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	02/07/2023

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 PSR completed on November 28, 2022 to the Recertification and State Licensure Survey completed on October 6, 2022. This visit was in conjunction with the Investigation of Complaints IN00396194 and IN00397311. Complaint IN00396194 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609 and F610. Complaint IN00397311 - Substantiated. No deficiencies related to the allegations are cited. Survey date: February 7, 2023 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 21 Total: 21 Census Payor Type: Medicaid: 20 Other: 1 Total: 21 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/9/23.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RAENITA DUMAS	RNDON	02/20/2023

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 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure an apical pulse was monitored and cardiac medications were held per blood pressure parameters for 1 of 3 residents reviewed for unnecessary medications. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 2/7/23 at 11:44 a.m. Diagnoses included, but were not limited to, hypertension and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS)	F 0757	**F757** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 2. The order to monitor apical pulse and blood pressure was corrected to state “hold if systolic BP is <100 or HR <60”. The medication is held when vital signs are found to be within the hold parameters. **Corrective Action(s) for Other Residents Potentially Affected**	02/20/2023

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	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 January 2023 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: - 1/14/23 at 9:00 a.m., blood pressure 107/80 - 1/15/23 at 9:00 a.m., blood pressure 105/95 - 1/15/23 at 6:00 p.m., blood pressure 102/81 - 1/19/23 at 6:00 p.m., blood pressure 106/80 - 1/26/23 at 9:00 a.m., blood pressure 103/82 - 1/26/23 at 6:00 p.m., blood pressure 107/73 The February 2023 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: - 2/5/23 at 9:00 a.m., no blood pressure or pulse was documented. - 2/5/23 at 6:00 p.m., no blood pressure or pulse was documented. - 2/6/23 at 6:00 p.m., blood pressure 106/89 Interview with the Director of Nursing on 2/7/23 at 3:36 p.m., indicated the order was put in wrong as it should be to hold for systolic blood pressure under 100.		All residents have the potential to be affected by this deficient practice, but only one resident was identified after another audit was performed on all residents receiving antihypertensive medication. All orders have been reviewed and monitoring apical pulse and blood pressure and to hold the medication have been applied to every cardiac medication even if resident receives multiple cardiac medications. Parameters of “hold if systolic BP is <100 or HR <60” based upon specific parameters are in place and are being followed. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and qualified medication aide staff have been re-educated on the need to carefully review and follow antihypertensive medication orders with hold parameter orders in place. Disciplinary actions will be taken if further infractions are found. ***The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of residents with antihypertensive hold parameter orders will be completed through Medication Administration Record	

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	This deficiency was cited on 10/6/22 and 11/28/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)		Audits by the DON or designee. The audits will be completed five times per week for one month, three times per week for one month, then every week for one month, then 2 times a monthly on-going Audits of Medication Administration Records will be discontinued when 100% compliance has been achieved for six months. QAPI Committee will determine the need for further revisions or corrective actions as well as the frequency and length of continued audits. DATE: 2/20/23	
F 0867 SS=E 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 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	F 0867	**F867** **Corrective Action(s) for Residents Affected by the Deficient Practice** No specific residents were identified as affected by the deficient practice.	02/15/2023

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	deficiencies cited involving quality of care for unnecessary medications. This deficient practice had the potential to affect all residents with medication parameters residing in the facility. Findings include: Interview with the Director of Nursing (DON) on 2/7/23 at 10:00 a.m., indicated the Quality Assessment and Assurance (QAA) Committee were having informal meetings every Wednesday. She indicated a formal meeting was scheduled for next week. The following deficiency was cited on this survey at an isolated scope with potential for more than minimal harm and had been cited previously as follows: - F757 Unnecessary Medications was previously cited on the Post Survey Revisit (PSR) dated 11/28/22 and Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. There was no evidence the facility had consistently 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 3:36 p.m., indicated the Physician Orders for blood pressure parameters had been audited, however, this resident's order had not been noted. The DON was also aware the above concern was a repeat deficiency and she indicated the area had been identified and the system needed to be revised to prevent recurrence. This deficiency was cited on 10/6/22 and 11/28/22.		**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 unnecessary medications as submitted here. Corrective actions will also be taken for areas of repeat deficient practices identified in previous surveys. Our QAPI committee will monitor department PIPs to ensure all potential deficient practices are identified ongoing and corrections are effective in assuring compliance. **Measures to Ensure the Deficient Practice Does Not Recur** The Quality Assurance and Performance Improvement committee met on 2/15/23 and will continue to meet monthly for the next 3 months then at least quarterly to review quality performance measures through the audits identified in this plan of correction as well as previous corrective action plans for repeat areas of deficient practice. Performance improvement projects will be developed and implemented when deemed necessary or appropriate. Departmental PIPs will be developed for each identified deficient practice and reviewed by the QAPI committee	

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-52(b)(2)		on a monthly basis. The PIP forms should be utilized to document the work of and follow the progress on each deficiency. Documentation of the QAPI meeting is available for review. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Monitoring of PIP and audits will determine the overall performance of the QAPI program and development of plans of actions when deficient practices are noted by department heads. The plan will include but not limited to the development and implementation of appropriate plans of action to correct identified deficiencies. The QAPI committee will oversee the development and progress of the action plans/PIPs for identified deficiencies on a monthly basis and offer recommendations where improvement is not noted via the audits. DATE: 2/15/23 QAPI meeting was held 2/15/23 and minutes are attached for your review. QAPI meetings will be held monthly until committee deems differently. !--[if="" !supportannotations]--="">	