

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

K010000	<p>A Quality Assurance Walk-Thru Survey and an investigation of Complaint Number IN00128316 was conducted by the Indiana State Department of Health.</p> <p>Complaint Number: IN00128316 Substantiated, Federal and State deficiencies related to the allegation are cited.</p> <p>Survey Date: 04/26/13</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 100275220</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor, Robert Sutton, Life Safety Code Specialist Trainee</p> <p>This one story facility was determined to be of Type II (222) construction and was not fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery operated smoke detectors in all resident rooms. The facility has a capacity of 46 and had a census of 22 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler</p>	K010000		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>coverage, however, it was in compliance with state law in regard to smoke detector coverage.</p> <p>Simmons Loving Care Health Facility was found not in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of Complaint Number IN00128316.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/30/13.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation, interview and record review; the facility failed to ensure 20 of 20 resident rooms were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all 22 residents throughout the facility as visitors and staff if smoke from a fire were to infiltrate the protective barrier walls.</p> <p>Findings include:</p> <p>Based on observation on 04/26/13 from 9:30 a.m. to 10:15 a.m. with the</p>	K010025	<p>K025</p> <ol style="list-style-type: none"> The fireblock foam will be removed and sprinkler contractor will provide proper fire blocking materiel. The fireblock foam was used initially in the rooms by sprinkler contractor but was removed and replaced with fire caulking. The facility was inspected for fire foam and found that some areas which previously had foam was replaced with the caulking but some foam was still able to be seen. All foam residues will be removed by custodian staff. Facility will keep some of the proper fire caulking on hand in the facility. Fire caulking will be inspected by Integrity Fire Protection, Inc. quarterly doing inspections of fire sprinkler system. Reports will be reviewed by administrator and discussed during Q.A. committee meetings quarterly. 	05/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>maintenance custodian and a private, outside contractor, sprinkler pipe penetrations in all resident rooms and throughout the facility were sealed with an expanding foam material. Based on interview during the time of observation, the maintenance custodian and private, outside contractor acknowledged the expanding foam material was applied the previous day (4/25/13) and produced a can of the expanding foam product which was called "Great Stuff Fireblock" and had a ASTM E 814 (modified) rating. Subsequent review of the expanding foam product revealed the product is recognized as a fireblocking material for residential construction only and not for penetrations of commercial construction. The polyurethane foam product is combustible when applied and after drying into a solid foam and cannot be used as part of a commercial fire/smoke stop system.</p> <p>3.1-19(b)</p>		5. May 26, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 5 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1.10 requires all means of egress to be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect any residents, staff and visitors evacuated through the dining room west hallway exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 04/26/13 from 9:30 a.m. to 10:15 a.m. with the maintenance custodian and a private, outside contractor, the west dining room hallway's four foot wide exit was being used for the storage of wire rack shelving laid on its side, a floor mop bucket, a floor buffer and a 44 gallon barrel. Based on interview, this was verified by the maintenance custodian and private, outside contractor during the time of observation.</p> <p>3.1-19(b)</p>	K010038	<p>K038</p> <p>1. Area cleared of objects. Contractor and Custodian Staff are aware to keep exit areas clear.</p> <p>2. Exit areas will be monitored to ensure that area remains free of all obstructions or impediments to full instant use in the case of fire or to other emergencies.</p> <p>3. In-service held with custodian staff and for all contractors about facility policy of keeping exit areas clear will be reviewed. Signs will also be posted to keep exit way clear at all times.</p> <p>4. Administrative designee will monitor this daily for 1 week then weekly times 1 monthly then monthly thereafter. Deficient practices will be reported to the administrator and person responsible for deficient practice will be disciplined. Q.A. committee will review any deficient practices quarterly.</p> <p>5. 4/26/13 (2)</p> <p>1. Fire alarm contractor was immediately and came out to the facility and corrected the 1 magnetically locked exit door to remain unlocked until the fire-protective signaling system has been manually reset.</p> <p>2. During monthly fire alarms the</p>	04/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 magnetically locked exit door was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.2 (d) allows doors in the means of egress to be equipped with an approved entrance and egress access control system provided that the activation of the building fire-protective signaling system shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect any residents, staff and visitors using the main entrance.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/26/13 with the private, outside contractor at 10:15 a.m., the east door of the main entrance double set of exit doors was provided with a magnetic lock which released when the fire alarm was activated but relocked when the fire alarm audible horns were silenced. This was acknowledged by the private outside contractor at the time of observation.</p> <p>3.1-19(b)</p>		<p>doors will be monitored for proper closure and reset.</p> <p>3. American Eagle will monitor system daily for alarms and will quarterly inspect proper functioning of fire alarm system. They will be responsible for repairs and maintenance of new system.</p> <p>4. Administrative designee will monitor proper door closure and will report any problems to administrator. Proper functioning of fire alarm system will be discussed during quarterly Q.A. committee meetings.</p> <p>5. 4/26/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to maintain 3 of 31 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air-handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 11 of 22 residents, staff and visitors on the east hallway.</p> <p>Findings include:</p>	K010051	<p>K051</p> <ol style="list-style-type: none"> 1. Facility was unaware of this regulation which was not identified as a concern in prior survey. American Eagle was immediately notified of the 3 smoke detectors location. The 3 smoke detectors were relocated from the air supply and are not 3 feet from an air supply diffuser or return air opening. 2. Smoke detector #15, 17, and 18 on the east wing was relocated by American Eagle Contractor. 3. Facility was not aware of this regulation during prior life safety survey. 4. No further planning is needed for this tag no other construction is planned requiring changes in the 	04/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Based on observation on 04/26/13 from 9:30 a.m. to 10:15 a.m. with the maintenance custodian and a private, outside contractor, three smoke detectors, identified as # 15, # 17 and # 18 were located one foot away from central air supply vents on the east hallway. Based on interview, this was verified by the maintenance custodian and private, outside contractor during the time of observation.</p> <p>3.1-19(b)</p>		<p>smoke detectors. 5. 4/26/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013	
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 3 of 3 areas. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect all residents as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 04/26/13 from 9:30 a.m. to 10:15 a.m. with the maintenance custodian and a private, outside contractor, the following was noted:</p> <p>a. The enclosed stairwell outside the west basement exit door was not provided with sprinkler coverage.</p>	K010056	<p>K 056 A. & B. We request a continuing waiver of this requirement. The enclosed stairwell outside the west basement exit door and the dining room to the roof stairwell are constructed of solid concrete, steel and brick and have no combustible finishing's such as carpet or wallboard. The two areas do not pose a threat to the residents or staff because these features compensate for the absence of a sprinkler head in this location. There are also sprinkler heads located at the exit door at the beginning of each stairwell exit. Picture of these areas are attached. If our request for a continuing waiver is denied, we request a temporary waiver of this requirement. The facility has been surveyed twice in the past by life safety on 2/1/13 and 3/18/13. The 2 areas were</p>	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>b. The stairwell from the dining room to the roof was not provided with sprinkler coverage.</p> <p>c. The main entrance canopy, which exceeded four feet in width, constructed of poured concrete but clad with vinyl was not provided with sprinkler coverage. Based on interview, the maintenance custodian and private, outside contractor during the time of observation., it was acknowledged these areas were not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>not identified as an area that needed to be sprinklered. The architect is currently in contact with Chris Greeny and Dennis Austill in regards to the cited areas because when Dennis Austill was asked what type of sprinkler head would be advisable since these stairwells are unheated and freezing of pipes could occur he was unknowledgeable of what would meet the NFPA standard. Heating these areas that are separated from the other compartments of the building would be prohibitively expensive. We are obtaining an estimate of what that would cost if it is ultimately determined to be the only solution. The architect will advise us after a confirmation of the NFPA regulation and agreement with Dennis Austill and Chris Greeny. ****Addendum****The 2 areas have been measured for the sprinkler system addition. A dry sprinkler system will be placed in the stairwell going to the roof top and stairwell leading upstairs from the basement. The sprinkler heads are special order and will take 3 weeks to receive and install. The core holes have been scheduled to be drilled on 6/5/13. After installation of additional sprinkler heads areas will be caulked.Completion Date: 6/30/13 C. We request a continuing waiver of this requirement. In the reviewed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>comments of the surveyor he was unaware that the canopy is constructed of concrete and has no combustible finishing's. This feature compensates for the absence of a sprinkler head und the canopy which does not pose a threat to residents or staff. The architect has conferred with Chris Greeny and City of Gary Fire Prevention Chief and agreed canopy structure does not have to be sprinklered. The architect will provide pictures and documentation for Mr. Austil regarding whether NFPA regulations require the concrete canopy to be sprinkled. *****Addendum*****According to conversations with Mr. Greeny, Mr. Austil and Mr. Bailey fire sprinklers are not necessary under the canopy which is metal siding not plastic. Please refer to correspondence between Mr. Austil and Mr. Bailey on May 29, 2013. Hey Dennis,Sorry for the delay in following up with this matter. We visited the facility yesterday and confirm the following:</p> <ul style="list-style-type: none"> ·The canopy at the main entrance of the facility is constructed of concrete and metal siding, per our discussion this should not require sprinklers because it is non-combustible. ·The roof stairway from the dining room to the roof will require a dry horizontal sidewall sprinkler, we have made arrangements to have the 8" thick masonry wall 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			<p>core drilled for the installation of the sprinkler.</p> <p>·The rear exterior covered stair will also require a dry horizontal sidewall sprinkler. The wall is 19" in thickness, so this sprinkler will require a special order to the supplier.</p> <p>We are in the process of getting delivery times for the sprinklers, I will advise as soon as we have the information from our supplier. Please feel free to contact me if you have any questions, your time and efforts are sincerely appreciated.</p> <p>Take Care, Cornelius Bailey INTEGRITY FIRE PROTECTION, INC. 18301 Stewart Avenue Homewood, IL. 60430 ph 708.524.0611 fx 708.524.5090 cell 708.743.3049</p>		