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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	11/28/2022

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on October 6, 2022. This visit was in conjunction with a PSR to the PSR completed on October 6, 2022 to the Investigation of Complaint IN00388228 completed on August 25, 2022. This visit was in conjunction with the Investigation of Complaint IN00395536. Complaint IN00388228 - Corrected. Complaint IN00395536 - Unsubstantiated due to lack of evidence. Survey date: November 28, 2022. Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 23 Total: 23 Census Payor Type: Medicaid: 21 Other: 2 Total: 23 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/2/22.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RAENITA DUMAS	RNDON	12/20/2022

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

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F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must			

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	include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.			
	Based on record review and interview, the facility failed to ensure the Annual Minimum Data Set (MDS) assessments were completed timely at least every 12 months for 1 of 9 residents whose MDS assessments were reviewed. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 11/28/22 at 1:30 p.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, and aphasia (difficulty speaking). The 10/5/22 Annual Minimum Data Set (MDS) assessment was still in progress not completed. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated they were looking for a	F 0636	**F636** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 6 – MDS assessments are now in compliance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. MDS assessments have been audited for all current residents and are in compliance with required completion dates. **Measures to Ensure the Deficient Practice Does Not**	01/13/2023

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	MDS Coordinator and some of the MDS assessments were not completed. 3.1-31(d)		**Recur** All staff disciplines that are involved in documentation related to MDS assessments have been in-serviced on assessment schedules, types of documentation required, time frames for completion, input methodology, and the importance of accurate and timely submission. The Director of Nursing has provided one-on-one training to licensed nurses that are assigned to complete specific MDS sections. The Director of Nursing will resume the responsibilities of MDS Coordinator until a qualified RN is recruited. MDS Team was in-serviced on 12/16/22 and in-servicing will continue on 1/3/23 and 1/4/23. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for four weeks, then once every week on-going. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary.	

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F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)			
	Based on record review and interview, the facility failed to ensure a Significant Change Minimum Data Set (MDS) assessment was completed in a timely manner for 1 of 9 residents whose MDS assessments were reviewed. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 11/28/22 at 11:30 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Significant Change Minimum Data Set (MDS) assessment, dated 10/7/22, was still in progress and not complete. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated the Significant Change MDS was not completed. 3.1-31(d)(1)	F 0637	**F637** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 7 – MDS assessments are now in compliance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. MDS assessments have been audited for all current residents and are in compliance with required completion dates. **Measures to Ensure the Deficient Practice Does Not Recur** All staff disciplines that are involved in documentation related to MDS assessments have been in-serviced on assessment schedules, types of	01/13/2023

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			documentation required, time frames for completion, input methodology, and the importance of accurate and timely submission. The Director of Nursing has provided one-on-one training to licensed nurses that are assigned to complete specific MDS sections. The Director of Nursing will resume the responsibilities of MDS Coordinator until a qualified RN is recruited. MDS Team was in-serviced on 12/16/22 and in-servicing will continue on 1/3/23 and 1/4/23. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for four weeks, then once every week on-going. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary.	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored			

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	group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 3 of 3 residents reviewed for activities. (Residents 9, 7, and 6) Findings include: 1. On 11/28/22 at 11:29 a.m., Resident 9 was seated in her wheelchair at a table in the dining room. The resident's wheelchair brakes were locked and she had her hand inside of her shirt. There was a picture in front of her and some crayons. The resident made no attempt to color the picture. At 11:53 a.m., CNA 1 was seated next to the resident and coloring her picture. No attempts were made from the resident to color. At 12:13 p.m., the resident was seated at another table in the dining room. A movie was on the television and popcorn had been served. The resident was positioned in the opposite direction of the television. The record for Resident 9 was reviewed on 11/28/22 at 12:14 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident was cognitively impaired for daily decision making.	F 0679	**F679** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 9. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. Resident 7. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. Resident 6. A care plan related to individualized activity programming has been developed and implemented. The Activities Quarterly Participation Review has been reviewed and updated. Activity progress notes are current. Staff who put the resident in bed are aware they need to verify that the TV is in his line of vision while he is awake. **Corrective Action(s) for Other Residents Potentially Affected**	01/13/2023

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	A Care Plan, dated 3/15/20 and reviewed on 9/11/22, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Interventions included, but were not limited to, ensure the activities the resident was attending were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed (such as large print, holders if resident lacked hand strength, and task segmentation), compatible with individual needs and abilities, and age appropriate. The Activity Quarterly Review, dated 9/11/22, indicated the resident participated in news/coffee, patio outings, music/meditation, and snacks/movie. She had a hard time staying focused during one to one activities as she needed to be redirected. Her favorite activity was watching movies while eating snacks. There was not an updated Activity Quarterly Review. The last activity progress note was dated 4/18/22. Interview with Activity Aide 2 on 11/29/22 at 2:45 p.m., indicated the resident had no current activity notes and she was not receiving 1 to 1 activities. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated an additional Activity Aide had been hired and the resident would be assessed for 1 to 1 activities. 2. On 11/28/22 at 9:24 a.m., Resident 7 was observed seated in a reclined geri chair in the dining room. The breakfast meal was being served. On 11/28/22 from 11:30 a.m., to 12:35 p.m., an activity of coloring was going on in the main dining room while the resident was in his room in front of the television.		All residents have the potential to be affected by this deficient practice. Residents have been interviewed and individualized care plans reflecting leisure interests and activity preferences are in place. Activity progress notes and Activities Quarterly Participation Reviews are current for all residents. Monthly Activity Calendars have been updated to reflect the preferred activities and are posted in the dining room. **Measures to Ensure the Deficient Practice Does Not Recur** Activity staff have been in-serviced on job responsibilities related to the facility Activity Program. Numerous activity supplies are available for the department to ensure that diverse activities can be offered. Activity Director and Administrative Designee will monitor activities and activity aides to ensure planned activities are done and meet the interest of each resident. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will be responsible for ensuring that planned activities occur on a daily basis Monday through Friday. Charge nurse will be responsible	

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	At 11:35 a.m. and 3:08 p.m., the resident was seated in a reclined geri chair in his room in front of the television. His eyes were closed at that time. The record for Resident 7 was reviewed on 11/28/22 at 11:30 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Significant Change Minimum Data Set (MDS) assessment, dated 10/7/22, was still in progress and not complete. A Care Plan, updated 8/21/22, indicated the resident may have some limited tolerance for activity programs due to his diagnosis of dementia with behaviors. The approaches were to bring the resident to activities before they were to begin and have the resident sit close to the leader. The last documented Activity Assessment was dated 9/28/22 and indicated staff were to provide 1 to 1 activities for the resident and he liked to listen to music. Interview with Activity Aide 2 on 11/28/22 at 2:45 p.m., indicated the resident was not receiving 1 to 1 activities. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated the resident has had a decline in the last couple of months and required 1 to 1 activities. 3. On 11/28/22 from 9:24 a.m., to 10:14 a.m., Resident 6 was observed sitting in his wheelchair in the main dining room for the breakfast meal. At		for ensuring that planned activities occur on weekends. Activity audits will be conducted by the Administrator or designee once weekly for two months, then once every two weeks for a month, then once every month for three months. Audits of the Activity Program will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further program revisions or corrective actions as well as the frequency and length of continued audits.	

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1/28/22 at 11:29 a.m., the resident was observed sitting up in his wheelchair in his room watching the television. At 1:41 p.m. to 2:04 p.m., the resident was observed in the main dining room sitting at the table eating lunch.

On 11/28/22 at 3:00 p.m., the resident was observed lying flat in bed and awake. The television, located on the wall, was turned on and positioned on an angle facing the resident, however, the privacy curtain was bundled and pulled approximately 2 feet and covering up more than half of the television. The resident's bed was positioned so that the head of the bed was against the south wall on the side where the room door was located. The television was positioned on the west wall and angled towards the room door. The resident could not see the entire television set.

The record for Resident 6 was reviewed on 11/28/22 at 1:30 p.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, and aphasia (difficulty speaking).

The 10/5/22 Annual Minimum Data Set (MDS) assessment was still in progress and not completed.

There was no Care Plan for Activities.

The last documented Activity Assessment was dated 9/12/21, which indicated the resident preferred 1 to 1 visits with staff.

There was no current Activity Assessment.

The 1 to 1 activities for the month of November 2022, indicated the resident was seen on 11/3/22 at 12:00 p.m., 11/9 at 12:30 p.m., and 11/17/22 at 1:30

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	p.m. The 1 to 1 guidance was to visit the resident 3 times a week for 15 minutes and/or 2 times a day for 5 minutes. There must be documentation of each visit and the resident's response to the visits. There were no other 1 to 1 activities completed for the resident. Interview with Activity Aide 2 on 11/28/22 at 2:45 p.m., indicated he was not doing 1 to 1 visits at least 3 times a week. There was no documentation of what he did for the resident or the resident's response to the 1 to 1 visit. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated the resident was to be receiving 1 to 1 visits and the CNA who put him to bed should have moved the privacy curtain to the other side of the room. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility	F 0684	**F684**	01/13/2023

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	failed to ensure a fall follow up assessment and documentation was completed for 1 of 2 residents reviewed for falls. (Resident 8) Finding includes: The record for Resident 8 was reviewed on 11/28/22 at 11:22 a.m. Diagnoses included, but were not limited to, schizophrenia, psychotic disorder, osteoarthritis, and insomnia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/22, indicated the resident was moderately cognitively impaired for daily decision making. Nurses' Notes, dated 11/6/22 at 6:51 a.m., indicated the resident had woken up at 11:00 p.m. cursing, yelling, very drowsy, and talking aloud for somebody to come and get him. He became very aggressive when redirected and put himself on the floor pretending as if he could not stand up nor walk. Nurses' Notes, dated 11/7/22 at 6:28 a.m., indicated the resident was lying across his bed screaming that [Name] stole his money. He continued to scream louder calling someone to come and get him to go take his money from [Name] and his brothers. At 3:00 a.m. the resident put himself on the floor and demanded coffee. He was then redirected. There was no Care Plan related to the resident having a behavior of putting himself on the ground. There was no documentation related to a fall follow up or a fall assessment completed.		**Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 8. The resident's care plan has been revised to include the new behavior of putting himself on the floor when he is agitated. The resident will be assessed for injury after any witnessed fall or after he is found on the floor. **Corrective Action(s) for Other Residents Potentially Affected** All residents with falls have the potential to be affected by this deficient practice. Facility policy related to fall follow-up assessments and documentation is being followed. **Measures to Ensure the Deficient Practice Does Not Recur** New systems have been implemented to ensure licensed staff are monitoring incidents/accidents and other condition changes. These include a Pertinent Charting Protocol and a written 24-hour report format with specific guides on use and the length of follow-up charting requirements. Licensed nurses have been in-serviced on the new systems and required documentation. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for auditing falls and follow-up assessment	

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	Interview with the Director of Nursing on 11/28/22 at 4:15 p.m., indicated the resident had a behavior of putting himself on the floor, but this was not included in his care plan. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)		documentation once weekly for two months, then once every two weeks for a month. Audits of falls and follow-up assessments will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain assessments were completed every shift for a resident who was receiving pain medication for 1 of 3 residents reviewed for pain. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 11/28/22 at 11:30 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Significant Change Minimum Data Set (MDS) assessment, dated 10/7/22, was still in progress and not complete.	F 0697	**F697** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 7. The resident continues to receive Naproxen 500mg twice daily. A Pain Interview Assessment has been completed. The physician will be informed of the Pain Interview Assessment results to ensure pain is being adequately managed. Pain Interview assessment will be done as an initial evaluation of pain complaint by resident. Pain Tool will be completed monthly to ensure resident's pain	01/13/2023

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	155845	A. BUILDING 00 B. WING	11/28/2022

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	A Care Plan, updated 8/21/22, indicated the resident was at risk for alteration in comfort related to pain and the chronic disease process. The last documented Pain Interview Assessment was dated 6/28/22 and the last documented Pain Tool Assessment was dated 5/28/22. There was no current Pain Assessment available for review. Physician's Orders, dated 3/29/21, and on the current 11/2022 Physician's Order Summary, indicated assess for pain every shift. Physician's Orders, dated 7/11/22, indicated Naproxen (an anti-inflammatory) Tablet 500 milligrams (mg) give 1 tablet by mouth two times a day for pain. The Medication Administration and Treatment Administration Records (MAR) and (TAR) for 11/2022 indicated the resident's pain level was not assessed every shift as ordered by the Physician. The medication of Naproxen was administered at 9:00 a.m. and 9:00 p.m., with a documented level of pain before each administration. There was no third shift pain assessment documentation. Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated there has been no new pain assessment nor has the resident's pain been assessed every shift as ordered by the Physician. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)		needs are evaluated and medical regime is effective. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Charge nurses are responsible for responding to verbal or non-verbal expressions of pain. Certified staff are responsible for reporting to charge nurses when aware of verbal or non-verbal expression of pain. The Pain Interview Assessment is utilized when any new physical condition or injury resulting in the potential for pain is apparent. This Pain Tool assessment is completed monthly for all residents. Pain management interventions are planned and implemented with care plans updated as necessary. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been re-educated on the need to report, monitor and provide interventions for any verbal or non-verbal expressions of pain. Licensed nurses have been in-serviced on the Pain Interview Assessment process and how to schedule these routinely. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Quality of Care audits for residents with condition changes are being	

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			conducted by the Nurse Consultant on a concurrent basis and will continue on-going. The audits include monitoring that appropriate interventions are planned and executed for any resident with a new injury or physical condition that could result in pain. The frequency of Quality of Care audits is directly dependent upon the frequency with which a change of condition occurs. This includes a change in physical or mental health status requiring physician intervention or an incident or accident resulting in injury requiring physician intervention. The Nurse Consultant monitors 24-hour reports in Point Click Care and completes a Quality of Care audit within five business days when these occurrences are evident. The Nurse Consultant notifies the DON of any concerns when found. The audits will be discontinued when 100% compliance has been achieved for one month. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of			

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	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 5) Finding includes: The record for Resident 5 was reviewed on 11/28/22 at 2:05 p.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The November 2022 Physician's Order Summary (POS), indicated the resident attended dialysis three times a week on Tuesday, Thursday, and Saturday. The resident's left graft (dialysis access site) was to be checked for bruit and thrill every shift as well as for signs and symptoms of infection. The November 2022 Treatment Administration Record (TAR), indicated the resident's AV fistula had not been checked for a bruit and thrill or signs and symptoms of infection on the following shifts: 7-3: 11/12 and 11/21/22 3-11: 11/12/22 Interview with the Director of Nursing on 11/28/22 at 4:00 p.m., indicated documentation should have been completed related to the resident's fistula. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence.	F 0698	**F698** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 5. Physician orders to listen for the bruit/thrill and check the AV fistula site for signs and symptoms of infection every shift are being completed as ordered. **Corrective Action(s) for Other Residents Potentially Affected** All residents with a dialysis access site have the potential to be affected by this deficient practice. Physician orders to listen for the bruit/thrill and check the AV fistula site for signs and symptoms of infection every shift are being completed as ordered. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed nurses have been re-educated on the need to complete physician orders and document the same in PCC. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of residents with dialysis access sites will be completed through Medication Administration Record Audits by	01/13/2023

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	3.1-37(a)		the DON or designee. The audits will be completed three times per week for one month, two times per week for one month, then every two weeks for one month, then monthly on-going. Audits of Medication Administration Records will be discontinued when 100% compliance has been achieved for three months. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

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	reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure an apical pulse was monitored and cardiac medications were held per blood pressure parameters for 1 of 3 residents reviewed for unnecessary medications. The facility also failed to ensure antibiotics were initiated in a timely manner for 1 of 1 residents reviewed for respiratory infections. (Residents 3 and 5) Findings include: 1. The record for Resident 3 was reviewed on 11/28/22 at 2:49 p.m. Diagnoses included, but were not limited to, hypertension and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/22, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 10/5/22, 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 60. The November 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: -11/13/22 at 9:00 a.m. and 6:00 p.m., blood pressure 101/68. No pulse was documented for 6:00 p.m. -11/21/22 at 6:00 p.m., blood pressure 105/72	F 0757	**F757** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 3. Orders to monitor apical pulse and blood pressure and hold parameters for antihypertensive medication are in place, and the medication is held when vital signs are found to be within the hold parameters. Resident 5. The antibiotic was initiated at 0600 on 11/29/22. The resident shows no signs of a respiratory infection. **Corrective Action(s) for Other Residents Potentially Affected** All residents 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. The facility makes every effort to initiate all new medication orders including antibiotics in a timely manner. **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.	01/13/2023

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	Interview with the Director of Nursing on 11/28/22 at 4:30 p.m., indicated the Metoprolol should have been held as ordered and the pulse documented. 2. The record for Resident 5 was reviewed on 11/28/22 at 2:05 p.m. Diagnoses included, but were not limited to, pneumonia, end stage renal disease, and dependence on renal dialysis. Nurses' Notes, dated 11/23/22 at 5:23 p.m., indicated after returning from dialysis the resident was lethargic, had slurred speech and drooling. His temperature was 102.8 degrees Fahrenheit, blood pressure was 141/102 (normal 120/80), and heart rate was 102 (normal 80). The resident was sent to the emergency room for evaluation. Nurses' Notes, dated 11/27/22 at 7:20 p.m., indicated the resident returned from the hospital. He was alert, verbally responsive, and his lungs were clear with even and unlabored respirations. The resident had a new order for Amoxicillin (an antibiotic) for an upper respiratory infection. A phone call was made to the pharmacy to see if the medication could be sent in tonight's delivery. The writer was informed the medication would be sent out tomorrow morning. The pharmacy was informed the EDK (emergency drug kit) box was not returned to the facility and they were unable to provide the medication for the resident. The writer was informed the pharmacist would be sent an email and the medication would be sent STAT. The Physician was notified of the new order. A Physician's Order, dated 11/27/22, indicated the resident was to receive Amoxicillin-Pot Clavulanate (an antibiotic) 500-125 milligrams (mg). Give 1 tablet by mouth two times a day for pneumonia for 3 Days.		They have also been in-serviced on communication with pharmacy when new medication orders are received, and the process of follow-up if medications are not delivered timely. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of residents with antihypertensive hold parameter orders and new medication orders will be completed through Medication Administration Record Audits by the DON or designee. The audits will be completed three times per week for one month, two times per week for one month, then every two weeks for one month, then monthly on-going. Audits of Medication Administration Records will be discontinued when 100% compliance has been achieved for three months. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

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	The November 2022 Medication Administration Record (MAR), indicated the resident's 6:00 a.m. dose was not available on 11/28/22. Interview with the Director of Nursing on 11/28/22 at 4:15 p.m., indicated the medication had still not arrived and the pharmacy had been contacted again. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose			

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure gradual dose reductions (GDR) for antipsychotic medications were attempted for 2 of 3 residents reviewed for unnecessary medications. (Residents 3 and 4) Findings include: 1. The record for Resident 3 was reviewed on 11/28/22 at 2:49 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, violent behaviors, and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS)	F 0758	**F758** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 3. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents has evaluated the resident’s behavior history through record review and interviews with staff. A Progress note is available. Resident 4. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents has evaluated the resident’s behavior	01/13/2023

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	assessment, dated 11/4/22 which was still in progress, indicated the resident was cognitively impaired for daily decision making. The resident was receiving antipsychotic medications on a routine basis and no gradual dose reduction (GDR) had been attempted. A Care Plan, dated 3/2/22 and reviewed 8/4/22, indicated the resident received psychotropic medications related to the diagnoses of psychotic disorder, depression, insomnia, and anxiety. Interventions included, but were not limited to, consult with the Pharmacy and Physician to consider a dosage reduction when clinically appropriate and at least quarterly. A Physician's Order, dated 1/26/22, indicated the resident was to receive Zyprexa (an antipsychotic medication) 10 milligrams (mg) twice a day for psychosis. A Physician's Order, dated 1/26/22, indicated the following behaviors were to be monitored each shift: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care. The November 2022 Medication Administration Record (MAR), indicated the resident had no behaviors on the day and night shifts from 11/11 - 11/28/22. The resident had no behaviors on the evening shift for the dates of 11/11 -11/20 and 11/22 -11/28/22. The only time the resident was coded as having a behavior was on the evening shift of 11/21/22. What type of behavior the resident had was not specified, only "yes" was coded.		history through record review and interviews with staff. A Progress note is available. **Corrective Action(s) for Other Residents Potentially Affected** All residents receiving antipsychotic medications have the potential to be affected by this deficient practice. The Psychiatric Nurse Practitioner who monitors psychotherapeutic agents continues to evaluate resident behavior history through record review and interviews with staff to determine the effective of current antipsychotic dose. GDRs will continue to be attempted unless contraindicated. Behavior frequency and type will continue to be monitored and documented in the electronic record. **Measures to Ensure the Deficient Practice Does Not Recur** The Psychiatric Nurse Practitioner will be provided data from each resident's behavior monitoring records to enable her to determine whether a GDR is appropriate. She is aware of the required frequency of GDR attempts, and the supportive documentation that is necessary if she determines that a GDR is contraindicated. Licensed staff have been re-educated on the need to monitor and document the type and frequency of behaviors for all residents receiving psychotherapeutic medications.	

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	There was no documentation of the behavior in the nurses' notes on 11/21/22. The last documented nurses' note had been completed on 11/16/22. No Weekly Skilled Charting notes had been completed between 11/15 and 11/24/22. The resident was seen by the Psychiatric Nurse Practitioner (NP) on 11/17/22 and the progress notes were emailed to the facility on 11/28/22. The 11/17/22 Psychiatric NP progress note, indicated the resident was seen today for a follow up visit for GDR evaluation due to concerns for brain based behaviors, major depression, recurrent psychosis, anxiety, and insomnia. She continued with agitation when redirected, yelling, psychotic screaming, and inappropriate language to staff. No further throwing herself on the floor reported since my last visit. Staff report intermittent behaviors were less frequent on current medication regimen. No GDR at this time due to instability. Will reassess in 3 months for possible GDR. Interview with the Director of Nursing on 11/28/22 at 5:00 p.m., indicated there were still no behaviors documented to support not attempting a GDR for the resident.2. The record for Resident 4 was reviewed on 11/28/22 at 12:15 p.m. Diagnoses included, but were not limited, insomnia, anxiety, schizoaffective disorder, post traumatic stress syndrome (PTSD), and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, completed 9/3/22 and was accepted on 10/26/22, indicated the resident had no behaviors of hallucinations, delusions, and physical or verbal abusive behavior. The resident		They have been reminded of the need to attempt nonpharmacological interventions when behaviors are observed and document the outcomes. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of residents receiving antipsychotic medications and require behavior monitoring will be completed through Medication/Treatment Administration Record Audits by the DON or designee. The audits will be completed three times per week for one month, two times per week for one month, then every two weeks for one month, then monthly on-going. GDRs will also be monitored through these audits. Audits of Medication/Treatment Administration Records will be discontinued when 100% compliance has been achieved for three months. If not achieved, the QAA Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits.	

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	displayed rejection of care 1 to 3 times during the assessment period. The Care Plan, revised on 9/21/22, indicated the resident used psychotropic medications related to the diagnosis of schizoaffective disorder and PTSD. Physician's Orders, dated 9/18/21, indicated Perphenazine (an antipsychotic medication) tablet 4 milligrams (mg). Give 1 tablet by mouth one time a day for anxiety. Physician's Orders, dated 3/29/21,indicated monitor behaviors for the following (specify) itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, cursing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care. A Nurse Practitioner (NP) Psychiatry Progress Note, dated 8/25/22, indicated the resident was seen today for follow-up visit due to concerns for adjustment with multiple chronic illnesses including major depression, PTSD, schizoaffective disorder, anxiety, and insomnia. Staff reported no changes in behaviors. The resident had shown continued intermittent mild breakthrough behaviors while receiving medication management treatment. Her behaviors would be much worse without medication management. She had periods of refusal of care including hygiene, staff report non-pharmacological interventions were ineffective. She had presented with unstable mood with periods of agitation and uncooperative at times. No GDR (Gradual Dose Reduction) at this time. This provider had reviewed the resident's medical record and consulted with nursing at the facility. Continue current medications and current			

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	155845	A. BUILDING 00 B. WING	11/28/2022

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SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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	plan of care including nursing assessment and documentation of daily mood. A NP Psychiatry Progress Note, dated 11/17/22, indicated the resident was seen today for a follow-up visit for GDR evaluation due to concerns for adjustment with multiple chronic illnesses including Major depression, PTSD, Schizoaffective disorder, anxiety, and insomnia. The resident has shown continuous intermittent mild breakthrough behaviors while receiving medication management treatment. Her behaviors would be much worse without medication management. She had periods of refusal of care including hygiene, staff report non-pharmacological interventions ineffective and no changes in behaviors. She presented with an unstable mood with periods of agitation and uncooperative at times. No GDR at this time. This provider has reviewed the resident's medical record and consulted with facility nursing. Continue current medications and current plan of care including nursing assessment and documentation of daily mood. There were no documented behaviors in Nurses' Notes from 11/11 to 11/28/22. The Weekly Skilled Charting for the day, evening, and night shifts, dated 11/12, 11/13, 11/16, 11/19, 11/20, 11/23, 11/26, and 11/27/22, indicated there were no changes in the resident's mood and/or behavior. The Medication Administration Record for 11/2022, indicated the resident had no behaviors from 11/11-11/28/22. Interview with the Director of Nursing on 11/28/22 at 5:00 p.m., indicated there were still no behaviors			

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	documented to support not attempting a GDR for the resident. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(b)(2)			
F 0867 SS=F Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;			
	Based on observation, record review, and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the number of deficiencies cited involving quality of care for pressure ulcers, pain, unnecessary medications, and infection control. This deficient practice affected 23 of 23 residents residing in the facility. Finding includes: Interview with the Director of Nursing on 11/28/22 at 4:43 p.m., indicated the Quality Assessment and Assurance (QAA) Committee had not met since the Recertification survey completed on 10/6/22. She indicated they were going to try and schedule a meeting for December 1, 2022.	F 0867	**F867** **Corrective Action(s) for Residents Affected by the Deficient Practice** No specific residents were identified as affected by the deficient practice. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Corrective actions will be taken for deficient practices involving fall follow-up assessments, dialysis, unnecessary medications including psychotropics, and infection control as submitted in this report. **Measures to Ensure the Deficient Practice Does Not**	01/13/2023

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	The following deficiencies were cited on this survey at an isolated scope with potential for more than minimal harm and had been cited previously as follows: - F684 Quality of Care was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F686 Pressure Ulcers was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F698 Dialysis was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F757 Unnecessary Medications was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F758 Unnecessary Psychotropic Medications was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F880 Infection Control was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. There was no evidence the facility had implemented complete and accurate action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Further interview with the DON at 4:55 p.m., indicated she was working with Point Click Care on some new monitoring tools. The DON was also aware the above concerns were repeat deficiencies and she indicated the areas had been identified and the systems needed to be revised to prevent recurrence. This deficiency was cited on 10/6/22. The facility		**Recur** **The Quality Assurance Program has been redeveloped by our Risk Management Agent.** The Quality Assurance and Performance Improvement committee will meet within the next thirty days and will continue to meet at least quarterly to review quality performance measured through the audits identified in this plan of correction. Performance improvement projects will be developed and implemented when deemed necessary or appropriate. New program has been developed and implementation of new documentation of recording vital deficient practices to ensure non-reoccurrences. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring will occur through all audits identified in this report. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary.	

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-52(b)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented,	F 0880	**F880** **Corrective Action(s) for Residents Affected by the**	01/13/2023

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	including those to prevent and/or contain COVID-19, related to mask use during random observations of infection control. (Residents 7 and 6) Findings include: 1. During a random observation on 11/28/22 at 11:29 a.m., Activity Aide 1 was seated at a table with a resident in the dining room. The Activity Aide had her mask pulled down beneath her chin and she was talking to the resident. She was also within 6 feet of the resident. Interview with the Administrator on 11/28/22 at 5:00 p.m., indicated the Activity Aide should have had her mask pulled up. 2. During a random observation on 11/28/22 at 9:45 a.m., Activity Aide 2 was observed sitting next to Resident 7 feeding him breakfast. At that time, his face mask was below his nose and part of his mouth. At 10:09 a.m., he got up and walked by residents with his face mask below his nose and mouth and into the kitchen. The Activity Aide came back out of the kitchen still wearing his face mask below his nose and part of his mouth. At 10:14 a.m., he pulled his face mask up over his nose and mouth. 3. During a random observation on 11/28/22 from 1:32 p.m. to 2:15 p.m., Activity Aide 1 was observed walking around the entire dining room serving lunch trays to the residents with her face mask around her chin and not covering her nose and mouth. She continued to wear her face mask around her chin for the entire lunch meal while other residents were seated at the dining room tables. She was observed walking in and out of the kitchen and the dining room with her face mask on her chin and not covering her nose and mouth.		**Deficient Practice** No specific residents were identified as affected by the deficient practice. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All staff are required to wear masks in proper positions while in direct resident contact. **Measures to Ensure the Deficient Practice Does Not Recur** All staff have been re-educated on the proper position and method of donning a mask. Disciplinary actions will be taken per facility policy if repeated infractions are identified. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Surveillance of mask compliance will be documented on Mask and Handwashing Compliance audit forms at least once per week for two months, then once every two weeks for four months by D.O.N. and designee. Increase in frequency of surveillance will be determined on findings of non-compliance. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary.	

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	4. During a lunch observation on 11/28/22 at 1:41 p.m., Resident 7 received his lunch tray. CNA 1 sat down beside him to assist with feeding. Her face mask was observed below her nose. She continued to feed the resident his entire lunch with her face mask below her nose. At 1:56 p.m., she brought out a dessert for Resident 6 and sat down to feed him with her face mask below her nose. Interview with the Administrator on 11/28/22 at 5:00 p.m., indicated she had just told those staff members to pull up their masks over their mouths and noses. This deficiency was cited on 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)			