi	on.			aπer any fall has occurred.		
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.  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		On 10/4/22 at 2:00 m m to 2:20 m m the mail to				Mossures to Engure the		1
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  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			-					
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  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			•					
black socks to both feet.  The record for Resident B was reviewed on 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  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							n	
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  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								
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  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		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,					ns	
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  The Modified Significant Change Minimum Data  Trepeated infractions are identified.  The Monitoring Process to Ensure the Deficient Practice Does Not Recur  Charge nurses on each shift are						1		
not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia.  The Modified Significant Change Minimum Data  The Modified Significant Change Minimum Data  The Modified Significant Change Minimum Data  The Monitoring Process to Ensure the Deficient Practice Does Not Recur Charge nurses on each shift are								
anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia.  The Modified Significant Change Minimum Data  The Modified Significant Change Minimum Data  The Modified Significant Change Minimum Data  The Monitoring Process to Ensure the Deficient Practice Does Not Recur  Charge nurses on each shift are						Topodiod IIII dollorio di o luciti	54.	
disorder with hallucinations, and insomnia.  Ensure the Deficient Practice Does Not Recur Charge Minimum Data  Charge nurses on each shift are						The Monitoring Process to		
The Modified Significant Change Minimum Data  Does Not Recur Charge nurses on each shift are						_	e	
The Modified Significant Change Minimum Data  Charge nurses on each shift are		alboraer with halla	- Indiana, and mooning.				•	
		The Modified Sign	ificant Change Minimum Data				are	
		_	_			_		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
		155845	B. W	ING		10/06/	/2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
CIMMONIC LOVING CARE LIEALTH FACILITY							
SIMMONS LOVING CARE HEALTH FACILITY			GART,	IN 46407			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		gnitively intact. The resident			prevention interventions are ir	า	
	_	with 1 person physical assist			place as planned. The monito	ring	
	-	d 1 person physical assist for			is documented on a daily Nurs	se	
		lent had 1 fall with injury			Rounds Sheet and will continu		
		e the last assessment. A			on-going. The DON or design	nee	
	fracture had not bee	en checked.			will continue to review all		
					Incident/Accident Reports and		
		d on 7/7/22, indicated the			investigate any incidents relat		
		for falls related to a history of			falls to determine root causes	and	
		and balance, impaired			potential need for new		
	cognition, and the use of psychotropic				interventions. The investigation		
	medication. The approaches were to ensure the				results will be documented an	d	
		ng appropriate footwear			will be reviewed per the QAA		
		eks) when ambulating or			Committee with further revision		
	mobilizing in the w	heelchair.			actions implemented as deem	ied	
	N. 131 . 1 .	1.6/0.6/00			necessary.		
	· ·	d 6/26/22 at 6:20 a.m., indicated			DATE 44/4/00		
	·	ident's roommate alerted staff			DATE:11/1/22		
		the floor. The resident had a			ADDENDUM		
		lip and slight bleeding from			F689		
		ver eyelid was swollen and fied and the resident was sent to			The DON or designee will rev		
	the emergency room				incident/accident reports once weekly for two months, then o		
	the emergency roof	ш.			every two weeks for two mont		
	A Cat Scan (CT) of	the face, neck and head, dated			then at least monthly on-going		
		he resident had an acute left			The DON or designee will con	•	
	· ·	ry complex fracture of the left			to investigate any incidents re		
		t inferior and lateral orbital wall			to falls to determine root caus		
		ry sinus (this type of fracture			and potential need for new	00	
		lunt trauma to the periorbital			interventions. Daily Rounds		
	area).				Sheets will be reviewed at lea	st	
	u.cuj.				once per week for two months		
	Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated				then once every two weeks fo		
	the resident was being transferred to another			months, then at least monthly			
	hospital due to a fracture of the facial bones. The				on-going. Fall investigation re		
	resident returned on 6/28/22.				will be documented and review		
					per the QAA Committee with		
	Nurses' Notes, date	d 7/7/22 at 1:37 a.m., indicated			further revisions or actions		
	the resident was ob	served on the floor mat next to			implemented as deemed		
	his bed at 7:00 p.m. The resident was assisted				necessary. The frequency and	t	

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

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

If continuation sheet

Page 32 of 62

12/07/2022 PRINTED:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  TO DESTIFICATION NUMBER A DUILDING DESTIFICATION NUMBER A DUILDING DESTIFICATION NUMBER A DUILDING DESTIFICATION NUMBER SIMMONS LOVING CARE HEALTH FACILITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL AND 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 bear weight. An x-ray was performed at the hospital was regula 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 was only the properties of the p		T OF HEALTH AND HU R MEDICARE & MEDIC					ORM APPROVED MB NO. 0938-039
SIMMONS LOVING CARE HEALTH FACILITY  (X4) ID  SUMMARY STATEMENT OF DEFICIENCY  TAG  SEGULATORY OR LSC IDENTIFYING INFORMATION  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 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 nebel to bear weight. An X-ray was performed which was negative for a fracture, but indicated degratized degratized behaviorable to bear weight. An X-ray was performed which was negative for a fracture, but indicated degratized degratized behaviorable 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 was ordered for pain.  A CT scan of the right hip, dated 7/11/22, indicated an impacted fracture to the femoral neck.  Physician's Orders, dated 6/28/22, indicated fall	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	A. BUILDING <u>00</u>		(X3) DATE SURVEY  COMPLETED	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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			700 E	21ST AVE	P COD		
(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	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	COMPLETION
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		(DON) was notified send the resident to evaluation. 911 w indicated the hospit bed available. The regarding the hospit left at the facility for A Nurses' Note, date indicated the reside responsive. He had right leg and hip and An x-ray was performed at the depending. Will conticulated the resident had complete to bear weight. A Coperformed at the hopending. Will conticulated the Physician will be resident had an hip. Naproxen (and 500 milligrams (magnain).  A CT scan of the right indicated an impact of the resident was to alert staff of transition. Interview with the staff of transitions are sident with the staff of transitions.	If who instructed the writer to the emergency room for an as called and the paramedic all was full and there was no DON was notified again tal status and the resident was or close observation.  Ited 7/11/22 at 4:48 p.m., and was alert and verbally continued to have pain to the d was unable to bear weight. The aints of pain when attempting to			eviews will be	

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

have been on the floor next to the bed at all times and the bed should be in the lowest position.

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 33 of 62

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY  COMPLETED  10/06/2022	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	B. WING	00		
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0695 SS=D Bldg. 00	to change out his beddone.  3.1-45(a)(2)  483.25(i) Respiratory/Trach Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goa 483.65 of this sub Based on record rev failed to assess lung pneumonia who wa for 1 of 1 residents infection. (Residen  Finding includes:  The record for Resi 10/5/22 at 3:30 p.m not limited to, end sed dependence on rena behaviors. The resi facility on 9/26/22.  The Quarterly Mini assessment, dated 7	e and tracheal suctioning, care, consistent with dards of practice, the erson-centered care plan, als and preferences, and part. View and interview, the facility grounds for a resident with as also receiving an antibiotic reviewed for respiratory t 22)  dent 22 was reviewed on  Diagnoses included, but were	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 COVII monitoring.  Corrective Action(s) for Other Residents Potentially Affected All residents with a respiratory infection have the potential to affected by this deficient pract There are currently no resider with a respiratory infection or require respiratory care.  Measures to Ensure the	er ed / be tice.	

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

A Care Plan, dated 9/30/22, indicated the resident

Event ID:

CWMF11 Facility ID: 000368

**Deficient Practice Does Not** 

If continuation sheet

Page 34 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. Building <u>00</u>		00	COMPLETED		
155845		B. WING 10/06/20		2022			
				CTREET	ADDRESS SITY STATE ZID SOD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CINANACNI	IC LOVING CARE				21ST AVE		
SIMMON	S LOVING CARE	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	was receiving antib	piotic therapy due to the			Recur		
	diagnosis of pneun	nonia. Interventions included,			Licensed nurses have been		
		ed to, administer antibiotics as			re-educated on standard		
		tate lungs and document			assessment practices when a		
	findings at least on	_			resident is being treated for a		
	8	,			respiratory infection. A new to	ol	
	A Physician's Orde	er, dated 9/28/22, indicated the			has been developed to assist		
	1 7	eive Levofloxacin (an			licensed staff with follow-up		
		ligrams (mg) daily, every other			assessments and documentat	ion	
		. The antibiotic was			post hospitalization or condition		
	discontinued on 9/3				change.	""	
	discontinued on 37.	50,22.			i diange.		
	A Physician's Order, dated 9/28/22, indicated the				The Monitoring Process to		
	1	eive Doxycycline Hyclate (an			Ensure the Deficient Practice	,	
		twice a day for pneumonia until			Does Not Recur	·	
	10/5/22.	twice a day for pheumoma until			Quality of Care audits for resid	donte	
	10/3/22.				with condition changes are be		
	The recident was re	eadmitted to the facility on			conducted by the Nurse	ıı ıg	
		n. There was no assessment of			Consultant on a concurrent ba	noio	
	his lung sounds.	i. There was no assessment of			and will continue for three mo		
	ilis fully soulids.				Audit results will be reviewed		
	There was no asses	ssment of the resident's lung			the QAA Committee with furth		
		es' notes dated 9/28, 10/1, 10/2,					
		es notes dated 9/28, 10/1, 10/2,		revisions or actions implemented			
	10/4, and 10/5/22.				as deemed necessary.		
	Interviore with 41-	Director of Nursing on 10/6/22			DATE: 11/11/00		
		<u>c</u>			DATE: 11/11/22		
	_	ated the resident's lung sounds			ADDENDUM		
		sssessed while he was being			F695		
	treated for pneumo	onia.			The frequency of Quality of Ca		
	2.1.45(.)(0)				audits is directly dependent up		
	3.1-47(a)(6)				the frequency with which a ch	~	
					of condition occurs. This inclu		
					a change in physical or menta		
					health status requiring physici	an	
					intervention or an incident or		
					accident resulting in injury		
					requiring physician interventio		
					The Nurse Consultant monitor		
					24-hour reports in Point Click		
					and completes a Quality of Ca	ire	

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/06/2022	
	PROVIDER OR SUPPLIEF		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0697 SS=D Bldg. 00	483.25(k) Pain Managemen §483.25(k) Pain M The facility must e management is pi require such servi professional stand comprehensive pe and the residents' Based on record rev failed to ensure a re fall and had compla	t Ianagement.	F 0697	audit within five business days when these occurrences are evident. The Nurse Consultant notifies the DON of any concer when found. The audits will be discontinued when 100% compliance has been achieved one month. If not achieved, the QAA Committee will determine need for further revisions or corrective actions as well as the frequency and length of continuadits.  F697 Corrective Action(s) for Residents Affected by the Deficient Practice	t rns e d for e e the ne
		for pain. (Resident B)		Resident B. Unable to correct. resident continues to receive Naproxen 500mg twice daily. A current Pain Interview assessr	4
	10/5/22 at 8:46 a.m not limited to, demo	dent B was reviewed on  Diagnoses included, but were entia with behaviors, glaucoma, essive disorder, psychotic		has been completed without evidence of pain per verbal or non-verbal expression.	
	disorder with hallud	sinations, and insomnia.  ficant Change Minimum Data		Corrective Action(s) for Othe Residents Potentially Affecte All residents have the potentia	ed

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

Set (MDS) assessment, dated 7/7/22, indicated the

Event ID:

CWMF11 Facility ID: 000368

be affected by this deficient

If continuation sheet

Page 36 of 62

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		 JILDING	onstruction 00	(X3) DATE COMPL 10/06/	ETED	
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident was not conneeded supervision for bed mobility and transfers. The reside (except major) since fracture had not been as a continuous fract	gnitively intact. The resident with 1 person physical assist d 1 person physical assist for lent had 1 fall with injury e the last assessment. A en checked.  d on 7/7/22, indicated the for falls related to a history of and balance, impaired use of psychotropic proaches were to ensure the g appropriate footwear ks) when ambulating or lichair.		practice. Charge nurses are responsible for responding to verbal or non-verbal expressipain. Certified staff are responsible for reporting to charge nurses when aware of verbal or non-expression of pain. The Pain Interview assessment tool is utilized when any new physic condition or injury is apparent Pain management interventionare planned and implemented care plans updated as necestically.  Measures to Ensure the Deficient Practice Does Not	ons of nsible s verbal al t. ns d with sary.	
	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.			Recur Licensed and certified staff has been re-educated on the need report, monitor and provide interventions for any verbal on non-verbal expressions of page 1.	d to r	
	6/26/22, indicated to zygomaticomaxillar zygomatic arch, left and the left maxilla was a result from blarea).  Nurses' Notes, dated the resident was bein hospital due to a fraresident returned or Nurses' Notes, dated the resident was observed.	the face, neck and head, dated the resident had an acute left by complex fracture of the left of inferior and lateral orbital wall, any sinus (this type of fracture funt trauma to the periorbital december of the facial bones. The facial bones. The facial bones. The facial bones of the facial bones of the facial bones of the facial bones of the facial bones. The facial bones of the fa		The Monitoring Process to Ensure the Deficient Practic Does Not Recur Quality of Care audits for resi with condition changes are be conducted by the Nurse Consultant on a concurrent be and will continue for three monitoring appropriate interventions are planned and executed for any resident with a new injury or physical condition that could result in pain. Audit results with reviewed per the QAA Common with further revisions or actions.	dents eing asis onths. that	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155845	B. W	B. WING 10/06/2022			/2022
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
SIVAVAOVI	S LOVING CARE H	JENI TH ENCILITY			21ST AVE		
SIIVIIVIUN	O LOVING CARE F	IEALTH FAUILIT		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the Director of Nursing			implemented as deemed		
		d who instructed the writer to			necessary.		
	send the resident to	the emergency room for an					
	evaluation. 911 wa	as called and the paramedic			DATE: 11/11/22		
	indicated the hospit	al was full and there was no			ADDENDUM		
	bed available. The	DON was notified again			F697		
	regarding the hospi	tal status and the resident was			The frequency of Quality of Ca	are	
	left at the facility for	or close observation.			audits is directly dependent up	oon	
					the frequency with which a ch	ange	
		ress Note, dated 7/7/22,			of condition occurs. This inclu	des	
	indicated acute visi	t for right hip pain and the			a change in physical or menta	I	
	inability to bear we	ight. The resident recently			health status requiring physici	an	
	returned from the hospital after an evaluation for				intervention or an incident or		
	facial fractures. Th	e resident had pain with range			accident resulting in injury		
	of motion to the rig	ht hip.			requiring physician interventio	n.	
					The Nurse Consultant monitor	s	
	The next document	ed Nurses' Note, was dated			24-hour reports in Point Click	Care	
	7/8/22 at 12:47 a.m	., which indicated the resident			and completes a Quality of Ca	are	
	was having difficul	ty standing. The resident was			audit within five business days	3	
	in bed most of the t	ime except for dinner. The			when these occurrences are		
	resident tolerated m	nedication and meals with no			evident. The Nurse Consultan	t	
	distress. Will contin	nue to monitor.			notifies the DON of any conce	rns	
					when found. The audits will be	)	
	Nurses' Notes, date	d 7/8/22 at 11:57 p.m.,			discontinued when 100%		
		nt was alert with confusion,			compliance has been achieve	d for	
		medications and meals. The			one month. If not achieved, th	е	
		nable to stand and remained in			QAA Committee will determine	e the	
	bed most of the tim	e. The resident was pleasant			need for further revisions or		
	and cooperative wit	th care, with no signs or			corrective actions as well as the	ne	
	symptoms of distre	ss. Will continue to monitor.			frequency and length of contir	nued	
					audits.		
		mentation or an assessment of					
	the resident in Nurs	ses' Notes on 7/9/22.					
	Nurses! Notes data	d 7/11/22 at 4:48 p.m.,					
		nt was alert and verbally					
		tinued to have pain to the right					
	_	s unable to bear weight. An					
		_					
		ed which was negative for a					

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155845	B. W	ING		10/06/	/2022
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP COD		
					1ST AVE		
SIMMON	S LOVING CARE H	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	nints of pain when attempting T scan was ordered and					
		spital and results were still					
		nue to monitor for any					
	changes.	·					
	Nurses' Notes, date	d 7/11/22 at 7:38 p.m.,					
		cian had called and indicated					
		impacted fracture to the right					
		anti-inflammatory medication)					
		twice a day was ordered for					
	pain.						
	A CT scan of the right hip, dated 7/11/22,						
		ed fracture of the femoral neck.					
	Physician's Orders.	dated 7/11/22, indicated					
	-	00 mg, give 1 tablet by mouth					
	two times a day for	pain.					
	The Medication Ad	ministration Record for 7/2022,					
		nt received the Naproxen for					
		2/22 at 9:00 a.m. There was no					
	other pain relief me	dication ordered or					
		resident after the fall with the					
	fracture.						
	The last Pain Asses	sment, completed on 6/28/22,					
		vas administered at the hospital					
	-	re and the resident was unable					
	to tell staff if he had	l pain.					
	There was no Dain	Assessment completed for the					
	resident after the fa	_					
		Director of Nursing on 10/5/22					
	_	ted a new pain assessment had					
	•	after the most recent fall.					
		toring of the resident's pain					
	anter the fall or med	lication given until 7/12/22.					

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 39 of 62

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155845 B. WING 10/06/2022 STREET ADDRESS, CITY, STATE, ZIP COD

NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE

SIMMON	IS LOVING CARE HEALTH FACILITY	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 0698 SS=D Bldg. 00	483.25(I) Dialysis §483.25(I) 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	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	11/11/2022
	arm and check for complications to the right AVF every shift.  Physician's Orders, dated 11/23/21, indicated to		Deficient Practice Does Not Recur Licensed nurses have been	

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 40 of 62

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155845	B. W	ING		10/06/2	2022	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				PAST AVE			
SIMMON	S LOVING CARE H	IFALTH FACILITY			IN 46407			
,								
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
	complications every	shift for renal dialysis.			document the same in PCC.			
	TI 4				Disciplinary actions will be take	en		
	_	reatment Administration			per facility policy if repeated			
		cated the resident's AV fistula ed for a bruit and thrill or signs			infractions are identified.			
		fection on the following shifts:			The Menitering Presents			
	and symptoms of m	rection on the following sinits.			The Monitoring Process to Ensure the Deficient Practice	,		
	7-3: 8/10 and 8/27/	22			Does Not Recur			
	. 5. 5/10 and 6/2//				Monitoring of residents with			
	3-11: 8/21 and 8/22	2/22			dialysis access sites will be			
					completed through Medication			
	11-7: 8/21/22				Administration Record Audits			
					weekly be the DON or designe	ee		
	Interview with the I	Director of Nursing on 10/5/22			for two months, then every two			
	at 4:30 p.m., indicat	ed documentation should have			weeks for one month. Audit			
	been completed rela	ted to the resident's fistula.			results will be reviewed per the	9		
					QAA Committee with further			
	3.1-37(a)				revisions or actions implement	ted		
					as deemed necessary.			
					DATE: 11/11/22			
					ADDENDUM			
					F698			
					Audits of Medication			
					Administration Records will be			
					discontinued when 100%			
					compliance has been achieved	d for		
					one month. If not achieved, the	Э		
					QAA Committee will determine	e the		
					need for further revisions or			
					corrective actions as well as th			
					frequency and length of contin	ued		
					audits.			
F 0732	183 35/a\(1\ /1\							
SS=C	483.35(g)(1)-(4) Posted Nurse Stat	fing Information						
Bldg. 00		Staffing Information.						
Diag. 00		a requirements. The facility						
	_	wing information on a daily						
	basis:	g mormation on a daily						

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 41 of 62

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155845	B. WING		10/06/2022		
		111111			10,00,2022		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
TWIND OF F	TIDEN ON BUILDEN		700 E 2	21ST AVE			
SIMMON	S LOVING CARE H	EALTH FACILITY	GARY, IN 46407				
(V4) ID	CUMMADV	CTATEMENT OF DEFICIENCIE	ID.	1	(V5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA			
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	(i) Facility name.						
	(ii) The current da	te.					
	(iii) The total numb	per and the actual hours					
	worked by the follo	owing categories of					
	licensed and unlic	ensed nursing staff directly					
		sident care per shift:					
	(A) Registered nu						
		tical nurses or licensed					
		(as defined under State					
	law).	(as demined direct state					
	(C) Certified nurse	aides					
	(iv) Resident cens						
	(iv) Nesidelii celis	us.					
	\$400.05(a)(0) Dag	*i=======					
	(0)( )	ting requirements.					
	•	st post the nurse staffing					
		paragraph (g)(1) of this					
	_	basis at the beginning of					
	each shift.						
	(ii) Data must be p	oosted as follows:					
	(A) Clear and read	dable format.					
	(B) In a prominent	place readily accessible to					
	residents and visit						
	8483.35(a)(3) Pub	olic access to posted nurse					
	(0)( )	facility must, upon oral or					
	_	ake nurse staffing data					
		iblic for review at a cost not					
	•						
	to exceed the com	imumity standard.					
	\$400 0E/~\/4\ F	ility data ratantia-					
	§483.35(g)(4) Fac	-					
	•	e facility must maintain the					
		e staffing data for a					
		onths, or as required by					
	State law, whiche						
		on and interview, the facility	F 0732	F732	10/17/2022		
		mely manner the daily staffing		Corrective Action(s) for			
	sheet which indicate	ed how many staff were		Residents Affected by the			
	working in the facil	ity and the facility census.		Deficient Practice			
	_	ial to affect the 22 residents		No residents were cited as			

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

who resided in the facility.

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

affected by this deficient practice.

Page 42 of 62

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			, , , , , , , , , , , , , , , , , , ,	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	A. BUILDING 00 COMPLETED  B. WING 10/06/2022			COMPLETED 10/06/2022
		100040	B. W			10/00/2022
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD	
SIMMON	S LOVING CARE H	HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	The posted staff schedule she	DATE
	Finding includes:				are being updated daily.	
	On 10/3/22 at 8:30 a.m., the daily staffing sheet				Corrective Action(s) for Othe	er
	located in the foyer	was dated 9/16 through			Residents Potentially Affected	
		per staffing sheet was not			All residents have the potentia	al to
	posted.				be affected by this deficient	
	Interview with the I	Director of Nursing on 10/6/22			practice. The posted staff schedule sheets are being	
		ated the staffing sheet had not			updated daily. Residents and	
	been updated from	_			families/responsible parties wi	ill be
	•				reminded that this information	
					posted in the front lobby.	
					Measures to Ensure the	
					Deficient Practice Does Not	
					Recur	
					Licensed staff have been	
					re-educated on the need to up	odate
					the posted staff schedule daily	/.
					The Monitoring Process to	
					Ensure the Deficient Practice	e
					Does Not Recur The DON or designee will be	
					responsible for monitoring tha	t the
					posted staff schedules are	
					updated daily. The monitoring	will
					be documented on an audit fo	
					once weekly for two months, t	
					every two weeks for one mont	
					Audit results will be reviewed the QAA Committee with furth	
					revisions or actions implemen	
					as deemed necessary.	
					DATE: 10/17/22	
					ADDENDUM	
					F732	
					Audits of posted staff schedule	es I

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

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368 \qquad \qquad \text{If continuation sheet} \quad \text{Page 43 of 62}$ 

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155845		A. BUILDING B. WING	00	COMPLETED 10/06/2022	
	ROVIDER OR SUPPLIER S LOVING CARE H		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				will be discontinued when 100 compliance has been achieved one month. If not achieved, the QAA Committee will determine need for further revisions or corrective actions as well as the frequency and length of continuaudits.	d for e e the ne
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnec Each resident's driftom unnecessary drug is any drug w §483.45(d)(1) In eduplicate drug their §483.45(d)(2) For §483.45(d)(3) Withor	xcessive dose (including rapy); or excessive duration; or nout adequate monitoring;			
	for its use; or §483.45(d)(5) In the consequences when should be reduced §483.45(d)(6) Any	ne presence of adverse ich indicate the dose I or discontinued; or combinations of the paragraphs (d)(1) through			
	failed to ensure an a pressures were mon were held per blood	iew and interview, the facility pical pulse and blood itored and cardiac medications pressure parameters for 3 of 5 or unnecessary medications.	F 0757	F757 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 7. Orders to monitor	10/10/2022

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

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

If continuation sheet

Page 44 of 62

12/07/2022 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (Residents 7, 1, and 20) apical pulse and blood pressure and hold parameters for Findings include: antihypertensive medication are now in place. 1. The record for Resident 7 was reviewed on Resident 1. Orders to monitor 10/5/22 at 10:52 a.m. Diagnoses included, but apical pulse and blood pressure were not limited to, hypertension and dementia and hold parameters for with behavior disturbance. antihypertensive medication are now in place. The Quarterly Minimum Data Set (MDS) Resident 20. Orders to monitor assessment, dated 8/4/22, indicated the resident apical pulse and blood pressure was cognitively impaired for daily decision and hold parameters for making. antihypertensive medication are

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

Corrective Action(s) for Other **Residents Potentially Affected** 

now in place.

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** 

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIER S LOVING CARE H		700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	REGULATORY OR documented.	LSC IDENTIFYING INFORMATION	TAG	Does Not Recur	DATE
	Interview with the I at 4:30 p.m., indicate been held as ordered to be clarified.  2. The record for R 10/4/22 at 10:52 a.m. were not limited to, cerebral palsy, aphahigh blood pressure. The Quarterly Miniassessment, dated 7 was not cognitively. Physician's Orders, Metoprolol Tartrate blood pressure and (mg). Give 1 tablet hold if systolic (top less than 100, diasted pressure was less than 60.  The Medication Ad 7/2022, indicated the documented prior to a.m., or 6:00 p.m. d.  The 8/2022 MAR, if rate documented prior to a.m., or 6:00 p.m. d.  The 8/2022 MAR, if rate documented prior to a.m., or 6:00 p.m. d.  Metoprolol was blat administered on 8/2 8/16/22 for the 6:00 p.m. d.	mum Data Set (MDS) /7/22, indicated the resident intact.  dated 4/16/22, indicated (a medication used to lower heart rate) tablet 25 milligrams by mouth two times a day, number) blood pressure was olic (bottom number) blood an 60 and heart rate was less  ministration Record (MAR) for the administration of the 8:00 ose of Metoprolol.  Indicated there was no heart for to the administration of the m.m. dose of Metoprolol. The ink and not signed out as being at 8:00 a.m., and 8/10 and		Monitoring of residents with antihypertensive hold parame orders will be completed thro Medication Administration Re Audits weekly be the DON or designee for two months, the every two weeks for one mor Audit results will be reviewed the QAA Committee with furt revisions or actions implement as deemed necessary.  DATE: 10/10/22 ADDENDUM F757 Audits of Medication Administration Records will be discontinued when 100% compliance has been achieve one month. If not achieved, the QAA Committee will determine need for further revisions or corrective actions as well as frequency and length of continued is audits.	ecord en er ed for he en en the en the
	-	ior to the administration of the .m. dose of Metoprolol.			

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 46 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (0) COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	A. BUILDING <u>00</u> COMPLETED  B. WING 10/06/2022		
		100070	_	A DDDEGG CHTW CT ATE THE COT	10/00/2022
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 21ST AVE	
SIMMON	IS LOVING CARE H	HEALTH FACILITY		, IN 46407	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION DATE
IAG	The 10/2022 MAR, rate documented pris 8:00 a.m., or 6:00 p  The last documente section was on 3/22  Interview with the I indicated the heart in to the administration.  3. The record for R 10/4/22 at 11:44 a.m. were not limited, to angina.  The Quarterly Mining assessment, dated 8 progress and not control of the Annual MDS a completed on 6/3/2: cognitively intact.  Physician's Orders, Metoprolol Tartrate blood pressure and (mg). Give 1 tablet hold if systolic (top less than 100, diastop pressure was less than 60.  The Medication Ad for 7/2022, 8/2022, there was no heart in the section of the section	indicated there was no heart for to the administration of the .m. dose of Metoprolol.  d heart rate in the Vital Sign /21.  Director of Nursing on 10/5/22, rate was not documented prior n of the Metoprolol.  desident 20 was reviewed on n. Diagnoses included, but high blood pressure and  mum Data Set (MDS) /20/22, indicated it was still in	IAG	DEFICIENCE I	DATE

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 47 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  10/06/2022	
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE COMPLETION DATE
	Interview with the at 1:30 p.m., indica	Director of Nursing on 10/5/22 ted the pulse was not o the administration of the			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1) Free from Unnec Use §483.45(e) Psych §483.45(c)(3) A p drug that affects b with mental proce	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any orain activities associated asses and behavior. These it are not limited to, drugs in gories:			
	resident, the facili §483.45(e)(1) Res psychotropic drug unless the medica	rehensive assessment of a ty must ensure that sidents who have not used as are not given these drugs ation is necessary to treat a as diagnosed and e clinical record;			
	reductions, and be unless clinically or to discontinue the §483.45(e)(3) Respsychotropic drug unless that medic	is receive gradual dose ehavioral interventions, ontraindicated, in an effort			

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

Event ID:

 $CWMF11 \quad {\it Facility ID:} \quad 000368$ 

If continuation sheet

Page 48 of 62

12/07/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0758 F758 11/11/2022 failed to ensure gradual dose reductions (GDR) for Corrective Action(s) for antipsychotic medications were attempted for 2 of Residents Affected by the 5 residents reviewed for unnecessary medications. **Deficient Practice** (Residents 7 and 20) Resident 7. The Psychiatric Nurse Practitioner who monitors Findings include: psychotherapeutic agents has evaluated the resident's behavior 1. The record for Resident 7 was reviewed on history through record review and 10/5/22 at 10:52 a.m. Diagnoses included, but interviews with staff. A Progress were not limited to, dementia with behavior note is available. disturbance, violent behaviors, and psychotic Resident 20. The Psychiatric disorder with delusions. Nurse Practitioner who monitors psychotherapeutic agents has The Quarterly Minimum Data Set (MDS) evaluated the resident's behavior assessment, dated 8/4/22, indicated the resident history through record review and was cognitively impaired for daily decision making interviews with staff. A Progress and she had no behaviors during the assessment note is available. reference period. The resident was receiving antipsychotic medications on a routine basis and Corrective Action(s) for Other no gradual dose reduction (GDR) had been **Residents Potentially Affected** attempted. All residents receiving

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

Event ID:

CWMF11

Facility ID: 000368

If continuation sheet

antipsychotic medications have

Page 49 of 62

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>		COMPLETED	
		155845	B. WIN	G		10/06	/2022
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					1ST AVE		
SIMMON	S LOVING CARE H	IEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
1710		3/2/22 and reviewed 8/4/22,		1710	the potential to be affected by	thic	DATE
		nt received psychotropic					
		to the diagnoses of psychotic			deficient practice. The Psychia		
					Nurse Practitioner who monito	rs	
	_	n, insomnia, and anxiety.			psychotherapeutic agents		
		led, but were not limited to,			continues to evaluate resident		
		armacy and Physician to			behavior history through recor		
	_	eduction when clinically			review and interviews with stat		
	appropriate and at le	east quarterly.			determine the effective of curre	ent	
					antipsychotic dose. GDRs will		
		, dated 1/26/22, indicated the			continue to be attempted unles	SS	
		ive Zyprexa (an antipsychotic			contraindicated. Behavior		
	medication) 10 mill	igrams (mg) twice a day for			frequency and type will continu	ue to	
	psychosis.				be monitored and documented	l in	
					the electronic record.		
	A Physician's Order	, dated 1/26/22, indicated the					
	following behaviors	were to be monitored each			Measures to Ensure the		
	shift: itching, picki	ng at skin, restlessness			Deficient Practice Does Not		
		increase in complaints, biting,			Recur		
		ssing, racial slurs, elopement,			Licensed staff have been		
		hallucinations, psychosis,			re-educated on the need to		
	aggression, and refu				monitor and document the type	<u> </u>	
					and frequency of behaviors for		
	The August 2022 M	Iedication Administration			residents receiving	an .	
	-	icated the resident had no			psychotherapeutic medications	2	
	documented behavio				They have been reminded of t		
	ascamonica ochavi	ors for the month.			need to attempt	110	
	The Sentember 202	2 MAR, indicated the resident			nonpharmacological interventi	one	
	_	12/22 on the 11-7 shift and on			'		
					when behaviors are observed	anu	
		shift. Which type of behavior			document the outcomes.		
	_	n the MAR. There was no			The Manufacture D		
		e nursing progress notes on			The Monitoring Process to		
	9/12 and 9/21/22.				Ensure the Deficient Practice	•	
		D (11)			Does Not Recur		
	-	rse Practitioner (NP) progress			The DON and Nurse Consulta		
		indicated the resident had a			have developed a calendar wh		
	_	ent behaviors of yelling,			identifies dates that GDR revie	ews	
		g herself on the floor, and			must be completed by the		
		age to staff. The staff			consultant pharmacist and/or t	he	
	reported the intermi	ttent behaviors were less			Psychiatric Nurse Practitioner.		

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

frequent. Nonpharmacological interventions were

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

If continuation sheet

They will monitor compliance at

Page 50 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	B. W		00	10/06/	
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	•	700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	<u> </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	effective at times. No GDR at this time due to				least once per month for three		
	instability.				months and document the res		
					Results will be reviewed per t	.he	
	There was no documentation of prior GDR				QAA Committee with further		
	attempts.				revisions or actions implemer	ıted	
	Integries, with the Director of Namine on 10/5/22				as deemed necessary.		
	Interview with the Director of Nursing on 10/5/22 at 4:30 p.m., indicated behavior charting on the				DATE: 11/11/22		
	_	h what was in the nurses' notes			ADDENDUM		
	for GDR purposes. 2. The record for Resident 20				F758		
	was reviewed on 10/4/22 at 11:44 a.m. Diagnoses				Compliance monitors of GDR	,	
	included, but were not limited, insomnia, anxiety,				documentation will be		
	schizoaffective disorder, post traumatic stress				discontinued when 100%		
	syndrome (PTSD), and major depressive disorder.				compliance has been achieve	ed for	
	, , , , , , , , , , , , , , , , , , , ,	<i>J</i> 1			one month. If not achieved, the		
	The Quarterly Min	imum Data Set (MDS)			QAA Committee will determin		
		8/20/22, indicated it was still in			need for further revisions or		
	progress and not co	ompleted.			corrective actions as well as t	the	
					frequency and length of conti	nued	
	The Annual MDS	assessment, dated as			audits.		
	completed on 6/3/2	22, indicated the resident was					
		In the last 7 days the resident					
		ti-anxiety and antidepressant					
	_	sychotic medication was coded					
	with a "0".						
	The Care Plan rev	ised on 8/2022, indicated the					
		notropic medications related to					
		hizoaffective disorder and					
	PTSD.						
		, dated 9/18/21, indicated					
		ntipsychotic medication) tablet					
		Give 1 tablet by mouth one time					
	a day for anxiety.						
	Physician's Orders	, dated 3/29/21,indicated					
		for the following (specify)					
	itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking,						

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155845		A. BUILDING 00  B. WING		COMF	COMPLETED  10/06/2022	
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP C 21ST AVE IN 46407	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		cial slurs, elopement, stealing, tions, psychosis, aggression,				
	Note, dated 8/25/22 seen today for follow adjustment with mu including major dep disorder, anxiety, ar changes in behavior continued intermitte behaviors while recent treatment. Her behawithout medication of refusal of care in non-pharmacological ineffective. She had mood with periods of at times. No GDR (of time. This provider medical record and facility. Continue of plan of care including documentation of data.	r (NP) Psychiatry Progress, indicated the resident was w-up visit due to concerns for litiple chronic illnesses ression, PTSD, schizoaffective ad insomnia. Staff reported no s. The resident had shown ent mild breakthrough eiving medication management viors would be much worse management. She had periods cluding hygiene, staff report all interventions were presented with unstable of agitation and uncooperative Gradual Dose Reduction) at this had reviewed the resident's consulted with nursing at the urrent medications and current and nily mood.				
	to support the docur recommended GDR medication.	nented progress note for no of the antipsychotic				
	at 1:30 p.m., indicat documentation of bo	Director of Nursing on 10/5/22 ed there was no continued chaviors for the GDR.				
F 0773 SS=D	3.1-48(b)(2) 483.50(a)(2)(i)(ii)	an Order/Notify of Results				
00-0	Lab Sives Filysicia	an Ordeninolliy of Results				Ī

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

Event ID:

 $CWMF11 \quad \text{Facility ID:} \quad 000368$ 

If continuation sheet

Page 52 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE SURVEY	
		i '	ſ ′	f '		f '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING		COMPLETED	
		155845	B. W	ING		10/06/2022	
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
SIMMON	S LOVING CARE H	HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
Bldg. 00	§483.50(a)(2) The	e facility must-					
	(i) Provide or obta	in laboratory services only					
	when ordered by a	a physician; physician					
	assistant; nurse p	ractitioner or clinical nurse					
	specialist in accor	dance with State law,					
	including scope of	f practice laws.					
	(ii) Promptly notify	the ordering physician,					
	physician assistar	nt, nurse practitioner, or					
	clinical nurse spec	cialist of laboratory results					
	that fall outside of	clinical reference ranges in					
	accordance with fa	acility policies and					
	procedures for notification of a practitioner or per the ordering physician's orders.  Based on record review and interview, the facility						
			F 0'	773	F773	11/11/2022	
		results were obtained in a		, , •			
	timely manner and	the Physician was notified for 1			Corrective Action(s) for		
		wed for hospitalization.			Residents Affected by the		
	(Resident 19)	•			Deficient Practice		
	,				Resident 19. The resident rec	eived	
	Finding includes:				treatment for hypernatremia in		
	J				hospital and returned to the fa		
	The record for Resi	dent 19 was reviewed on			on 10/12/22. He remains in st	•	
	10/6/22 at 10:25 a.r	n. Diagnoses included, but			condition.		
		end stage renal disease,					
		troke, non-Alzheimer's			Corrective Action(s) for Othe	er	
	dementia, and schiz				Residents Potentially Affects		
	·,	1			All residents with orders for		
	Physician's Orders.	dated 9/2/22, indicated the			laboratory monitoring have the	e	
		y tests were to be collected:			potential to be affected by this		
		ount (CBC) with differential			deficient practice. The lab has		
	every 3 months star				provided results of all laborate		
	-	(a test for monitoring blood			tests completed in September	•	
	_	ery month starting on the 23rd.			new laboratory orders have be		
		est to measure anticonvulsant			received.		
	medication) every 3				Todalivad.		
	, ,	ng hormone (TSH) every month			Measures to Ensure the		
	-	related to hypothyroidism			Deficient Practice Does Not		
	(low thyroid).	Totalou to hypomyroidishi			Recur		
	• /	el (a test to evaluate liver,			The DON has obtained a dire	ct	
	-	ney function) every 3 months					
	electrolyte, and kid	ney function) every 3 months	1		contract with the laboratory w	HIGH	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B			COMPL	ETED	
		155845	B. W	ING		10/06/	/2022	
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹						
SIVAVAOVI	S LOVING CARE H	HEALTH EACH ITY		700 E 21ST AVE GARY, IN 46407				
SIIVIIVIOIN	O LOVING CARE F	ILALIII FAOILII I		GART,	IIN →U4U <i>I</i>			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	starting on the 12th				includes the requirement that	lab		
		vithout microscopic test every 3			results be transmitted to the			
	months starting on	the 12th.			facility as soon as the results			
					available. Licensed nurses ha			
		on 9/19/22. The laboratory			been in-serviced on the labora	atory		
		to the Physician by the lab on			arrangement.			
		ity received the lab results from						
	-	0/5/22. There was no			The Monitoring Process to			
		follow up with the lab for			Ensure the Deficient Practice	€		
	I	ty. The lab results indicated			Does Not Recur			
		emia (low blood count),			The DON or designee will	1:4 -		
		anction, elevated TSH levels,			complete laboratory testing au	Idits		
	urinary tract infecti	acid levels, and a possible			monthly.			
	urmary tract infecti	on (O11).			Audit results will be reviewed the QAA Committee with furth			
	During on interview	v with LPN 1 on 10/5/22 at 2:00						
	_	the resident was admitted to			revisions or actions implemen as deemed necessary.	leu		
	1 ~	pernatremia (an elevated			as deemed necessary.			
	sodium level).	ernauenna (an elevated			DATE: 11/11/22			
	soulum level).				DATE: 11/11/22			
	Interview with the l	Director of Nursing (DON) on						
		m., indicated the lab they were						
		ne facility and the lab never						
	_	acility, but rather directly to						
		DON also indicated the facility						
	· ·	to online lab results. She						
	could not produce a	a copy of the contract with the						
	lab and she indicate	ed the contract may be held by						
	the Physician.							
	3.1-49(f)(2)							
F 0867	483.75(g)(2)(ii)							
SS=F	QAPI/QAA Improv							
Bldg. 00	§483.75(g) Quality	y assessment and						
	assurance.							
		e quality assessment and						
	assurance commi							
	(ii) Develop and ir	nplement appropriate plans						

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet Page 54 of 62

DEPARTMENT OF HEALTH AND HUN	MAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES
am , men ren m on preproven cores	TIAL DE CAME ED (OTT

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/06/2022	
NAME OF PROVIDER OR SUPPLI			700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407			
PREFIX (EACH DEFICE	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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
deficiencies; Based on observatinterview, the fact quality deficiencies on previous surved developed and interview developed and interview in the deficiencies of and assurance (Quanter for transmassessments, present medications, and practice affected facility.  Findings include:  Interview with that 1:34 p.m., indial Assurance (QAA quarterly and the Medical Director Infection Control (MDS) Nurse, the Supervisor, the Public The Quality Assurance (Qa Entrance Conference survey by the DC outline of how to what the committed Five of the plan in performance imput the QAPI program program planning.	tion, record review, and lity failed to identify unresolved es, some of which had been cited eys, and ensure actions were plemented to attempt to correct trough the quality assessment AA) process as evidenced by ideiencies cited involving quality itting Minimum Data Set (MDS) sure ulcers, pain, unnecessary infection control. This deficient e2 of 22 residents residing in the e2 of 22 residents residing in the e3 committee consisted of the e3 committee consisted of the e4 the Administrator, the DON, earned early plan requested at the earned early plan was a general east up a QAPI committee and dee should do. Chapters Four and east up a QAPI committee and east out implement overment projects (PIP) as part of an and implementing the QAPI and processes.  deficiencies were cited on this east scope with potential for	F 08	867	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 be affected by this deficient practice. Corrective actions we taken for deficient practices involving transmitting Minimum Data Set assessments, pressulcers, pain, unnecessary medications, and infection corrective actions we taken for deficient practices involving transmitting Minimum Data Set assessments, pressulcers, pain, unnecessary medications, and infection corrective actions we assubmitted in this report.  Measures to Ensure the Deficient Practice Does Not Recur The Quality Assurance and Performance Improvement committee will continue to me least quarterly to review quality performance measured through a understand the developed and implemented we developed and implemented we developed and implemented we developed and implemented we deemed necessary or appropedite the Deficient Practice Does Not Recur Monitoring will occur through audits identified in this report.	ed al to ill be m ure ntrol et at ty gh a e when riate.	11/11/2022	

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 55 of 62

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/06/2022		
		ROVIDER OR SUPPLIER		700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE 1, IN 46407	
		S LOVING CARE F  SUMMARY (EACH DEFICIENT REGULATORY OF More than minimal previously as follow - F684 Quality of C Recertification survand 4/27/21 F686 Pressure Uld Recertification survand 4/27/21 F698 Dialysis was Recertification survand 4/27/21 F757 Unnecessary cited on Recertification survand 4/27/21, and 4/27/2- F758 Unnecessary was previously citedated 4/21/22, 10/2- F880 Infection Correcertification survand 4/27/21.  2. The following d survey at a pattern spotential for no more - F640 Transmitting assessments was precertification survand 10/29/21.  There was no evidential for the survey at a pattern spotential for no more recertification survand 4/27/21.	HEALTH FACILITY  STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION harm and had been cited ws:  Care was previously cited on veys dated 4/21/22, 10/29/21, cers was previously cited on veys dated 4/21/22, 10/29/21, s previously cited on veys dated 4/21/22, 10/29/21, y Medications was previously ution surveys dated 4/21/22, v21. y Psychotropic Medications d on Recertification surveys 9/21, and 4/27/21. ontrol was previously cited on veys dated 4/21/22, 10/29/21, efficiency was cited on this scope with no actual harm with re than minimal harm. g of Minimum Data Set (MDS) eviously cited on veys dated 4/21/22 and ence the facility had identified,	700 E	21ST AVE	DATE I per her nted  ved in
		continued to monitor when these deficier  Interview with the lindicated she and the	permented action plans and/or or any corrective actions taken noises were cited previously.  DON on 10/6/22 at 1:45 p.m., ne Nurse Consultant were			
	addressing the issue of transmitting the MDS					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155845	B. W	ING		10/06	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			1ST AVE		
SIMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		nad been an ongoing issue.					
		aware the above concerns					
	-	ncies and she indicated some					
		en identified and ongoing					
	-	pe put into place to prevent					
	recurrence.						
	3.1-52(b)(2)						
F 0880	483.80(a)(1)(2)(4)	)(e)(f)					
SS=D	Infection Prevention						
Bldg. 00	§483.80 Infection						
J	•	establish and maintain an					
		on and control program					
		de a safe, sanitary and					
		onment and to help prevent					
		and transmission of					
	•	seases and infections.					
	§483.80(a) Infection	on prevention and control					
	program.						
	The facility must e	establish an infection					
	prevention and co	ontrol program (IPCP) that					
		minimum, the following					
	elements:						
	§483.80(a)(1) A s	ystem for preventing,					
	identifying, reporti	ng, investigating, and					
	controlling infection	ons and communicable					
	diseases for all re	sidents, staff, volunteers,					
	visitors, and other	individuals providing					
	services under a	contractual arrangement					
	based upon the fa	cility assessment					
	conducted accord	ing to §483.70(e) and					
	following accepted	d national standards;					
	. , , ,	tten standards, policies,					
		or the program, which must					
	include, but are no						
	(i) A system of sur	rveillance designed to					

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 57 of 62

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155845	B. W	ING		10/06	/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> —                                   </u>		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				1ST AVE			
SIMMON	IS LOVING CARE I	HEALTH EACH ITV			IN 46407			
SIMMONS LOVING CARE HEALTH FACILITY			GART,	III 40407				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		communicable diseases or						
	infections before	they can spread to other						
	persons in the fac							
	(ii) When and to v	vhom possible incidents of						
	communicable dis	sease or infections should						
	be reported;							
	(iii) Standard and	transmission-based						
	precautions to be	followed to prevent spread						
	of infections;							
		v isolation should be used						
		luding but not limited to:						
		duration of the isolation,						
		he infectious agent or						
	organism involved							
	. ,	t that the isolation should be						
		e possible for the resident						
	under the circums							
		nces under which the facility						
	must prohibit emp	-						
		sease or infected skin						
		t contact with residents or						
		t contact will transmit the						
	disease; and							
		ene procedures to be						
	<u> </u>	nvolved in direct resident						
	contact.							
	0400.00( \/4\ 1							
	- ' ' ' '	ystem for recording						
		d under the facility's IPCP						
		e actions taken by the						
	facility.							
	\$492 90/a) Linan							
	§483.80(e) Linens							
		andle, store, process, and						
	-	o as to prevent the spread						
	of infection.							
	\$492 90/f\ App.:-	Lroviow						
	§483.80(f) Annua	I ICVICW.						

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

The facility will conduct an annual review of its IPCP and update their program, as

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 58 of 62

12/07/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation, record review, and F 0880 F880 11/11/2022 interview, the facility failed to ensure infection Corrective Action(s) for control guidelines were in place and implemented, Residents Affected by the including those to prevent and/or contain **Deficient Practice** COVID-19, related to mask use and hand hygiene during random observations of infection control Resident 5. Physician 1 wears a and 1 of 1 treatments observed. (Residents 5 and mask when visiting the resident. Resident 2. The resident remains in the hospital. Findings include: Corrective Action(s) for Other 1. During a random observation on 10/4/22 at 2:05 **Residents Potentially Affected** p.m., Dietary Cook 1 entered the dining room with All residents have the potential to her mask pulled down below her nose and mouth. be affected by this deficient She was serving cake to the residents at that time. practice. She briefly pulled up her mask, however, it was All staff are required to wear positioned beneath her nose. At 2:07 p.m., she masks in proper positions while in proceeded to enter the kitchen and came back to direct resident contact and to use the dining room with another cake. Again, the proper hand hygiene while Cook's mask was positioned beneath her nose. providing care to residents. Interview with the Director of Nursing on 10/6/22 Measures to Ensure the at 10:20 a.m., indicated the Cook should have had **Deficient Practice Does Not** her mask pulled up when she was serving cake to Recur the residents. All staff have been re-educated on the proper position and method of 2. During a random observation on 10/5/22 at 9:53 donning a mask and the proper a.m., Physician 1 entered the dining room with his hand hygiene techniques. mask pulled down below his nose and mouth. He Disciplinary actions will be taken proceeded to the table where Resident 5 was per facility policy if repeated seated. He pulled up his mask and it was infractions are identified. positioned below his nose. Physician 1 started talking to the resident. When the resident The Monitoring Process to indicated he couldn't hear him, he pulled down his **Ensure the Deficient Practice** mask and it rested below his chin. **Does Not Recur** Surveillance of mask and After speaking with the resident, Physician 1 handwashing compliance will be

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

proceeded to listen to the resident's heart with his

mask pulled down. After he was done speaking

Event ID:

CWMF11 Facility ID: 000368

documented on Mask and

Handwashing Compliance audit

If continuation sheet

Page 59 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/06/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINEDIG BLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		OMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
	with the resident, h	e pulled up his mask but it was		forms at least once per week	for		
	positioned below h	is nose. He shook hands with		two months, then once every			
	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			weeks for four months by D.0			
				Designee Audit results will be			
				reviewed per the QAA Comn			
				with further revisions or actio			
				implemented as deemed			
		at 10:20 a.m., indicated Physician 1 should have		necessary.			
	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			······,			
				DATE: 11/1/22			
	_	id not perform hand hygiene					
		g the wound, prior to the					
	_	iHoney gel and a clean					
		with LPN 1 at that time,					
	_	ware she should have					
		giene prior to applying a clean					
	dressing.	giene prior to apprying a cican					
		Director of Nursing on 10/5/22					
	_	ted she would be in-servicing					
	staff related to hand	d hygiene during treatments.					
		sease Control and Prevention,					
		Healthcare Settings," last					
		0, indicated "Hand Hygiene					
		care personnel should use an					
		rub or wash with soap and					
		ving clinical indicationsafter					
		body fluids, or contaminated					
	surfaces"						
	3.1-18(b)						
F 0921	492 00(:)						
SS=E	483.90(i) Safe/Functional/S	sanitary/Comfortable Environ					

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 60 of 62

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       10/06/202			ETED	
	PROVIDER OR SUPPLIER S LOVING CARE H			700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE 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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00	The facility must p sanitary, and compresidents, staff and Based on observation failed to keep the reand in good repair residents staff and in good repair residents start toilet seats, dirty based a missing cord for the halls throughout the Halls)  Finding includes:  During the Environa a.m., the following a.m., the following a.m., the following a.m., the following a.m. and there was light. Two residents residents shared the b. Room 113 - The loose. Two residents residents shared the west Hall  a. Room 108 - The following and there was baseboard in the base of the toilet. Two reand four residents significant for the toilet.	on and interview, the facility sident's environment clean elated to loose faucets and seboards and toilet bases, and the bathroom call light for 2 of 2 of facility. (The East and West emental tour on 10/6/22 at 10:00 was observed:  Toilet seat was observed to be no cord for the bathroom call resided in the room and two bathroom.  Sink faucet was observed to be as resided in the room and four bathroom.  Toilet seat was observed to be adhered dirt along the throom and around the base sidents resided in the room	F 09	921	F921 Corrective Action(s) for Residents Affected by the Deficient Practice No residents were identified a affected by the deficient pract Room 105 – the toilet seat hat been secured and a cord for the bathroom room call light is in place. Room 113 – the sink faucet hat been secured to the wall. Room 108 – The toilet seat hat been cleaned. The baseboard this bathroom and the base of toilet have been cleaned.  Corrective Action(s) for Other Residents Potentially Affected. All residents have the potential be affected by this deficient practice. A facility-wide environmental evaluation has been completed identify any loose toilet seats, loose sinks, and that any area adhered dirt have been cleaned. Call lights cords are in place, 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	ice. s he as as d in f the ed ed to as of ed. and	11/11/2022

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

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Page 61 of 62

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	A. BUILDING 00 COMPLETE		(X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
1.40	3.1-19(f)			monitor the safety of resident equipment and the cleanliness the environment on a regular basis. They are aware of their responsibility to submit request for any needed supplies or reparts in a timely manner.  The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Administrator or designed complete an environmental assessment of equipment, has 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 QAA Committee for review wit further revisions or actions implemented as deemed necessary.  DATE: 11/11/22 ADDENDUM F921 Environmental assessments who is discontinued when 100% compliance has been achieve one month. If not achieved, the QAA Committee will determined for further revisions or corrective actions as well as the frequency and length of continuation.	s of ests pair  e will lls, the th  vill d for e e the e the		

Event ID: CWMF11 Facility ID: 000368 If continuation sheet Page 62 of 62