

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F0000	<p>This visit was for the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00116865. This visit resulted in an extended survey- Immediate Jeopardy.</p> <p>Complaint IN00116865-Substantiated: Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Survey Dates: 11/26, 11/27, 11/28, 11/29, 11/30, and 12/3/12</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 100275220</p> <p>Survey Team: Heather Tuttle, R.N.- T.C. Lara Richards, R.N. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 23 NF 23 Total</p> <p>Census Payor Type: 22 Medicaid 1 other 23 Total</p>	F0000		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 7, 2012 by Bev Faulkner, RN</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure the State client advocacy group and information on how to file a complaint with the State Agency was prominently displayed in the facility where residents and visitors could view. This had the potential to affect 23 of 23 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During the Environmental tour on 11/29/12 at 8:20 a.m., the sign for the local Ombudsman, the State Ombudsman, the State Department of Health, and Adult Protective Services was observed located in a corner on the west side of the facility. There was a treatment cart also located in the corner, making it</p>	F0156	<p>F 0156</p> <p>1. ****(This is the new location) ***The poster with the names, addresses, and telephone numbers of all pertinent State client advocacy groups was moved and placed on the wall at the entrance to the dining room. A copy of Resident Council minutes will be turned into the Administrator and another copy will be kept in the resident council minutes binder. Previous activity director discussed the minutes with the Administrator and D.O.N. but no copy of the minutes were left with administrator and when the previous activity director quit minutes were not left.2. All residents and their family members will receive a copy of the pertinent numbers for state client advocacy groups including State Department of Health complaint number, Local and State</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>difficult for residents in wheelchairs to view the poster. The poster was not located in a prominent place for residents and visitors to view.</p> <p>Interview with the Administrative Assistant on 11/29/12, at 9:00 a.m., indicated the sign was still located in the corner where the old pay phone used to be and was not in a prominent place where residents and visitors were able to view.</p> <p>2. Interview with the Resident Council President on 11/30/12 at 1:35 p.m., indicated she had no idea on how to file a complaint with the State Agency. She could not recall if she has been given information regarding this or not.</p> <p>On 11/30/12 at 1:45 p.m., the Administrator was interviewed in regards to the posting on how to file a complaint with the State Department of Health. She indicated there used to be a sign on the wall posted by all the other numbers for the State Agencies.</p> <p>Interview with the Administrative Assistant at that time, indicated the sign was located on the north wall in the corner where the old pay phone used to be. The sign was not in a</p>		<p>Ombudsman number and Adult Protective Services. Resident council minutes will be audited monthly by Social Service Department and copies given to Administrator and D.O.N.3. ****(Location)**<b>The poster was moved and placed on the wall entrance to the dining room.</b>Social Service will hold a meeting with residents and their families and give them a copy of the forms. The form will also be included in the admission packet so that all residents and their family are aware of the advocacy groups available to the residents.4. Social Service will hold a residents council meeting and invite their families to attend and review the complaint procedure, how to contact the ombudsman and adult protective services. <b>The Administrator will also inform the residents and their families that complaints should be reported to her for immediate action and or clarification and the process for filing a complaint with the State Board of Health and significant agency telephone numbers. The administrator is the advocate for each resident in the facility and the first to resolve the complaint if she is informed.</b> Chain of command and department heads will also be reviewed with the residents and their families. Administrator receives all complaints from any department. D.O.N. responsible for complaints regarding the nursing department,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>prominent view for residents and visitors. Upon further observation, the treatment cart was located right in front of this area and pushed back into the corner making it difficult to view for any resident who was in a wheelchair.</p> <p>Interview with the Administrator on 12/3/12 at 9:00 a.m., indicated she was unable to locate the Resident Council meeting minutes from January 2012 until present. She indicated she had looked in the office and could not find them. She further indicated the area where the Complaint hot line phone number was located was not viewable to the residents. She also indicated she was unaware if the residents were given anything in writing on how to file a complaint with the state agency.</p> <p>The Activity Director who was in charge of the Resident Council was unavailable for an interview.</p> <p>3.1-4(j)(2) 3.1-4(j)(3)</p>		<p>Custodial, Maintenance, Housekeeping Department head responsible for complaints for the indicated departments, FSS responsible for complaints for dietary department, Social Service complaints in regards to clothing along with that department head, and payment complaints. All complaints will be logged and given to the Administrator and the department head for the concerned area. Q.A. Meeting will be held to evaluate the corrective measures and will review complaint log monthly and monthly resident council minutes.5. 1/2/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician was notified of Registered Dietitian (RD) recommendations for 1 of 3 residents</p>	F0157	F Tag 157 Physician Notifications 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 25 physician was informed of the	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>reviewed for nutrition of the 4 who met the criteria for nutrition. The facility also failed to ensure the resident's Physician was notified of a low blood sugar reading for 1 of 10 residents reviewed for unnecessary medications. (Residents #F and #25)</p> <p>Findings include:</p> <p>1. The record for Resident #25 was reviewed on 11/28/12 at 7:33 a.m. The Registered Dietitian (RD) progress note, dated 8/30/12, indicated that nursing had reported the resident had attempted to drink liquid other than thickened liquid and was being redirected by staff. A recommendation was made to consider re-evaluation for Speech Therapy on next review.</p> <p>There was no order for a Speech Therapy evaluation. Further, there was no documentation to indicate if the resident's Physician had been notified of the RD's recommendation.</p> <p>Interview with the Administrator on 11/30/12 at 12:00 p.m., indicated the resident had improved since being admitted to the facility and should be referred to Speech Therapy based on the RD recommendations. She further indicated the resident's</p>		<p>dietician recommendation and scheduled for a speech evaluation and cookie swallow. Blood sugar policy was reviewed with all licensed nurses and records were reviewed for Resident F and care plan was updated. A one to one in-service was held with the nurse who worked 10/15, 11/3, 11/28.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Due to the census being 22 during the survey all records were reviewed by the surveyors. We have 5 diabetics and all blood sugars were reviewed. All dietician recommendations were addressed.No other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In- Service on Physician notification will be presented to nurses. Physician notification policy and Dietician Recommendation will be reviewed and made available to nurses. Review of the blood glucose policy was held with all licensed nurses. 4. How the corrective action will be monitored to ensure the deficient practice will not recur.D.O.N. assistant nurse will be assigned to audit dietician recommendations bi-monthly and blood sugar monitoring weekly for diabetic</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Physician should have been notified of the RD's recommendation.</p> <p>2. The record for Resident #F was reviewed on 11/29/12 at 9:19 a.m. The resident had diagnoses that included, but were not limited to, insulin dependent diabetes.</p> <p>There was a care plan dated 7/20/12, that indicated</p> <p>"Problem: (Resident #F's name) is diabetic Goal: blood glucose to remain between 60 and 100 Approaches: -discuss food preferences -ncs (no concentrated sweet) diet -nourishing snacks -monitor compliance with diet -monitor blood glucose -medicate with lantus (type of insulin) -notify md (medical doctor) if blood glucose is below 60 -monitor for s/s (sign and symptoms) n/v (nausea/vomiting), thirst, excessive urination, dry skin -monitor for s/s of</p>		<p>residents which is currently 5 residents. She will also evaluate skills testing of nurses taking blood sugars and informing physician when blood sugar is below 60 and above 275. QA committee will monitor blood sugar logs and dietician recommendation monthly to ensure compliance.5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>hypo-hyperglycemia (low-high blood glucose)."</p> <p>Review of the October 2012 Medication Administration Record, indicated the resident had Physician's Orders for blood glucose monitoring twice daily.</p> <p>The resident's blood glucose level was 45 on 10/15/12 at 7:00 a.m. There was no evidence the Physician was notified of the resident's low blood sugars.</p> <p>Review of the November 2012 Medication Administration Record, indicated the resident's blood glucose level was 54 on 11/3/12 and was 57 on 11/28/12. Both of these blood sugars were obtained at 7:00 a.m. There was no evidence in the record that the physician was notified of the low blood glucose levels.</p> <p>Interview with the Director of Nursing (DoN) on 11/29/12 at 1:41 p.m., indicated when a resident had a blood glucose reading below 60 the physician was to be notified.</p> <p>The policy titled, "Blood Sugar Monitoring" that was undated, was provided by the Administrative Assistant on 11/29/12. She indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>the policy was current. The policy indicated, "If blood glucose level is above or below normal range, document the time the physician was notified."</p> <p>On 11/30/12 at 1:45 p.m., interview with the DoN indicated the staff should have notified the physician of the low blood sugar reading.</p> <p>3.1-5(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0172 SS=C	<p>483.10(j)(1)&amp;(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>resident's right to deny or withdraw consent at any time.</p> <p>Based on observation and interview, the facility failed to ensure all of the residents were aware of who the local Ombudsman was. This had the potential to affect 23 of 23 residents who resided in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council President on 11/30/12 at 1:35 p.m., indicated she had no idea who the Ombudsman was or how to contact him.</p> <p>Observation of the posted sign on the wall with information on how to contact the State and Local Agencies indicated the new Ombudsman's name had not been written in on the sign.</p> <p>Interview with the Administrator on 12/3/12, at 9:00 a.m., indicated she was not sure if the residents had met the new Ombudsman or not. Further interview indicated she was unable to locate the Resident Council meeting minutes from January 2012 until present to see if the Activity Director had gone over that information with the residents. She indicated she had looked in the office, but could not find</p>	F0172	<p>F 0172</p> <p>1. ****(This is the new location) ***<b>The poster with the names, addresses, and telephone numbers of all pertinent State client advocacy groups was moved and placed on the wall at the entrance to the dining room.</b> A copy of Resident Council minutes will be turned into the Administrator and another copy will be kept in the resident council minutes binder. Previous activity director discussed the minutes with the Administrator and D.O.N. but no copy of the minutes were left with administrator and when the previous activity director quit minutes were not left.2. All residents and their family members will receive a copy of the pertinent numbers for state client advocacy groups including State Department of Health complaint number, Local and State Ombudsman number and Adult Protective Services. Resident council minutes will be audited monthly by Social Service Department and copies given to Administrator and D.O.N.3. ****(Location)**<b>The poster was moved and placed on the wall entrance to the dining room.</b>Social Service will hold a meeting with residents and their families and give them a copy of the forms. The form will also be included in the admission packet so that all residents and their family are aware</p>	01/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>them.</p> <p>The Activity Director was unavailable for interview during the survey.</p> <p>3.1-8(b)(4)</p>		<p>of the advocacy groups available to the residents.4. Social Service will hold a residents council meeting and invite their families to attend and review the complaint procedure, how to contact the ombudsman and adult protective services. <b>The Administrator will also inform the residents and their families that complaints should be reported to her for immediate action and or clarification and the process for filing a complaint with the State Board of Health and significant agency telephone numbers. The administrator is the advocate for each resident in the facility and the first to resolve the complaint if she is informed.</b> Chain of command and department heads will also be reviewed with the residents and their families. Administrator receives all complaints from any department. D.O.N. responsible for complaints regarding the nursing department, Custodial, Maintenance, Housekeeping Department head responsible for complaints for the indicated departments, FSS responsible for complaints for dietary department, Social Service complaints in regards to clothing along with that department head, and payment complaints. All complaints will be logged and given to the Administrator and the department head for the concerned area. Q.A. Meeting will be held to evaluate the corrective measures</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
			and will review complaint log monthly and monthly resident council minutes.5. 1/2/2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure each resident was free from physical restraints related to a chair that prevents rising for 1 of 3 residents reviewed for physical restraints of the 8 who met the criteria for physical restraints. (Resident #9)</p> <p>Findings include:</p> <p>1. On 11/26/2012 at 11:33 a.m., and 2:08 p.m., Resident #9 was observed lying in a geri recliner with the tray table attached across the resident's body and legs.</p> <p>On 11/27/12 at 12:08 p.m., Resident #9 was observed lying in a geri recliner in the dining room. She was seated at the round table. There was no tray top attached to her chair. The resident was not leaning to one side or leaning forward in the chair.</p> <p>On 11/27/12 at 2:01 p.m. and 2:50 p.m., Resident #9 was observed lying in a geri recliner in the dining room.</p>	F0221	F Tag 221 RESRAINT FREE 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 9 geri tray was discontinued. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with restraint were reviewed and restraint is appropriate for the resident at this time. All residents who require restraints assessments were audited. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses will follow the restraint criteria for residents who require restraint use which includes the following: completing a restraint assessment, restraint implementation starting with the least restrictive device and residents response and outcome of use with the device. An In-Service on Restraint Policy and Protocol will be held with all	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>There was no tray top attached to her chair. The resident was not leaning to one side or leaning forward in the chair.</p> <p>On 11/28/12 at 5:44 a.m., 6:24 a.m., 8:34 a.m., 10:35 a.m., and 12:45 p.m., the resident was observed in the dining room lying in the geri recliner. There was no tray top attached to the chair. The resident was not leaning forward or to one side in her chair.</p> <p>On 11/29/12 at 8:33 a.m., the resident was observed lying in a geri recliner chair. The tray table top was observed up and in place across the resident's legs. The resident was not leaning forward or to one side while lying in the chair.</p> <p>On 11/29/12 at 1:01 p.m., and 2:14 p.m., the resident was observed lying in the geri recliner in her room. The tray table top was observed in place and over the resident's legs. The resident was reclined at this time and was not observed leaning forward or to one side in the chair.</p> <p>On 11/29/12 at 3:00 p.m. and 3:45 p.m., the resident was observed lying in the geri recliner with the tray table top up in place over her legs. The</p>		<p>charge nurses and daily report on restraint use with C.N.A.'s during shift to shift report. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Assistant to D.O.N. nurse will be assigned to audit weekly restraint usage. . Restraint use will me evaluated quarterly for restraint reduction or resident change in condition by nurses weekly and by D.O.N. monthly times one month and quarterly thereafter QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>resident was in the dining room.</p> <p>Interview with CNA #4 who works primarily the evening shift, on 11/29/12 at 3:45 p.m., indicated she normally sees the resident's tray top in the down position. She indicated she has taken care of the resident before and does not know why the tray top is up.</p> <p>On 11/30/12 at 9:01 a.m., the resident was observed lying in the geri recliner in her room. The tray table top was not attached to the geri chair. The resident was not leaning forward or to one side while in the geri recliner.</p> <p>Interview with CNA #1 on 11/30/12 at 9:04 a.m., indicated the resident was to have the tray table top in place on the geri chair. She then pointed to the side of the chair, where the tray should be and it was located on the floor next to the recliner. The CNA then picked up the tray table top and attached it to the chair and placed it across the resident's body and legs. The resident was not observed to be leaning to any one side or forward at this time.</p> <p>Interview with LPN #1 on 11/30/12 at 2:02 p.m., indicated the resident was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>always supposed to have the tray table up and in place over the geri recliner. She indicated she could not remember the last time the resident tried to get up and out of the chair by herself. She further indicated the resident was always reclined in the chair and rarely sits in the upright position.</p> <p>On 11/30/12 at 2:33 p.m., the resident was observed being pushed down the hallway by CNA #3. The resident did not have the tray table top attached to her chair at that time.</p> <p>On 12/3/12 at 9:00 a.m., the resident was observed lying in the geri recliner. The tray table top was noted in the upright position and across the resident's body and legs. The resident was reclined in the chair, and was making no attempts to get out of the chair unassisted, or leaning to one side.</p> <p>The record for Resident #9 was reviewed on 11/27/12 at 2:05 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, Alzheimer's disease, history of falls, left knee surgery, psychosis with delusions, seizure disorder, senile cachexia, aphasia, and dysphasia.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Review of the current Physician recap for the month of November 2012 indicated there was no current Physician's Order for the resident to be in the geri recliner with the tray in the upright position. Further review of Physician's Orders, dated 1/16/12, indicated "resident to have a cushion while up in the recliner with table".</p> <p>Review of the pre-restraining assessment, dated 7/10/12, indicated it was incomplete. The recommendation part on the form was incomplete. This assessment was the only assessment completed in the resident's record.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/30/12, indicated the resident was rarely understood and rarely understands. The resident had no behaviors coded. The resident needs extensive assist with two person physical assist with personal hygiene, dressing, eating, transfers, and bed mobility. The resident had limited range of motion to her lower extremities and was always incontinent of bowel and bladder. The resident was coded as having a physical restraint of a chair that prevents rising.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Review of the current plan of care indicated there was no current care plan for the geri recliner and the tray table top restraint.</p> <p>Review of Nursing Progress Notes for the months of October and November 2012 indicated there was no evidence or documentation the resident tried to get out of the geri recliner unassisted, or the resident was leaning forward in the geri recliner.</p> <p>Interview with the Director of Nursing on 12/3/12 at 10:00 a.m., indicated the resident has had a decline in her physical condition and probably did not need the tray to be up in place across the geri chair. She further indicated there were no attempts made to reduce the restraint.</p> <p>3.1-26(o)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure the residents' dignity was maintained related to indicating a resident who needed assistance with eating was a "feeder" for 3 of 7 residents who were dependent on staff for eating. The facility also failed to ensure clothing protectors were not torn or frayed for 6 of 21 residents who ate in the dining room. (Residents #C, #3, #6, #7, #12 and #14)</p> <p>Findings include:</p> <p>1. On 11/27/12 at 8:14 a.m. and 12:14 p.m., Resident #3 was observed in the dining room. The top right hand corner of the resident's tray card indicated the resident was a "feeder." This was listed in 1 inch bold print and visible from all areas of the dining room.</p> <p>On 11/28/12 at 8:17 a.m., as well as on 11/29/12 at 8:40 a.m., the resident was again observed in the dining room and her tray card indicated that</p>	F0241	<p>F 241 1. Feeder was covered up immediately on the dietary tray cards for residents C, 3, 6,7,12 and 14. A whole case of plastic clothing protectors were available on the silver cart located in the dining room alcove. All clothing protectors in poor condition were removed. 2. Laundry Supervisor will monitor clothing protectors for replacement weekly. 3. In-service will be held with all C.N.A.'s to not use torn clothing protectors and to invorm the laundry supervisor when clothing protectors need replacing. D.O.N. will reprint dietary tray cards and remove the word of feeder. 4. Q.A. committee will monitor new dietary cards and clothing protector replacement log quarterly. 5. 1/2/13</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>she was a "feeder".</p> <p>Interview with the Administrator on 11/30/12 at 12:00 p.m., indicated the word "feeder" would be removed from the resident's tray card.</p> <p>2. Resident #7 was observed on 11/27/12 at 8:14 a.m., in the Main Dining Room. He was seated at the table where the residents that required assistance with eating were seated. The resident's tray card was 8 1/2 inches by 6 inches in size and was placed in front of the resident. On the card the word "Feeder" was printed. Each letter was 1 inch in size and could be read from any area of the dining room.</p> <p>3. Resident #C was observed on 11/27/12 at 8:28 a.m. The resident was in the Main Dining Room. His tray card was placed on the table in front of him. The resident's tray card was 8 1/2 inches by 6 inches in size. On the card the word "Feeder" was printed. Each letter was 1 inch in size and could be read from any area of the dining room. The resident was feeding himself his breakfast.</p> <p>Interview with the Administrator on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>11/30/12 at 11:15 a.m., indicated the word "feeder" was written in very large print on the tray cards and could be seen from any area in the dining room.</p> <p>4. On 11/26/12 at 8:20 a.m., Resident #7, Resident #6, Resident #12 and Resident #C were observed in the Main Dining Room eating breakfast. The residents all had clothing protectors on that were torn and tattered.</p> <p>5. Resident #14 and Resident #3 were observed on 11/28/12 at 8:11 a.m., in the Main Dining Room eating breakfast. The residents had torn and tattered food protectors on.</p> <p>On 11/29/12 at 11:25 a.m., a stack of clothing protectors were observed in the Main Dining Room on a shelf. The clothing protectors were observed to be in poor condition, they were torn and tattered. Interview with the Administrator at that time, indicated the clothing protectors that were in the dining room were in poor condition and should not have been used on the residents. She indicated she had new clothing protectors that were to be used.</p> <p>Interview with CNA #1 on 11/29/12 at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>11:25 a.m., indicated the residents did have torn clothing protectors on during the past few days. She indicated that she had informed the other CNAs to only use clothing protectors that were in good condition.</p> <p>3.1-3(t)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's choice was honored related to receiving showers for 1 of 2 residents reviewed for choices of the 2 residents who met the criteria for choices. (Residents #F)</p> <p>Findings include:</p> <p>Resident #F was interviewed on 11/26/12 at 10:26 a.m., he indicated the staff makes him get up in the morning to take a bath, he indicated he only received tub baths, and was not offered showers.</p> <p>The record for Resident #F was reviewed on 11/29/12 at 9:19 a.m. The annual Minimum Data Set (MDS) assessment, dated 5/27/12, and the quarterly MDS dated 11/27/12, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was</p>	F0242	<p>F 2421. A conference with Resident F, Responsible party and son will be held with social service. Responsible party for Resident F has stated she wants him to have a tub bath daily. C.N.A.'s were shown the shower heads located in each tub area.</p> <p><b>Update:</b> Resident F son usually visited several times a week but his last visit was 12/15/12. Social service had been trying to contact the son to schedule a conference but was not able to reach him. A conference has not been held with resident F or the responsible party. Resident's F son was found dead and currently the family is dealing with finding out the cause of death and making funeral arrangements. An informal conference was held with Resident F and he thinks the difference between a shower and tub bath is that he stands up for a shower and sits down for a bath. The resident has an unsteady gait and is not able to stand up to take a shower. After further investigation even when resident is seated in the shower chair and the shower head is</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>cognitively intact.</p> <p>The annual MDS, dated 5/27/12, indicated it was somewhat important to the resident to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>The quarterly MDS, dated 11/27/12, indicated the resident required physical help in part of bathing activity, with 1 staff member to assist.</p> <p>The resident was interviewed on 11/29/12 at 2:19 p.m. He indicated he would rather take showers in the morning. He indicated the staff had only offered to assist him with tub baths. He indicated he was not aware there was a shower in the facility.</p> <p>The form titled, "Progress Notes Listing," dated 6/6/12, indicated, "Resident refuses to take a tub bath daily. Staff encourages him to take a tub bath at least three to four times a week."</p> <p>Interview with CNA #1 on 11/30/12 at 11:30 a.m., indicated she was not aware there was a shower in the facility.</p> <p>During observation on 11/30/12 at 11:45 a.m., there was a functional</p>		<p>used during this am care he still thinks that is a bath not a shower. A discussion with the responsible party and the administrator discussing Resident F and the responsible party stated that he to take a bath everyday due to his strong body odor when he refuses am care related to resident's incontinence. Resident F needs cues and coaxing for his hygiene needs to be met. He will try to put on soiled clothing and keep soiled items in his nightstand. Resident F is allowed to make a decision of taking a shower or bath daily but he still does not associate the difference between having a bath or shower since he is seated for both. Staff will continue to explain the difference to Resident F and offer him a shower or bath each day however for the month of January resident has refused am care daily except for once a week and currently has an extreme body odor. A conference will be held with Resident F and the responsible party within the next 2 weeks after the family has completed the funeral process for his son. Currently the facility has not been informed of the final funeral arrangements for his son.2. No other complaints of tub baths noted.3. C.N.A.'s will be in-service by D.O.N. assistant on resident choices to take a shower, bath, bed bath or refusal of am care. C.N.A.'s will be shown the shower heads in tub areas, resident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
	shower in the East Unit shower room.  3.1-3(u)(1)		log sheet which indicates tub bath, shower, or bed bath. Resident F will be encouraged to take a bath or shower each day to prevent body odor. Charge Nurse will monitor whether the residents take a tub bath, shower or bed bath and record it on the tub surveillance sheet.4. D.O.N. will monitor weekly the tub surveillance sheet. Q.A. committee will monitor surveillance sheets monthly. After Q.A. review it was decided to revise the tub surveillance form and the updated form will be discussed in the next Q.A. meeting.5. 1/2/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0278 SS=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set assessment was coded accurately related to height and restraint use for 2 of 3 residents reviewed for nutrition of the 4 who met the criteria for nutrition and for 1 of 3 residents</p>	F0278	F Tag 278 Assessment Accuracy 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The current MDS for Resident 25 height was corrected from 77 inches to 74 inches. Resident 3 restraint was corrected to chair that prevents rising. Resident C	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>reviewed for restraints of the 8 who met the criteria for restraints. (Residents #C, #3, and #25)</p> <p>Findings include:</p> <p>1. The record for Resident #25 was reviewed on 11/28/12 at 7:33 a.m. An admission Minimum Data Set (MDS) assessment was dated 8/12/12. Review of Section K Swallowing/Nutritional status, indicated the resident was 77 inches tall.</p> <p>The quarterly MDS assessment, dated 11/12/12, indicated the resident was coded as being 77 inches tall under Section K Swallowing/Nutritional status.</p> <p>The Initial nutritional assessment form completed by the Registered Dietitian (RD) on 8/11/12, indicated the resident's height was 6 feet tall (72 inches).</p> <p>There was no height documented on the admission nursing assessment dated 7/30/12.</p> <p>Interview with LPN #2 on 11/29/12 at 11:46 a.m., indicated the resident was just measured and was 74 inches long.</p>		<p>was corrected his height was 60 inches and weight 134. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All current MDS height and weight were reviewed.No other Resident affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. MDS In –Service will be presented with focus on accuracy of assessments and the D.O.N. assistant is now responsible for the MDS process. 4. How the corrective action will be monitored to ensure the deficient practice will not recur.D.O.N. assistant will be assigned to review MDS for accuracy related to height, weight and restraint use.Director of Nursing will audit MDS for accuracy prior to transmission. The nursing staff will also be trained during January for the new MDS computer system.Nursing staff will also be in-serviced by HP in February through their webinar presentations. Webinar training will occur ongoing to ensure accuracy.QA will review the effectiveness of the new MDS computerized program and make recommendation as needed. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
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>Interview with LPN #3 on 12/3/12 at 11:00 a.m., indicated the MDS had been coded inaccurately related to the resident's height.</p> <p>2. On 11/27/12 at 8:00 a.m., 12:14 p.m., and 2:05 p.m., Resident #3 was observed seated in a highback chair with a lap tray in place.</p> <p>The record for Resident #3 was reviewed on 11/28/12 at 11:15 a.m. The Significant Change MDS assessment, dated 7/15/12, indicated under Section P, Restraints, that the resident used a trunk restraint daily. Chair prevents rising was not coded.</p> <p>The Quarterly MDS assessment, dated 10/15/12, indicated under Section P, Restraints, that the resident used a trunk restraint daily. Chair prevents rising was not coded.</p> <p>Interview with the Director of Nursing on 12/3/12 at 11:00 a.m., indicated the MDS had been coded incorrectly, it should have been coded "chair that prevents rising" rather than trunk restraint.</p> <p>3. The record for Resident #C was reviewed on 11/27/12 at 9:46 a.m. He had diagnoses that included, but</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>were not limited to, Huntington's Chorea.</p> <p>The "Nutritional Assessment Form" completed by the Registered Dietitian on 7/28/12, indicated the resident's height was 60 inches and his weight 134 pounds.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/31/12, indicated the resident's height was 70 inches.</p> <p>LPN #2 was interviewed on 11/27/12 at 2:10 p.m. She indicated the MDS was inaccurate. She indicated the resident's height should have been coded as 60 inches and not 70 inches. She indicated that she had discussed the error with the Registered Dietitian, but the MDS had not been corrected.</p> <p>3.1-31(d)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a care plan was initiated related to dental issues, medications, nutrition, and restraints for 1 of 2 residents reviewed for dental of the 2 residents who met the criteria for dental, 1 of 10 residents reviewed for unnecessary medications, 1 of 3 residents reviewed for nutrition of the 4 residents who met the criteria for nutrition, and for 1 of 3 residents reviewed for restraints of the 4 residents who met the criteria for restraints. (Residents #B, #F, #2, and</p>	F0279	F 2791. Resident 2 care plan was revised to include plan of care for anti-depressant, insulin and anti-hypertensive medication use. Resident B care plan was updated to include seat belt restraint in his wheelchair. Resident F & 17 will be scheduled for a dental exam. 2. All residents care plans were reviewed in reference to dental issues, medications, nutrition and restraints. No other residents noted to be affected at this time.3. Social Service will be notified of all Dental referrals and schedule dental exams for the residents.4. Care plans have been divided with the licensed	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>#17)</p> <p>Findings include:</p> <p>1. The record for Resident #2 was reviewed on 11/27/12 at 1:59 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, diabetes, and depression.</p> <p>Review of the November 2012 Physician's order summary (POS), indicated the resident was receiving the following medications: Celexa (an anti-depressant) 10 milligrams (mg), a 1/2 tablet daily, Lantus insulin 13 units subcutaneously (sq) daily, and Nifedipine (a medication to treat high blood pressure) 60 mg daily.</p> <p>Review of the resident's plan of care, dated 11/1/12, indicated that he did not have a care plan related to the use of an anti-depressant, insulin and an anti-hypertensive.</p> <p>Interview with the Director of Nursing on 12/3/12 at 12:30 p.m., indicated the resident should have had a care plan for the above medications.</p> <p>2. On 11/28/12 at 5:50 a.m.,</p>		<p>nursing staff. It is that nurse's responsibility to keep the care plan updated weekly according to the resident's needs, changes in medication and changes in condition. The D.O.N. and assistant to the D.O.N. monitor care plans monthly according to quarterly schedule coordinated with the MDS calendar. Nursing will do oral assessments of residents and if problems are noted with the oral cavity, dentures and dental complaints social service will be notified to schedule dental appointments. Dental exams will be done upon admission and then as needed. Q.A. Committee will monitor dental issues, medications, nutrition and restraints related to resident's care plan monthly according to MDS calendar. 5. 1/2/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Resident #B was observed sitting in a wheelchair with seatbelt restraint noted around his waist.</p> <p>The record for Resident #B was reviewed on 11/27/12 at 9:53 a.m. The resident's diagnoses included, but were not limited to, hypoxia, cerebral palsy, seizures, aphasia, Downs Syndrome, mental retardation, behavior disorder, and muscle spasms.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/9/12, indicated the resident was severely impaired for cognition. The resident was extensive assist for most of his activities of daily living. The resident had a trunk restraint that was used daily.</p> <p>Review of the current plan of care indicated there was no care plan for the seatbelt restraint the resident used daily.</p> <p>Interview with LPN #2 on 11/29/12 at 10:10 a.m., indicated all of the resident's current care plans were on the chart.</p> <p>3. The record for Resident #F was reviewed on 11/29/12 at 9:19 a.m. The resident had diagnoses that included, but were not limited to,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>diabetes and dysphagia (difficulty swallowing).</p> <p>The annual Minimum Data Set (MDS) assessment, dated 5/27/12, indicated the resident had broken or loosely fitting dentures. The Care Area Assessment (CAA) Summary, dated 5/27/12, indicated, "see care plan for Dental Care."</p> <p>Review of the current care plan for the resident indicated there was no care plan for dental status.</p> <p>Interview with LPN #3 on 11/29/12 at 3:15 p.m., indicated there was no current care plan for the resident's dental status.</p> <p>4. The record for Resident #17 was reviewed on 11/27/12 at 3:04 p.m. The resident had diagnoses that included, but were not limited to, end stage renal disease and hypertension. The resident received dialysis three times per week.</p> <p>The November 2012 Physician Order Sheet, indicated the resident received a regular diet with no added salt, double protein at breakfast and supper, and no fresh tomatoes.</p> <p>The annual MDS, dated 4/28/12,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>indicated the resident had obvious or likely cavity or broken teeth and received a therapeutic diet. The Care Area Assessment (CAA) summary indicated "see care plan for Nutritional Status" and "see care plan for Dental Care."</p> <p>Review of the current plan of care indicated there was no nutritional care plan and no dental care plan.</p> <p>Interview with LPN #3 on 11/28/12 at 11:01 a.m., indicated there should be a care plan in place for nutritional status and dental status.</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident's responsible party was invited to the care plan conference for 1 of 1 residents reviewed for care plan participation of the 1 resident who met the criteria for care plan participation.</p> <p>The facility also failed to ensure the plan of care was reviewed and revised as needed related to activities of daily living, restraints, dialysis, and medications for 1 of 3 residents reviewed for activities of daily living of the 8 who met the criteria for activities of daily living, 1 of 3 residents reviewed for restraints of the 8 who</p>	F0280	<p>F Tag 280 Comprehensive Care Plan</p> <p>1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Conference was held with Social Service Department, D.O.N. and Administrator to discuss the procedure of inviting the family and residents to care conferences. Resident 25 and responsible party were scheduled for a care conference. Resident 9 geri-chair tray was discontinued and care plan updated. Resident 17 care plan updated to change permacath to AV fistula. Resident 7 care plan was updated to eliminate anti-depressant medication. 2. All care plans were reviewed by the</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>met the criteria for restraints, 1 of 1 residents reviewed for dialysis of the 1 who met the criteria for dialysis, and for 1 of 10 residents reviewed for unnecessary medications. (Residents #7, #9, #17, and #25)</p> <p>Findings include:</p> <p>1. Interview with Resident #25's responsible party on 11/26/12 at 1:50 p.m., indicated that she was not aware of what a care plan meeting was and she indicated that she had not been invited to a care plan meeting.</p> <p>The record for Resident #25 was reviewed on 11/28/12 at 7:33 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury and agitation with aggressive behavior.</p> <p>Review of the current plan of care, located in the resident's record, indicated there was no sign in sheet attached as to who attended the conference.</p> <p>There was a care plan narrative note, dated 8/12/12, which indicated what the resident was capable of doing. This narrative note was the last care plan updated available for review.</p>		<p>surveyors since our census was 21. The care plans have been divided with the nursing staff. Social Service reviewed their invitations to the family members to the care conference and no other residents were affected.3. Care plans will assign by the D.O.N. to the charge nurses then reviewed by the D.O.N. assistant. In-service will be held with all charge nurses regarding accurate and updating care plans by the D.O.N.</p> <p>4. D.O.N. and Assistant to the D.O.N. will review care plans according to the MDS schedule and new orders and changes that occur with the residents ongoing. 4 Care Plans will be reviewed each week until all care plans are reviewed and revised times 5 weeks. Then weekly audits will be performed according to MDS schedule. Q.A. Committee will review audits monthly.</p> <p>5. 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Review of the Social Service Progress notes for the dates of 8/1-11/27/12, indicated there was no documentation related to inviting the resident and/or his responsible party to a care plan conference.</p> <p>Interview with the Social Service Director on 11/30/12 at 9:15 a.m., indicated that she was responsible for inviting families to care plan meetings. She indicated a sign was usually posted in the resident's room and a letter was mailed to the family.</p> <p>Interview with the Social Service Director on 12/3/12 at 8:46 a.m., indicated if the resident's responsible party was notified, documentation should have been in the resident's record.</p> <p>2. On 11/29/12 at 8:33 a.m., Resident #9 was observed lying in a geri recliner chair. The tray table top was observed up and in place across the resident's legs. The resident was not leaning forward or to one side while lying in the chair.</p> <p>On 11/29/12 1:01 p.m., and 2:14 p.m., the resident was observed lying in the geri recliner in her room. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>tray table top was observed in place and over the resident's legs. The resident was reclined at this time and was not observed leaning forward or to one side in the chair.</p> <p>On 11/29/12 at 3:00 p.m. and 3:45 p.m., the resident was observed lying in the geri recliner with the tray table top up in place over her legs. The resident was now in the dining room.</p> <p>The record for Resident #9 was reviewed on 11/27/12 at 2:05 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, Alzheimer's disease, history of falls, left knee surgery, psychosis with delusions, seizure disorder, senile cachexia, aphasia, and dysphasia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/30/12, indicated the resident was rarely understood and rarely understands. The resident had no behaviors coded. The resident needs extensive assist with two person physical assist with personal hygiene, dressing, eating, transfers, bed mobility. The resident had limited range of motion to her lower extremities and was always incontinent of bowel and bladder.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>The resident was coded as having a physical restraint of a chair that prevents rising.</p> <p>Review of a care plan, dated 4/30/12, indicated the resident required the use of a restraint (e.g. trunk/limb). The care plan was incomplete and none of the nursing approaches were specific to the resident.</p> <p>There was no current plan of care for the tray table top attached to the geri recliner.</p> <p>Interview with LPN #2 on 11/29/12 at 3:32 p.m., indicated the resident's current care plans were in the clinical record.</p> <p>3. On 11/28/12 at 10:49 a.m., Resident #17 was observed seated in his wheelchair in his room. The resident's chest was observed, he did not have a permacath (a tube surgically placed for dialysis access) in place in his chest. The resident's left arm was observed and he did not have a pressure dressing on his left arm. Interview with LPN #3 at that time, indicated the resident did not have a permacath in his chest. She also indicated he did not have a pressure dressing on his left arm.</p> <p>The record for Resident #17 was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>reviewed on 11/27/12 at 3:04 p.m. He had diagnoses that included, but were not limited to, end stage renal disease, hypertension, and left AV (arteriovenous) fistula for dialysis access. The resident received dialysis three times per week.</p> <p>There was a current care plan, dated 8/29/11, that indicated: Problem: "I have a new AV fistula in my left arm for dialysis treatment." Goal: "My AV fistula will remain intact and free from infection." -keep pressure dressing intact per order -monitor for bleeding -keep arm straight at all times</p> <p>There was a current care plan, dated 4/5/11, that indicated: Problem: "I receive hemodialysis 3 times a week and have a permacath to left chest." Goal: "I will attend dialysis as ordered." -arrange transportation -encourage resident to attend all tx's (treatments) -monitor permacath for bleeding, swelling -weigh resident before and after tx</p> <p>Interview with LPN #3 on 11/28/12 at 10:49 a.m., indicated the care plans</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>had not been updated and did not reflect the resident's current status. She indicated the resident's permacath was removed a long time ago and he had the dialysis shunt created surgically a long time ago. She indicated the Director of Nursing had assigned the nurses to update the care plans, but it had not been completed.</p> <p>4. The record for Resident #7 was reviewed on 11/28/12 9:25 a.m. The resident had diagnoses that included, but were not limited to, dementia, depression, and atypical psychosis.</p> <p>There was a current care plan, dated 1/31/12, that indicated: Problem: "behavioral medication (resident's name) receives antidepressant medication." Goal: "will take medications as ordered." Approaches: -administer medications as ordered -check mouth to be sure medication has been given -consult md (medical doctor) about change in drug regime, -staff will offer comfort and support when resident displays s/s (signs and symptoms) of depression</p> <p>Review of the November 2012</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Physician Order Sheet indicated the resident had no Physician Order for an antidepressant medication.</p> <p>Interview with the Administrative Assistant on 11/29/12 at 10:19 a.m., indicated the resident's care plan did not reflect the resident's current status, as he did not receive antidepressant medication.</p> <p>3.1-35(c)(2)(C) 3.1-35(d)(2)(B)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to the administration of medications, checking and changing a resident prior to leaving the facility, diet orders, the use of hand rolls, and monitoring blood pressure and blood sugars for 3 of 10 residents reviewed for unnecessary medications, for 1 of 3 residents reviewed for nutrition of the 4 residents who met the criteria for nutrition, for 1 of 3 residents reviewed for range of motion of the 7 residents who met the criteria for range of motion, and for 1 of 3 residents reviewed for activities of daily living of the 8 residents who met the criteria for activities of daily living. (Residents #B, #C, #D, #E, #F, and #G)</p> <p>Findings include:</p> <p>1. The record for Resident #G was reviewed on 11/27/12 at 11:09 a.m. The resident was re-admitted to the facility on 10/23/12 with an order for</p>	F0282	F Tag 282 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident G physician orders were reviewed and Senna order clarified. Resident E blood pressures at 6am & 5pm order clarified and monitored daily since blood pressure is regulated with anti-hypertensive medication. Resident B charge nurse responsibility for checking resident prior to leaving for school. Resident D hand roll was placed in residents hand and he was encouraged to keep hand roll in his hand to prevent further contracture of left hand. Resident F review of blood sugars and in-service held with nurse taking blood sugar for 10/15, 11/3, 11/28. Resident C double portions was added to tray card and updated on physician orders. Medication administration for 7/18-7/22/12 according to delivery from pharmacy and returns medication was administered to resident for the period of 7/18-7/22/12, however the staff associated with that time period is no longer employed by the facility. D.O.N. assistant will review dietician recommendation and	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Senna (a stool softener) 8.6 milligrams (mg) by mouth nightly.</p> <p>Review of the November and December 2012 Physician's Order Summary (POS), indicated the order for the Senna was not listed.</p> <p>Review of the November 2012 Medication Administration Record (MAR), indicated the Senna was not listed and the resident had not received the medication for the month of November.</p> <p>Interview with LPN #3 on 12/3/12 at 1:09 p.m., indicated she readmitted the resident on 10/23/12 and got his readmission orders. She indicated she wrote the order for the Senna on the 10/12 MAR but it must not have gotten carried over to the November MAR.</p> <p>2. The record for Resident #E was reviewed on 11/29/12 at 1:28 p.m.</p>		<p>review MAR weekly.2. No other residents affected.3. Care plans reviewed for hand roll residents. All residents monthly Physician orders recaps reviewed. Monthly MARs and TARs were reviewed to ensure accuracy. Dietary orders reviewed with FSS and dietary cards updated.In –Service will be presented to the nursing staff on care plan interventions, diet orders and recaps by D.O.N. assistant. Charge Nurse is responsible for informing the CNA staff of plan of care for each resident during shift to shift report.4. How the corrective action will be monitored to ensure the deficient practice will not recur.Director of Nursing and or designee will audit compliance weekly of MAR's, TAR's and physician orders. Dietician recommendations will be monitored semi-monthly. FSS will monitor tray cards during all 3 meals bi-weekly times 2 months then quarterly thereafter.</p> <p>FSS and D.O.N. will monitor dietician recommendations during each facility visit. This will be an ongoing practice. QA will receive reports and review quarterly and make recommendations as needed. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>The resident was admitted to the facility on 6/1/12. The resident's diagnoses included, but were not limited to, stroke, and high blood pressure.</p> <p>Review of Physician Orders, dated 6/1/12, indicated blood pressure twice a day.</p> <p>Review of the Medication Administration Record (MAR), dated 10/12, indicated the blood pressure was not recorded as being done at 6:00 a.m., on 10/2, 10/3, 10/6, 10/8, 10/16,10/20, and 10/26/12.</p> <p>Review of the 10/12 MAR indicated the blood pressures were not completed on evening shift on at 5:00 p.m., on 10/6, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/12</p> <p>Interview LPN #2 on 11/29/12 at 3:37 p.m., indicated the resident's blood pressure was supposed to be taken and documented on the MAR two times a day.</p> <p>3. On 11/28/12 at 5:50 a.m., Resident #B was observed sitting in a wheelchair with a seatbelt restraint</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>noted around his waist.</p> <p>On 11/28/12 at 7:40 a.m., the resident was brought out of the dining room by CNA #7 and placed in front of the Nurses station. The resident was wearing street clothes and tennis shoes. The CNA indicated the resident was going to be picked up and taken to school (workshop) in which he attends everyday Monday through Friday. The CNA then walked back into the dining room. The CNA did not take the resident into the bathroom or back to his room to check him for incontinence.</p> <p>On 11/28/12 at 7:46 a.m., the resident left the facility by the way of an ambulance transportation and again he was not checked for incontinence before leaving the facility.</p> <p>The record for Resident #B was reviewed on 11/27/12 at 9:53 a.m. The resident diagnoses included, but were not limited to, hypoxia, cerebral palsy, seizures, aphasia, Downs Syndrome, mental retardation, behavior disorder, and muscle spasms.</p> <p>Review of the current undated care plan indicated "I go to school Monday</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>through Friday and I will be clean and my chair will be cleaned also. The Nursing approaches were staff will check daily before leaving for school, receives a bath daily, receives oral care daily, and chair checked daily for cleanliness.</p> <p>Interview with CNA #7 on 11/28/12 at 5:55 a.m., indicated she normally works the day shift. She also indicated the resident was supposed to be checked for incontinence before he leaves and if he was wet then they change him.</p> <p>Interview with LPN #2 on 11/29/12 at 4:09 p.m., indicated the resident was supposed to be checked for incontinence and if needed changed prior to leaving the facility.</p> <p>4. Resident #D was observed on 11/27/12 at 10:35 a.m., he was in bed. His left hand was clenched in a fist on his lap, there was no hand roll in place in his left hand.</p> <p>On 11/27/12 at 2:15 p.m., the resident was in bed. His left hand was in a fist like position, there was no hand roll in place. Interview with the resident at that time, indicated that the staff sometimes puts a roll in his hand, but not every day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Observations on 11/27/12 at 3:25 p.m. and on 11/28/12 at 5:55 a.m., indicated the resident had no hand roll in his left hand.</p> <p>On 11/28/12 at 7:30 a.m., the resident was in bed. His left hand was clenched in fist like position, there was no hand roll in place. Interview with the resident at that time indicated he could not open his left hand.</p> <p>Interview with LPN #4 on 11/28/12 at 7:30 a.m., indicated there was no hand roll in the resident's hand. The LPN provided passive range of motion to the resident's left hand and was able to extend his fingers fully.</p> <p>Observation of the resident on 11/28/12 at 11:15 a.m., indicated there was no hand roll in the resident's left hand.</p> <p>The record for Resident #D was reviewed on 11/27/12 at 1:49 p.m. The resident had diagnoses that included, but were not limited to, seizures and stroke.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 8/17/12, indicated the resident had functional limitation in range of motion with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>impairment on one side to his upper extremities.</p> <p>There was a care plan, dated 8/11/12, that indicated:</p> <p>Problem: "I have a contracture of my left hand." Goal: "I will have no further contracture to my hand." Approaches: -provide hand roll -provide PROM (passive range of motion) exercises daily -encourage resident to use unaffected hand to exercise affected hand -keep hand clean and dry -monitor swelling or further contracture</p> <p>On 11/30/12 at 10:40 a.m., the resident was observed with no hand roll in his left hand. Interview with CNA #1 at that time, indicated the resident did not have a hand roll in his left hand. She indicated she was not aware he was to have a hand roll in his hand.</p> <p>5. The record for Resident #F was reviewed on 11/29/12 9:19 a.m. The resident had diagnoses that included, but were not limited to, insulin dependent diabetes.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>There was a care plan, dated 7/20/12, that indicated:</p> <p>Problem: "(Resident #F's name) is diabetic." Goal: blood glucose to remain between 60 and 100 Approaches: -discuss food preferences -ncs (no concentrated sweet) diet -nourishing snacks -monitor compliance with diet -monitor blood glucose -medicate with Lantus (type of insulin) -notify md (medical doctor) if blood glucose is below 60 -monitor for s/s (sign and symptoms) n/v (nausea/vomiting), thirst, excessive urination, dry skin -monitor for s/s of hypo-hyperglycemia (low-high blood glucose)</p> <p>Review of the October 2012 Medication Administration Record, indicated the resident had Physician's Orders for blood glucose monitoring twice daily.</p> <p>The resident's blood glucose level was 45 on 10/15/12 at 7:00 a.m. There was no evidence the Physician was notified of the resident's low blood sugars.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Review of the November 2012 Medication Administration Record, indicated the resident's blood glucose level was 54 on 11/3/12 and was 57 on 11/28/12. There was no evidence in the record that the physician was notified of the low blood glucose levels.</p> <p>Interview with the Director of Nursing (DoN) on 11/29/12 at 1:41 p.m., indicated when a resident had a blood glucose reading below 60 the physician was to be notified.</p> <p>The policy titled "Blood Sugar Monitoring" that was undated, was provided by the Administrative Assistant/Social Service Director on 11/29/12. She indicated the policy was current. The policy indicated, "If blood glucose level is above or below normal range, document the time the physician was notified."</p> <p>On 11/30/12 at 1:45 p.m., interview with the DoN indicated the staff should have followed the resident's care plan and notified the physician of the low blood sugar reading.</p> <p>6. Resident #C was observed on 11/27/12 at 8:28 a.m. The resident was in the Main Dining Room. His</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>tray card indicated his diet was pureed with super cereal. He received 2 bowls of cereal one dark in color and one light in color. He also was served one bowl of pureed food. He was not served double portions.</p> <p>At lunch time on 11/27/12 at 12:07 p.m., the resident was served 1 bowl of pureed sweet potato, one bowl of pureed meat, 1 bowl of pureed bread, 1 bowl pureed salad and jello. The resident did not receive double portions.</p> <p>On 11/28/12 at 8:12 a.m., the resident received 1 bowl of pureed prunes, 1 bowl of pureed grilled cheese sandwich, one bowl of super cereal and 1 bowl of pureed sausage. He did not receive double portions.</p> <p>For lunch on 11/28/12 at 12:27 p.m., the resident received 1 bowl of pureed chicken, 1 bowl of pureed cabbage, 1 bowl of pureed carrots and 1 bowl of pudding, he did not receive double portions.</p> <p>Interview on 11/29/12 at 11:44 a.m., with the Dietary Manager indicated there was only 1 resident in the facility who received a pureed diet with double portions and it was Resident #14. He indicated that a resident with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>a pureed diet order of double portions received 2 bowls of each item. He indicated Resident #C had not received double portions, he stated the resident had received super cereal only.</p> <p>The record for Resident #C was reviewed on 11/27/12 at 9:46 a.m. He had diagnoses that included, but were not limited to, Huntington's Chorea.</p> <p>There was a Physician Order, dated 7/28/12, to discontinue ensure plus 1.5, and a new order give 1 can house supplement with each meal, and double portions of puree diet per "Dietary Recommendations."</p> <p>An entry in the Nurse's Notes, dated 7/31/12 at 12 p.m., indicated, "resident continues to eat 100% of double portion meals without assist."</p> <p>An entry in the Nurse's Notes, dated 8/7/12 at 1:30 p.m., indicated, "continues to consume 100% of meals (double portions) house supplement offered per orders . . ."</p> <p>Review of the physician's orders, dated 7/28/12 through 11/27/12, indicated there was no order to discontinue the double portions. Review of the dietary notes indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>there was no dietary recommendation to discontinue the double portions.</p> <p>A telephone interview with the Registered Dietitian on 11/30/12 at 1:25 p.m., indicated the resident was to receive double portions of a pureed diet as ordered by the physician.</p> <p>The resident was admitted to the facility on 7/18/12. The admission orders dated 7/18/12, indicated the resident was to receive:</p> <p>Depakote ER (a mood stabilizer medication) 500 mg (milligrams) by mouth every evening. Haloperidal tablet (an anti-psychotic medication) 2 mg by mouth every evening. Remeron (an antidepressant medication) 15 mg by mouth every evening.</p> <p>Review of the July 2012 Medication Administration Record, indicated there was no evidence the Depakote was administered on 7/18 through 7/21/12. There was no evidence the Haloperidal 2 mg was administered 7/18 through 7/22/12. There was no evidence the Remeron was administered 7/18 through 7/22/12.</p> <p>Interview with LPN #2 on 11/27/12 at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>1:24 p.m., indicated the resident was admitted to the facility on 7/18/12 and his medications were not administered as ordered by the physician on 7/18/12, 7/19/12, 7/20/12, 7/21/12 and 7/22/12.</p> <p>This Federal tag relates to Complaint IN00116865.</p> <p>3.1-35(g)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to the monitoring and the assessment of a dialysis shunt for 1 of 1 residents reviewed for dialysis and for the treatment of low blood glucose levels for 1 of 10 residents reviewed for unnecessary medications. (Resident #F and Resident #17)</p> <p>Findings include:</p> <p>1. The record for Resident #17 was reviewed on 11/27/12 at 3:04 p.m. He had diagnoses that included, but were not limited to, end stage renal disease, hypertension, and left AV (arteriovenous) fistula for dialysis access. The resident received dialysis three times per week.</p> <p>Review of the November 2012 Physician Order Sheet indicated there were no Physician's Orders to monitor or assess the resident's AV fistula.</p>	F0309	<p>F 3091. D.ON. developed a policy and procedure for AV fistula care for dialysis residents. <b>All charge nurses were in-serviced on hemodialysis assessment policy and listen to the bruit q shift, feel the thrill q shift and look at AV fistula site for complications</b> was added to the M.A.R. for resident 17. Resident F Policy reviewed with nurses for treatment of blood sugar below 60.2. The facility only has one dialysis resident and 5 diabetic residents. All dialysis and diabetic residents' records were reviewed. No other residents affected.3. Blood sugar policy was reviewed with all licensed nurses and records were reviewed for Resident F and care plan was updated. A one to one in-service was held with the nurse who worked 10/15, 11/3, 11/28.An In- Service on Hemodialysis Assessment, Physician Notification, and Blood Glucose policy will be presented to licensed nurses and new licensed nursing staff. 4. How the corrective action will be monitored to ensure the deficient practice will not recur.D.O.N.</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Review of the Nurse's Notes indicated there was no assessment of the resident's AV fistula. There was no evidence the staff assessed the AV fistula for a thrill (a pulse felt at the AV fistula site) or a bruit (a sound heard when a stethoscope was placed on the AV fistula). There was no evidence the staff routinely assessed the AV fistula for bleeding, patency or function.</p> <p>On 11/28/12 at 10:49 a.m., the resident was observed seated in his wheelchair in his room. The resident's left arm was observed. Interview with the resident at that time, indicated his left arm was where his dialysis was done.</p> <p>LPN #3 was interviewed on 11/28/12 at 10:49 a.m. When asked how she assessed the resident's fistula, she indicated that she looked at his fistula and applied cream to it before he went to dialysis. She indicated she felt the site. When asked if she used a stethoscope to assess the shunt she indicated, "No."</p> <p>On 11/28/12 at 11:20 a.m., LPN #2 was interviewed. She indicated she did not check the resident's dialysis shunt for patency and function. She</p>		<p>assistant will do skills testing of all licensed nurses taking blood sugars and blood sugar policy of informing physician when blood sugar is below 60 and above 275.</p> <p>DON and/or assistant to D.O.N. will audit medication administration record weekly, physician notifications weekly on Wednesday and dietician reports bi-monthly.</p> <p>D.O.N. will monitor weekly times one month then monthly thereafter and as needed upon concerns from designee.QA committee will AV fistula monitoring log, blood sugar logs and dietician recommendation monthly to ensure compliance for 3 months then q 6 months thereafter.5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>indicated the area was assessed by the staff at the dialysis unit. She further indicated she only applied the cream to the site to reduce pain.</p> <p>Interview with the Director of Nursing (DoN) on 11/29/12 at 1:34 p.m., indicated she did not have a policy for the assessment and care of the fistula site for a dialysis patient. She indicated the staff were to apply a gel on the area prior to dialysis and they would at that time feel the area. She indicated the staff were not monitoring and assessing the area on a daily basis for patency and for signs of problems such as bleeding. She indicated the staff were not assessing the thrill and the bruit of the shunt.</p> <p>Interview with the DoN on 11/29/12 at 4:39 p.m., indicated the staff would be trained to check the bruit using a stethoscope, and feel the thrill at the fistula site routinely to assess for problems.</p> <p>The policy titled "Hemodialysis Assessment Policy," dated 12/2012, was provided on 12/3/12 at 8:45 a.m., by the DoN. She indicated the policy was current. The policy indicated:</p> <p>"Purpose: To ensure AV fistula of dialysis resident is assessed every</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>shift and pre dialysis and post dialysis by a licensed nurse. Simmons Loving Care Health Facility will communicate with the dialysis center via the dialysis communication sheet, scheduled appointments for dialysis therapy and provide documentation of the resident's condition prior to dialysis unit.</p> <p>Instructions for A/V fistula for Hemodialysis Assessment:</p> <ol style="list-style-type: none"> <li>Licensed nurse will assess the following <ul style="list-style-type: none"> <li>-If vital signs are needed (DO NOT TAKE BLOOD PRESSURE IN ARM WITH A/V FISTULA)</li> <li>-LISTEN to the BRUIT Q (every) SHIFT using a stethoscope to ensure AV fistula has blood flow. A continuous low-pitched bruit should be present if change in tone notify physician immediately.</li> <li>-FEEL the THRILL Q SHIFT. A thrill (purring or vibration) indicates blood flow through the AV fistula. A continuous thrill should be present. LOOK at AV fistula site for complications: bleeding and signs &amp; symptoms of infection, redness, swelling or drainage.</li> </ul> </li> <li>Notify physician immediately if any complications occur."</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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. The record for Resident #F was reviewed on 11/29/12 9:19 a.m. The resident had diagnoses that included, but were not limited to, hypertension and insulin dependent diabetes.</p> <p>There was a care plan, dated 7/20/12, that indicated Problem: "(Resident #F's name) is diabetic." "Goal: blood glucose to remain between 60 and 100 Approaches: -discuss food preferences -ncs (no concentrated sweet) diet -nourishing snacks -monitor compliance with diet -monitor blood glucose -medicate with Lantus (type of insulin) -notify md (medical doctor) if blood glucose is below 60 -monitor for s/s (sign and symptoms) n/v (nausea/vomiting), thirst, excessive urination, dry skin -monitor for s/s of hypo-hyperglycemia (low-high blood glucose)."</p> <p>Review of the October 2012 Medication Administration Record, indicated the resident had Physician's Orders for blood glucose monitoring twice daily.</p> <p>The resident's blood glucose level</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>was 45 on 10/15/12 at 7:00 a.m. There was no evidence the Physician was notified of the resident's low blood sugars. Review of the Nurse's Notes indicated there was no evidence that the resident was assessed for hypoglycemia on 10/15/12. There was no evidence that immediate treatment was provided to the resident for the low blood glucose level.</p> <p>Review of the November 2012 Medication Administration Record, indicated the resident's blood glucose level was 54 on 11/3/12 and was 57 on 11/28/12. Both of these blood sugars were obtained at 7:00 a.m. There was no evidence in the record the physician was notified of the low blood glucose levels. There was no evidence the resident was assessed for hypoglycemia symptoms and there was no evidence that immediate treatment was provided on 11/3/12 and 11/28/12.</p> <p>Interview with the DoN on 11/29/12 at 1:41 p.m., indicated when a resident had a blood glucose reading below 60 the physician was to be notified.</p> <p>The policy titled "Blood Sugar Monitoring" that was undated, was provided by the Administrative</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Assistant/Social Service Director on 11/29/12. She indicated the policy was current. The policy indicated, "If blood glucose level is above or below normal range, document the time the physician was notified."</p> <p>The policy titled, "Physician Order For the Treatment of Hypoglycemia," dated 12/05, was provided by the Administrative Assistant on 11/29/12, she indicated the policy was current. The policy indicated: "Treatment for resident if blood sugar is 60 or below: Encourage caloric intake immediately such as: 1. 8 oz (ounce) Orange Juice with 1 teaspoon of sugar 2. 8 oz grape juice 3. 8 oz supplement Nutrition drink such as Diabetic Resource or boost. Recheck blood sugar if reading is still below notify physician for further treatment and monitor resident's status."</p> <p>On 11/30/12 at 1:45 p.m., interview with the DoN indicated the staff should have notified the physician and provided the resident with supplements to increase the resident's blood sugar.</p> <p>3.1-37(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure facial hair was removed for 2 of 3 residents reviewed for activities of daily living of the 8 residents who met the criteria for activities of daily living. (Residents #9 and #25)</p> <p>Findings include:</p> <p>1. On 11/27/12 at 8:00 a.m., Resident #25 was observed with a goatee style beard. The other half of the resident's face was clean shaven.</p> <p>On 11/28/12 at 8:06 a.m., the resident was observed in the dining room eating breakfast. The resident had an accumulation of facial hair around his goatee. At 12:27 p.m., the resident continued to have the accumulation of facial hair around his goatee.</p> <p>On 11/29/12 at 8:40 a.m., the resident was observed in his room in bed. The resident was awake and dressed. The resident had an</p>	F0312	<p>F 3121. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 9 was shaved of facial hair. Resident 25 allowed male C.N.A. to shave him that evening. C.N.A.'s were also informed of completing their out of stock forms and turning them in to the housekeeping supervisor. Each C.N.A. is responsible for restocking their care carts each morning. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All 22 residents were observed by surveyors and staff. No other residents were noted to be deficient with facial hair on their face. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In- Service on out of stock form and C.N.A. documentation on care log. Charge Nurse will monitor shaving of residents daily. 4. How the corrective action will be monitored to ensure the deficient</p>	01/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>accumulation of facial hair around his goatee. When asked if he had been shaved, the resident indicated that he had not.</p> <p>On 11/30/12 at 9:15 a.m., the resident was observed with a slight growth of facial hair around his goatee.</p> <p>The record for Resident #25 was reviewed on 11/28/12 at 7:33 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury and agitation with aggressive behavior.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/12/12, indicated the resident was dependent on staff for personal hygiene.</p> <p>The Care plan narrative note, dated 8/12/12, indicated "he is totally dependent in ADL's. Staff provides tub bath daily, dress, and grooms him. He is clean and free from odor."</p> <p>The Quarterly MDS assessment, dated 11/12/12, indicated the resident remained dependent on staff for personal hygiene.</p> <p>Interview with CNA #1 on 11/30/12 at 9:34 a.m., indicated that she</p>		<p>practice will not recur. Out of Stock forms are to be turned into Supervisor weekly on Thursday and supplies are issued weekly. The charge nurse will monitor resident's facial hairs daily during tub surveillance. ADL logs will be monitored weekly by CNA team leader weekly. The D.O.N. designee will monitor monthly. QA committee will receive a report on resident shaving quarterly for 6 months then semi-annually. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>attempted to shave the resident this morning, she indicated that he only allowed her to do half of his face before he wanted her to stop. She indicated this was a normal behavior for the resident. She also indicated the last time she attempted to shave the resident was Monday or Tuesday, she hadn't attempted since then because the facility just got razors back in stock yesterday (Thursday).</p> <p>2. On 11/26/2012 at 11:33 a.m., and 2:08 p.m., Resident #9 was observed lying in a geri recliner with the tray table attached across the resident's body and legs. The resident had gray facial hair on her chin.</p> <p>On 11/27/12 at 12:08 p.m., Resident #9 was observed lying in a geri recliner in the dining room. She was seated at the round table. The resident had gray facial hair on her chin.</p> <p>On 11/27/12 at 2:01 p.m. and 2:50 p.m., Resident #9 was observed lying in a geri recliner in the dining room. The resident had gray facial hair on her chin.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>On 11/28/12 at 5:44 a.m., 6:24 a.m., 8:34 a.m., 10:35 a.m., and 12:45 p.m., the resident was observed in the dining room lying in the geri recliner. The resident had gray facial hair on her chin.</p> <p>On 11/29/12 at 8:33 a.m., the resident was observed lying in a geri recliner chair. The resident had gray facial hair on her chin.</p> <p>Interview with CNA #1 on 11/30/12 at 9:04 a.m., indicated she shaved the resident's chin yesterday. She further indicated the resident was shaved every two to three days due to the hair growth. The CNA indicated there were no razors available on Monday, Tuesday, or Wednesday so she could not shave the resident until yesterday (Thursday). She further indicated the resident was totally dependent on staff for shaving and personal hygiene.</p> <p>The record for Resident #9 was reviewed on 11/27/12 at 2:05 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, Alzheimer's disease, history of falls, left knee surgery, psychosis with delusions, seizure disorder, senile cachexia, aphasia, and dysphasia.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/30/12, indicated the resident was rarely understood and rarely understands. The resident had no behaviors coded. The resident needs extensive assist with two person physical assist with personal hygiene, dressing, eating, transfers, bed mobility.</p> <p>Review of the care plan, dated 10/17/11, with no other updated version indicated the resident was totally dependent for all activities of daily living approaches were tub bath/shower, daily shampoo, and nail care provided.</p> <p>3.1-38(a)(3)(D)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to ensure that a resident with a limitation of range of motion received appropriate treatment related to the lack of using a hand roll for 1 of 3 residents reviewed for range of motion of the 3 residents who met the criteria for range of motion services. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D was observed on 11/27/12 at 10:35 a.m., in bed. His left hand was clenched in a fist on his lap, there was no hand roll in place in his left hand.</p> <p>On 11/27/12 at 2:15 p.m., the resident was in bed. His left hand was in a fist like position, there was no hand roll in place. Interview with the resident at that time, indicated that the staff sometimes puts a roll in his hand but not every day.</p>	F0318	<p>F 318</p> <p>1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident D hand roll was placed in residents hand and he was encouraged to keep hand roll in his hand to prevent further contracture of left hand.2. No other residents affected.3. Care plans reviewed for hand roll residents. In –Service will be presented to the nursing staff on care plan interventions.Charge Nurse is responsible for informing the CNA staff of plan of care for each resident during shift to shift report.4. How the corrective action will be monitored to ensure the deficient practice will not recur.Charge Nurse will monitor for hand rolls during nurse rounds throughout each shift. Director of Nursing and or designee will audit anti-contracture log weekly to ensure compliance. QA will receive reports and review quarterly and make recommendations as needed. 5. Date completed: 1/2/13</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Observations on 11/27/12 at 3:25 p.m. and on 11/28/12 at 5:55 a.m. indicated the resident had no hand roll in his left hand.</p> <p>On 11/28/12 at 7:30 a.m., the resident was in bed. His left hand was clenched in fist like position, there was no hand roll in place. Interview with the resident at that time indicated he could not open his left hand. Interview with LPN #4 at that time, indicated there was no hand roll. The LPN was able to provide passive range of motion and was able to extend his fingers fully.</p> <p>Observation of the resident on 11/28/12 at 11:15 a.m., indicated there was no hand roll in the resident's left hand.</p> <p>On 11/30/12 at 10:40 a.m., there was no hand roll in his left hand. Interview with CNA #1 at that time, indicated the resident did not have a hand roll in his left hand. She indicated she was not aware he was to have a hand roll in his hand.</p> <p>The record for Resident #D was reviewed on 11/27/12 at 1:49 p.m. The resident had diagnoses that included, but were not limited to, seizures and stroke.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>The admission Minimum Data Set (MDS) assessment, dated 8/17/12, indicated the resident had functional limitation in range of motion with impairment on one side to his upper extremities.</p> <p>There was a care plan, dated 8/11/12, that indicated:                      Problem: I have a contracture of my left hand                      Goal: I will have no further contracture to my hand                      Approaches:                      -provide hand roll                      -provide PROM (passive range of motion) exercises daily                      -encourage resident to use unaffected hand to exercise affected hand                      -keep hand clean and dry                      -monitor swelling or further contracture</p> <p>3.1-42(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0323 SS=L	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to maintain hot water temperatures between 100 and 120 degrees Fahrenheit, resulting in the risk for potential for serious harm and/or injury related to hot water temperatures ranging from 128 degrees to 166 degrees Fahrenheit for 20 of 23 residents who resided in the facility on the East and West Wings.</p> <p>The Immediate Jeopardy began on 11/19/12, when the mixing valve for the hot water heater was in need of repair and the facility did not turn down the hot water heater to prevent serious injury or harm to the residents. The Administrative Assistant was notified of the Immediate Jeopardy on 11/26/12 at 1:08 p.m. The Immediate Jeopardy was removed on 11/29/12, but non compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p>	F0323	<p>F Tag 323 Free Of Accident Hazards/Supervision/Devices 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Mixing valve was replaced by plumber to maintain water temp between 100-120 degrees. Entire staff In-Service was done to show staff how to calibrate the thermometer, test the water temps, how to shut off the hot water supply, how to tag out the system with danger signs on the sink handle and shut off valve and to inform maintenance supervisor. The thermometers were placed in every room along with the danger water sign instructions. Charge Nurse tested and recorded water temps during nurse rounds which occur at 12a, 3a, 5a, 8a, 11a, 2p, 4p, 6p, 9p (all shifts). Staff instructed to monitor water temps every 2-3 hours. Water temp taken by maintenance at 12:45p.m. Temps were taken by the supervisor at 6:00p.m. Administrator and D.O.N. called the facility throughout the night to monitor water temps. D.O.N. will monitor water temps</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Findings include:</p> <p>On 11/26/12 at 12:03 p.m., the hot water temperature in Room 110 was 155 degrees Fahrenheit.</p> <p>Interview with Maintenance Employee #1 on 11/26/12 at 12:35 p.m., indicated the mixing valve was broken and needed repaired. He further indicated this happened sometime last week and the part was on order.</p> <p>Interview with the Administrative Assistant on 11/26/12 at 12:35 p.m., indicated the plumbers had been called out to the facility on 11/19/12. She further indicated the problem was with the mixing valve, as it needed to be replaced. She also indicated all of the paper work the plumbers left was locked in the Administrator's office and she was not able to obtain it, as the Administrator was out of the facility and was not coming into the facility. She did indicate, the mixing valve was ordered at that time, and they were waiting on the part to come in.</p> <p>On 11/26/12 at 12:45 p.m., the hot water temperatures were taken in all of the rooms that were occupied with residents on the West Wing. The</p>		<p>during nurse round times. A one to one in-service will be given to the evening and night nurse by the D.O.N. upon their arrival to work and the D.O.N. will call during round times to check the water temps throughout the night. The D.O.N. will record the temps on a water temp log sheet when she calls to verify the water temps.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.Water temps remain within normal limits of 100-120 degrees.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In Service held on calibrating thermometer, proper water temps (100-120 degree) in resident areas, Tag-Out procedure, how to cut off of water supply in resident rooms. Water temps were monitored during nurse rounds times one week, then q shift times one week, then daily times one week then weekly on each shift. 4. How the corrective action will be monitored to ensure the deficient practice will not recur.Maintenance Supervisor staff will monitor water temps 2 weekly times one month then weekly thereafter. D.O.N. designee will monitor weekly water temp sheets times one month and as needed when water temp feels too hot or too cold to staff during</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>temperatures were as follows:</p> <p>Room 102: 166 degrees Fahrenheit two residents resided in this room</p> <p>Room 104: 162 degrees Fahrenheit two residents resided in this room</p> <p>Room 106: 158 degrees Fahrenheit two residents resided in this room</p> <p>Room 108: 148 degrees Fahrenheit two residents resided in this room</p> <p>Room 120: 162 degrees Fahrenheit two residents resided in this room</p> <p>West Shower Room: 160 degrees Fahrenheit</p> <p>On 11/26/12 at 12:55 p.m., the hot water temperatures were taken in all of the resident rooms that were occupied with residents on the East Wing as follows:</p> <p>Room 101: 129 degrees Fahrenheit two residents resided in this room</p> <p>Room 103: 134 degrees Fahrenheit two residents resided in this room</p> <p>Room 105: 129 degrees Fahrenheit two residents resided in this room</p> <p>Room 109: 130 degrees Fahrenheit one resident resided in this room</p> <p>Room 113: 130 degrees Fahrenheit two residents resided in this room</p> <p>Room 115: 128 degrees Fahrenheit one resident resided in this room</p> <p>East Shower Room: 140 degrees</p>		<p>care.</p> <p>Director of Nursing and or designee will in-service new staff on water temp procedure.</p> <p>D.O.N. will develop the policy for calibrating a thermometer and policy for taking water temperatures.</p> <p>Q.A. Committee will determine effectiveness of the water temp. policy and procedures.</p> <p>5. Completion Date: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Fahrenheit</p> <p>Interview with Maintenance Employee #1 on 11/26/12 at 12:57 p.m., indicated there were two hot water heaters in the facility. The hot water heater that maintained the West Wing also was connected with the kitchen and the laundry room. He further indicated that hot water heater (that provided hot water to the West Wing) was set at 180 degrees Fahrenheit due to the supply of hot water to the kitchen and the washing machines. He also indicated that he had not turned the hot water heater down after knowing the mixing valve and anti-scald valve were broken and needed repair.</p> <p>Review of the hot water temperature log provided by Maintenance Employee #1 on 11/26/12 at 1:22 p.m., indicated his last recorded temperatures were on 11/20/12 which indicated:</p> <p>West shower room: 142 Room 102: 122 degrees Fahrenheit Room 104: 130 degrees Fahrenheit Room 106: 132 degrees Fahrenheit Room 108: 130 degrees Fahrenheit Room 110: 124 degrees Fahrenheit Room 112: 122 degrees Fahrenheit</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>All the rooms on the East Wing were between 109 and 118 degrees Fahrenheit. Interview with Maintenance Employee #1 on 11/26/12 at 12:57 p.m., indicated the above water temperatures were taken during the day and he had stopped taking hot water temperatures after 11/20/12.</p> <p>Interview with the Administrative Assistant on 11/26/12 at 1:45 p.m., indicated the hot water temperatures were also taken on the West and East Wings including both shower rooms, during the evening by the Maintenance Director on 11/20, 11/21, 11/22, and 11/23/12.</p> <p>Review of the hot water temperature logs that were taken on the evening shift by the Maintenance Director, indicated the hot water temperature ranged between 114-119 degrees Fahrenheit for all the above mentioned days.</p> <p>Interview with the Maintenance Director on 11/26/12 at 2:02 p.m., indicated she had taken the hot water temperatures during the evening shift at 3:30 p.m., on 11/20, 11/21, 11/22, and 11/23/12. She further indicated the hot water temperatures were not obtained during the day shift on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>above mentioned days or over the weekend on 11/24 and 11/25/12. The Maintenance Director was not able to explain how the hot water temperatures were all within normal range when the mixing valve was still in need of repair.</p> <p>Interview with CNA #1 on 11/26/12 at 2:33 p.m., indicated he normally works the 2-11 shift. He further indicated he had last worked on 11/25/12 and the water was very hot on both wings in the resident rooms. He indicated that he obtained water from the kitchen due it being so hot in some resident rooms.</p> <p>Interview with CNA #2 on 11/26/12 at 2:33 p.m., indicated she normally works the 2-11 shift. She indicated she last worked on Friday 11/23/12. The CNA indicated the water was so hot that she had to mix cold water with it in order to provide resident care.</p> <p>On 11/27/12 at 8:11 a.m., the hot water temperature in room 110 was still 140 degrees Fahrenheit.</p> <p>On 11/27/12 at 8:50 a.m., the hot water temperatures were taken in the following rooms on the West Wing:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Room 104: 146 degrees Fahrenheit Room 106: 140 degrees Fahrenheit Room 120: 150 degrees Fahrenheit West Wing shower room: 148 degrees Fahrenheit The hot water had been turned off in the rest of the resident rooms on the West Wing.</p> <p>On 11/27/12 at 8:54 a.m., the hot water temperatures were taken in the following rooms on the East Wing:</p> <p>Room 103: 108 degrees Fahrenheit Room 109: 102 degrees Fahrenheit Room 118: 102 degrees Fahrenheit East Wing Shower Room: 102 degrees Fahrenheit The hot water had been turned off in the the rest of the resident room on the East Wing.</p> <p>The Immediate Jeopardy that began on 11/19/12 was removed on 11/29/12 when the facility had ensured all of the hot water was turned off in the resident rooms. The facility also inserviced the entire Nursing, Dietary and Maintenance staff regarding on how to monitor and take the hot water temperatures and turn off the hot water at the resident sinks. The facility also put a plan together to monitor the hot water temperatures in the resident rooms</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>every three hours with the Maintenance Director overseeing the temperatures and ensuring the temperatures were taken timely, but the non compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-19(r) 3.1-45(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interview, the facility failed to ensure Registered Dietitian (RD) recommendations were implemented and diet orders were followed for 2 of 3 residents reviewed for nutrition of the 4 residents who met the criteria for nutrition. (Residents #C and #25)</p> <p>Findings include:</p> <p>1. On 11/27/12 at 8:00 a.m., Resident #25 was observed in the dining room. He consumed 100% of his breakfast which was a pureed consistency. At 8:30 a.m., the resident came back into the dining room asking for more food. The resident was given some extra food at this time. At 12:13 p.m., the resident was observed in his room laying down. The resident indicated that he already ate lunch. The resident's empty tray was in the dining room.</p>	F0325	<p>F Tag 325 MAINTAIN NUTRITIONAL STATUS1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 25 speech consult and cookie swallow test scheduled for this resident. Resident C double portions D.O.N. assistant will review dietician recommendation and tray card corrected with current diet order.2. No other residents affected.3. Dietary orders and tray cards were reviewed and updated with FSS, dietician and D.O.N. In -Service was held with licensed nursing staff on diet orders and recaps by D.O.N. Social Service made the arrangements for a speech therapist consult however it will have to be pre-authorized by Medicaid prior to resident been seen by the therapist. Resident did have a cookie swallow evaluation completed. Physician and family will be informed of the findings of speech and cookie swallow.4. How the corrective action</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>CNA #7 indicated the resident was served a pureed diet and that he ate 100%.</p> <p>On 11/28/12 at 5:47 a.m., the resident was observed ambulating in the dining room. At 7:20 a.m., the resident was seated in the dining room. He was wanting to know when the kitchen was going to be open. At 8:02 a.m., the resident was feeding himself breakfast in the dining room, he ate 100%. At 8:17 a.m., CNA #7, indicated the resident usually eats 100% and receives double portions when he asks for them.</p> <p>The record for Resident #25 was reviewed on 11/28/12 at 7:33 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury, anemia, and dysphagia (difficulty swallowing).</p> <p>A Physician's order, dated 10/8/12, indicated the resident was to receive a Puree NAS (no added salt) diet. The resident's honey thickened liquids were discontinued on 10/8/12.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/12/12, indicated the resident had not had a significant weight loss or gain and that he received a mechanically</p>		<p>will be monitored to ensure the deficient practice will not recur. Dietician recommendations will be monitored semi-monthly by D.O.N. designee and FSS ongoing. FSS will monitor tray cards during all 3 meals bi-weekly times 2 months then quarterly thereafter.</p> <p>The D.O.N. will review completion of dietician recommendations and provide report to the QA committee monthly for 3 months then review quarterly thereafter. If deficient practice noted then Q.A. committee will review recommendations as needed. 5. Date completed: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>altered/therapeutic diet. The Quarterly MDS assessment, dated 11/12/12, indicated the same thing.</p> <p>The resident's weight on admission on 7/30/12 was recorded as 155 pounds. The resident's November 2012 weight was documented as 158 pounds.</p> <p>A nutritional progress note completed by the Dietary Food Manager on 7/30/12, indicated the resident consumed 100% of his meals and had good food and fluid intake.</p> <p>A nutritional progress note completed by the Dietary Food Manager on 8/1/12, indicated the resident was still consuming 100% of all meals and the resident had to be watched so he would not eat off of other resident's plates.</p> <p>The Initial Nutritional assessment form completed by the Registered Dietitian (RD) on 8/11/12, did not address the resident trying to eat off of the other resident's plates. The assessment indicated the resident's BMI was within normal limits.</p> <p>The RD progress note, dated 8/30/12, indicated that she had been informed by nursing the resident had attempted</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>to drink liquid other than thickened liquids and was being redirected by staff. The RD recommended to consider Speech Therapy re-evaluation for next reviewed.</p> <p>The RD progress note, dated 9/15/12, indicated there was no documentation related to the Speech Therapy referral. Documentation indicated the resident was eating well per nursing and no recommendations were made.</p> <p>The RD progress note, dated 11/24/12, indicated the resident's weight was slowly rising and this was desired. Documentation indicated the resident was observed feeding himself in the dining room and he ate 100%. Continue current plan and follow up as needed. Again, there was no reference made to the Speech Therapy Evaluation.</p> <p>The 8/12/12 Restorative eating plan assessment summary indicated, the resident "must be supervised at meals. He will eat from other resident's plates and will drink their fluids. He receives pureed diet with honey thick liquids. He is encouraged to comply with prescribed diet. He consumes 100% of most meals but then will attempt to take leftovers from other plates. Staff supervises to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>ensure resident eats his prescribed diet. Continue care plan x (times) 90 days."</p> <p>Interview with LPN #3 on 11/28/12 at 11:08 a.m., indicated the resident had a good appetite and usually eats 100%. She indicated if he asks for more, they will get him more.</p> <p>Interview with CNA #7 on 11/28/12 at 12:30 p.m., indicated the resident had a good appetite, usually eats everything. The CNA indicated his Mom was visiting and just brought him Wendy's and he ate all of that plus he was currently eating his lunch.</p> <p>Interview with the resident's Responsible Party on 11/26/12 at 1:50 p.m., indicated that she wished he could see a Speech Therapist for a possible diet upgrade.</p> <p>Interview with the Administrator on 11/30/12 at 12:00 p.m., indicated the resident had improved since being admitted to the facility and should be referred to Speech Therapy based on the RD recommendations.</p> <p>2. Resident #C was observed on 11/27/12 at 8:28 a.m. The resident was in the Main Dining Room. His tray card indicated his diet was pureed with super cereal. He received</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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 bowls of cereal one dark in color and one light in color. He also was served one bowl of pureed food. He was not served double portions.</p> <p>At lunch time on 11/27/12 at 12:07 p.m., the resident was served 1 bowl of pureed sweet potato, one bowl of pureed meat, 1 bowl of pureed bread and 1 bowl pureed salad and jello. The resident did not receive double portions.</p> <p>On 11/28/12 at 8:12 a.m., the resident received 1 bowl of pureed prunes, 1 bowl of pureed grilled cheese sandwich, one bowl of super cereal and 1 bowl of pureed sausage. He did not receive double portions.</p> <p>For lunch on 11/28/12 at 12:27 p.m., the resident received 1 bowl of pureed chicken, 1 bowl of pureed cabbage, 1 bowl of pureed carrots and 1 bowl of pudding, he did not receive double portions.</p> <p>Interview on 11/29/12 at 11:44 a.m., with the Dietary Manager indicated there was only 1 resident in the facility who received a pureed diet with double portions and it was Resident #14. He indicated that a resident with a pureed diet order of double portions received 2 bowls of each item. He</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>indicated Resident #C had not received double portions, he stated the resident had received super cereal only.</p> <p>The record for Resident #C was reviewed on 11/27/12 at 9:46 a.m. He had diagnoses that included, but were not limited to, Huntington's Chorea.</p> <p>The "Nutritional Assessment Form," completed by the Registered Dietitian on 7/28/12, indicated the resident's height was 60 inches and his weight 134 pounds. It also indicated he had chewing problems. It indicated, "new admission res (resident) admitted to facility dx (diagnosis) of Huntington's Chorea disease ambulates in hallway and room per observation feeds self with supervision/setup. Has increased caloric needs due to increased movements plan 1) dc (discontinue) ensure 1.5, 1 can with meals, 2) double portions of puree diet 3) give house supplement 1 can with each meal slow wt (weight) gain or wt maintenance."</p> <p>There was a Physician Order, dated 7/28/12, to discontinue ensure plus 1.5, a new order give 1 can house supplement with each meal, and double portions of puree diet per</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>"Dietary Recommendations."</p> <p>An entry in the Nurse's Notes, dated 7/31/12 at 12 p.m., indicated, "resident continues to eat 100% of double portions meals without assist."</p> <p>An entry in the Nurse's Notes, dated 8/7/12 at 1:30 p.m., indicated, "continues to consume 100% of meals (double portions) house supplement offered per orders..."</p> <p>Review of the Physician's Orders, dated 7/28/12 through 11/27/12, indicated there was no order to discontinue the double portions. Review of the dietary notes indicated there was no dietary recommendation to discontinue the double portions.</p> <p>Interview with the Administrator on 11/30/12 at 1:10 p.m., indicated the weekly nutrition meetings have not been held lately. She indicated there needed to be a closer watch on the dietary recommendations.</p> <p>A telephone interview with the Registered Dietitian on 11/30/12 at 1:25 p.m., indicated the resident was to receive double portions of a pureed diet to maintain his weight.</p> <p>3.1-46(a)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
	3.1-46(a)(2)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F0329 SS=E	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs related to duplicate medication therapy, indications for the use of medications, the lack of gradual dose reductions, and interventions attempted prior to the use of psychoactive medications for 5 of 10 residents reviewed for unnecessary medications. (Residents #C, #E, #G, #7 and #18)</p>	F0329	F 329 Unnecessary Drugs 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident G order clarified and duplicate order was labeled duplicate. Resident did not receive a double dose of medication because of the individual dispensing system from In-Touch Pharmacy. Resident 18 diagnosis GERD was added for the use of Protonix. Resident E Blood Pressure frequency will be clarified with physician. Resident 7 diagnosis for	01/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Findings include:</p> <p>1. The record for Resident #G was reviewed on 11/27/12 at 11:09 a.m. The resident's diagnoses included, but was not limited to, gastroesophageal reflux disease (GERD).</p> <p>A Physician's order, dated 8/23/12, indicated the resident was to receive Zantac (a medication used to treat GERD) 150 milligrams (mg) by mouth twice a day at 6:00 a.m. and 5:00 p.m.</p> <p>The resident was readmitted to the facility on 10/23/12. A Physician's order, dated 10/23/12, indicated the resident was to receive Zantac 150 mg, take 2 tablets by mouth twice a day at 9:00 a.m. and 5:00 p.m.</p> <p>Review of the November 2012 Medication Administration Record (MAR), indicated that both orders for the Zantac were listed. One Zantac was signed out as given at 6:00 a.m., from 11/1-11/11 and 11/14-11/16/12. Documentation on the MAR as of 11/17/12, indicated the Zantac was a duplicate order. The two 150 mg tablets of Zantac were signed out at 9:00 a.m., for the dates of 11/1-11/30/12.</p>		<p>Claritin use was obtained from the physician and Zyprexa discontinued. Resident C documentation by the L.P.N. was discussed in staff meeting with all charge nurses and a review of the proper protocol for proper use of psychoactive medications for residents exhibiting behavior problems. Resident C medication was reviewed with physician and prn medication was discontinued due to non -use.Gradual dose reductions will be attempted 2 times in the first year of initial antipsychotic therapy q 6 months and annually thereafter.</p> <p>2 . How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be takenRecords of all residents receiving psychotropic medications was reviewed by surveyors. No other residents receive prn medication. No other residents affected at this time.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.An Unnecessary Drug In-Service will be presented to nurses.The pharmacy has been called and the consultant pharmacist will review all of the physician orders for unnecessary drugs and will make recommendations as needed for dose reductions and discontinuation of unnecessary medication.4. How the corrective action will be monitored to ensure</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>The resident received duplicate doses of the Zantac medication for a total of 450 mg within three hours from 11/1-11/11/12, and from 11/14-11/16/12.</p> <p>Interview with LPN #3 on 12/3/12 at 1:09 p.m., indicated she readmitted the resident on 10/23/12 and got his readmission orders. She also indicated on the 11/12 Physician's order summary (POS), there were 2 orders for the resident's Zantac and they should have been clarified rather than receiving both doses.</p> <p>2. The record for Resident #18 was reviewed on 11/28/12 at 7:45 a.m. The resident's diagnoses included, but were not limited to, dehydration, high blood pressure, diabetes, arthritis, hard of hearing, agitation, hyperlipidemia, cataract, altered mental status, congestive heart failure, chest pain, and hypothyroidism.</p> <p>Review of Physician Orders on the current 11/12 recap indicated the resident was receiving Protonix (a medication used for reflux disease) 40 milligrams (mg) daily.</p>		<p>the deficient practice will not recur. Charge Nurse will indicate any behavior problems in the nurse recommendations columns for the physician to address in his progress note. The consultant pharmacist will review physician orders monthly Director of Nursing and or designee will review and audit physician orders for unnecessary medications weekly times 4 weeks then monthly for 3 months then every 6 months. QA will review audits quarterly and make recommendation as needed. 5. Date completed: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Further record review indicated the resident had no indication or diagnosis for the use of Protonix</p> <p>Interview with LPN #2 on 11/29/12 at 3:37 p.m., indicated the resident was started on the medication when she came back from the hospital. She further indicated she was taking the medication at the hospital and there was no diagnosis for the Protonix.</p> <p>3. The record for Resident #E was reviewed on 11/29/12 at 1:28 p.m. The resident was admitted to the facility on 6/1/12. The resident's diagnoses included, but were not limited to, stroke, and high blood pressure.</p> <p>Review of Physician Orders, dated 6/1/12, indicated blood pressure twice a day. Further review of Physician Orders, dated 6/1/12, indicated Metoprolol (a medication used to treat high blood pressure) 50 mg twice a day.</p> <p>Review of the Medication Administration Record (MAR), dated 10/12, indicated the blood pressure was not recorded as being done at 6:00 a.m., on 10/2, 10/3, 10/6, 10/8, 10/16, 10/20, 10/26/12.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Review of the 10/12 MAR indicated the blood pressures were not completed on the evening shift at 5:00 p.m., on 10/6, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/12</p> <p>Interview LPN #2 on 11/29/12 at 3:37 p.m., indicated the resident's blood pressure was supposed to be taken and documented on the MAR two times a day.</p> <p>4. The record for Resident #7 was reviewed on 11/28/12 at 9:25 a.m. The resident had diagnoses that included, but were not limited to, dementia, depression and atypical psychosis.</p> <p>The November 2102 Physician Order Sheet indicated the resident received Claritin (an antihistamine medication) 10 mg (milligrams) by mouth daily. The original order date was 10/6/12.</p> <p>There was no diagnosis or indication for the use of Claritin.</p> <p>An entry in the Nurse's Notes, dated 10/6/12 at 12 p.m., indicated, "New order Claritin initiated without adverse reaction noted at this time . . . no complaint of pain or discomfort noted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>at this time..." There was no indication for the use of Claritin in the record.</p> <p>The November 2102 Physician Order Sheet indicated the resident received Zyprexa (an antipsychotic medication) 2.5 mg by mouth daily.</p> <p>The forms titled, "Antipsychotic Medication Quarterly Evaluation/AIMS" were reviewed. The evaluations were completed on 10/14/12, 7/14/12, 4/24/12, 1/24/12/ 10/24/11 and 7/24/11. The forms indicated the resident had, "No behaviors" and received the same dose of Zyprexa, 2.5 mg, from 7/11/11 through October 2012.</p> <p>The "Antipsychotic Medication Quarterly Evaluation/AIMS" form indicated, "An antipsychotic GDR (gradual dose reduction) should be attempted twice within the first year of initiation of therapy in two separate quarters and annually thereafter." The form indicated there had been no gradual dose reductions attempted from 7/11/11 through 10/14/12.</p> <p>On 11/28/12 at 11:59 a.m., interview with the Administrative Assistant/Social Service Director indicated the nursing staff and the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Physician were responsible for gradual dose reductions of antipsychotic medications.</p> <p>The policy titled "Medication Monitoring," dated June 4, 2009, was provided by the Administrative Assistant/Social Service Director on 11/29/12. She indicated the policy was current. The policy indicated: "The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record. Effects of the medications are documented as a part of the care planing process. Unless medically contraindicated, periodic dosage reductions are attempted and the results documented."</p> <p>Review of the Physician Progress Notes, dated 7/13/11, 9/7/11, 9/14/11, 10/5/11, 10/12/11, 12/7/11, 2/8/12, 4/11/12 and 6/6/12, indicated there was no documentation of a specific rationale which described why a dose reduction attempt was clinically contraindicated for the resident.</p> <p>Interview with the Administrative Assistant/Social Service Director on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>11/29/12 at 10:19 a.m., indicated the resident's dose of Zyprexa was last reduced on 12/8/10. She indicated there was no gradual dose reduction attempted for the resident's use of Zyprexa since that time.</p> <p>5. The record for Resident #C was reviewed on 11/27/12 at 9:46 a.m. The resident had diagnoses that included, but were not limited to, Huntington's Chorea, anxiety, agitation with aggressive behavior and depression.</p> <p>The resident was admitted to the facility on 7/18/12. The admission Physician's Orders, dated 7/18/12, were reviewed.</p> <p>There were Physician's Orders for: Diazepam (an antianxiety medication) 10 mg (milligrams) by mouth twice daily prn (as needed) for anxiety Haloperidal (Haldol) injection 5 mg IM (intramuscularly) q (every) HS (hour of sleep) prn if pt (patient) refuses oral meds (medications) Haloperidal 2 mg by mouth at HS (hour of sleep)</p> <p>The July 2012 Medication Administration Record (MAR) indicated the resident received Haldol IM on 7/21/12 at 9:30 p.m. and on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>7/24/12 at 1:30 a.m., for inappropriate behavior, there was no evidence that the resident had refused his oral medications.</p> <p>The Nurse's Notes, dated 7/21/12, were reviewed, there was no evidence in the record the resident refused his oral Haldol medication.</p> <p>The Nurse's Notes, dated 7/24/12 at 1:35 a.m., indicated, "Resident up in the dining [sic] watching TV, and drinking water. After 2 hours writer informed resident he need [sic] to go to bed and writer turn the TV off, resident turn the TV back on. He became loud using profanity toward staff. He stated, "This is my TV." Res walk back and fare [sic] looking out windows resident sit in chair and calm down refused to go to bed. PRN Haldol IM given at 130 a.m. will cont. (continue) to monitor." There was no evidence the resident had refused oral Haldol. Review of the July 2012 MAR, indicated the resident had received oral Haldol 2 mg at 9:00 p.m., on 7/23/12.</p> <p>The July 2012 MAR indicated the resident received diazepam prn twice on 7/22/12; twice on 7/23/12; once on 7/25/12; twice on 7/27/12; once on 7/28/12; twice on 7/29/12; twice on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>7/30/12 and once on 7/31/12. The August 2012 MAR indicated diazepam was administered once on 8/2/12 and twice on 8/7/12.</p> <p>There was no evidence in the record for the indication of the use of the antianxiety medication, diazepam. There was no evidence that non-pharmacological interventions were attempted prior to the use of the diazepam.</p> <p>The policy titled, "Medication Monitoring," dated June 4, 2009, was provided by the Administrative Assistant/Social Service Director on 11/29/12. She indicated the policy was current.</p> <p>The policy indicated: "Nonpharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber in assessing the continued need for psychoactive medication."</p> <p>Interview with LPN #2 on 11/27/12 at 1:24 p.m., indicated non-pharmacological interventions were to be attempted prior to the use of an as needed antianxiety</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>medication. She indicated there was no evidence non-pharmacological interventions were attempted prior to the use of the diazepam in July and August 2012. She also indicated the Physician Order for the Haldol, indicated the intramuscular injection was to be used when the resident refused the oral route. She indicated the documentation on the July 2012 MAR indicated the Haldol injection was administered for inappropriate behavior, not for medication refusal.</p> <p>3.1-48(a)(3) 3.1-48 (a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F0356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post the Nurse Staffing sign in a prominent view for all residents and visitors to see. This had the potential to effect 23 of 23 residents who resided in the facility.</p>	F0356	F 3561. Nursing Staffing will be posted by the visitors sign in register.2. No resident verbalized concern about the posting of the nurse staffing sign.3. It will be the responsibility of the D.O.N. to post the nurse staffing	01/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Findings Include:</p> <p>During the environmental tour on 11/29/12 at 8:34 a.m., the staffing sign was observed in a corner by the employee time clock. The staffing sign was not prominently displayed for the residents and visitors to see.</p> <p>Interview with the Administrative Assistant on 11/29/12 at 9:00 a.m., indicated the staffing sign was located by the employee time clock and it was not in a prominent area for visitors and residents to view.</p> <p>3.1-13(a)</p>		<p>personnel. The form will be revised by the D.O.N. and will coincide with the weekly schedule.4. D.O.N. will monitor the proper posting of the nursing staff and maintain the records for 18 months.Q.A. Committee will review staff posting times 1 month then quarterly thereafter.5. 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0363 SS=F	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interviews, the facility failed to follow the menu for 3 of 3 meals observed and for 1 of 1 residents. This had the potential to effect 23 of 23 residents who resided in the facility. (Resident #B)  Findings include:  1. On 11/28/12 at 7:30 a.m., Resident #B was observed sitting up in a wheelchair in the dining room at the round table. The resident was served his breakfast and was being fed by CNA #7. He was served a glass of water and two bowls of pureed food. The first bowl was oatmeal and the second bowl was pureed prunes. CNA #7 indicated at the time, the resident was fed his breakfast early because he goes to workshop everyday and leaves at 7:30 a.m. She further indicated this was the only food he received for breakfast.</p>	F0363	<p>F 363 MENUS 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Conference held with the FSS and changes in the dietary department are upcoming. New dietary staff will be hired. It is a simple thing to read and take pride in what they are doing as part of the dietary staff she further stated she would not accept any more deficient practices from this area. It was also stressed by the administrator to the dietary staff that the menu must be served as posted. Food orders are done weekly and all food items were present. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficiencies noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Resident B breakfast items will be prepared ahead of time and ready for him at 7:00a.m. The dietary</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>Continued observation of Resident #B indicated he ate all of his oatmeal and kept shaking his head, no, in regards to the prunes and the water. After surveyor intervention, another CNA walked over to the kitchen and brought out a glass of orange juice. The resident was then observed to drink all of the juice. Resident B was assisted out of the dining room and placed by the nurse's station. The resident was not offered any other type of food or milk to drink. The resident was not served sausage or a grilled cheese sandwich.</p> <p>Review of the menu that was posted in the Main Dining Room indicated the breakfast meal for Wednesday was one bowl of hot or cold cereal, two sausage links, a grilled cheese sandwich, and cooked prunes. Milk and juice were the beverages listed on the menu.</p> <p>Interview with the Dietary Food Manager on 11/28/12 at 9:45 a.m., indicated he was the only dietary employee preparing breakfast. He further indicated the resident did not receive the sausage links or the grilled cheese sandwich because they were not prepared. He further indicated Resident #B's breakfast meal was supposed to be ready</p>		<p>staff will serve the menu as planned. All menus were reviewed by the dietician and an in-service will be held by the dietician. New dietary supervisor will be hired to ensure regulations are followed. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Menu served log will be used daily and monitored daily by dietary supevisor for 1 month then quarterly for 6 months. Menu served log will be monitored bi-weekly by the dietician. Ongoing in-services will continue to be done and reminders will be placed on the serve tray line. QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>before 7:30 a.m., Monday thru Friday, because he usually gets picked up to attend his workshop.</p> <p>2. During the Brief Kitchen Tour on 11/26/12 at 8:17 a.m., the menued breakfast was posted above the food prep area. The menu indicated the meal to be prepared was 6 ounces rice cereal or 3/4 cup dry cereal, 1 egg scrambled, 1 biscuit with 1/2 cup sausage gravy, 1/2 cup cooked pineapple, 1 cup 2% milk, coffee or hot chocolate. Observation of the kitchen area indicated there was no sausage gravy prepared.</p> <p>Interview with the Dietary Manager at that time, indicated he did not prepare gravy because the resident's do not like it.</p> <p>Observation of the breakfast meal served to the residents on 11/26/12 at 8:45 a.m., indicated no residents were served gravy with their meals.</p> <p>3. Observation on 11/27/12 at 8:21 a.m., indicated there was a weekly menu posted in the main dining room. The breakfast menued for 11/27/12 was a 2 inch by 2 inch hash brown egg bake, 1/2 cup fried apples, 6 ounces hot cereal or 3/4 cup dry cereal, 1 slice of buttered toast, 2 slices of bacon and 1 cup 2% milk.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Observation of the residents' breakfast foods indicated no fried apples were served.</p> <p>CNA #1 was interviewed on 11/27/12 at 8:21 a.m. She indicated she had served breakfast to the residents. She indicated there were no fried apples served to the residents with their breakfast.</p> <p>3.1-20(i)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the food was stored and prepared under sanitary conditions related to improper hair covering, the lack of dish detergent for the dishwasher and out of date leftover food stored in the refrigerator. This had the potential to affect 23 of 23 residents in the facility, who received food prepared in the kitchen.</p> <p>Findings include:</p> <p>1. The Brief Kitchen Tour was completed on 11/26/12 at 8:12 a.m. LPN #3 was in the kitchen at the tray line. She was taking trays from the food prep area. She had a hair net on the top of her head, but the hair net did not adequately cover all of her hair.</p> <p>2. On 11/30/12 at 9:22 a.m., the Kitchen Tour was completed with the Dietary Manager. The following was noted:</p>	F0371	F 371 FOOD SANITATION 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Out dated cranberry sauce was disposed of my dietary staff. Proper wearing of hairnet in dietary area was covered with nursing staff to ensure all hair is covered by hair net. Eco Lab provides supplies and orders are turned in on a 2 week basis. Detergent was ordered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices relative to food sanitation noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-services will be ongoing. New dietary staff will be trained and new dietary supervisor will be hired. In-service will be held with all staff on proper placement hair net and proper labeling of food items in storage according to facility policy and daily work log sheet. 4. How the corrective	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>a. The low temperature dishwashing machine was observed. The container of detergent for the dishwasher was empty. Interview with the Dietary Manager at that time, indicated the detergent had been out since 11/25/12. The bleach sanitizer for the dishwasher was in place. He indicated the routine order of detergent had not arrived to the facility and it would have to be ordered. He indicated the dishes were washed manually then placed in the dishwasher for sanitizing.</p> <p>b. The reach in refrigerator had a container of cranberry sauce, dated 11/22/12. Interview with the Dietary Manager at that time, indicated left over food items were to be kept for 72 hours, after 72 hours the leftovers were to be discarded. He indicated the cranberry sauce should have been thrown away.</p> <p>3.1-21(i)(3)</p>		<p>action will be monitored to ensure the deficient practice will not recur. All sanitation rules and menu served logs will be reviewed by the dietician during in-services. Menu served log will be used daily and monitored daily by dietary supervisor and administrator times 2 months then quarterly for 6 months. This log will be used to ensure proper labeling of food items in storage areas. Proper Hair Net usage in-services will be done quarterly and as needed by D.O.N. designee QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. After all deficient practices have been resolved Q.A. committee meetings will resume to being quarterly however we reserve the right to meet more frequently if needed. During Q.A. the dietician will express her concerns if the proper criteria for ensuring that dietary staff is storing, preparing, distributing and serving food under sanitary conditions. At that time if no deficient practices are noted it will be determined to stop audits. If audits show a deficient practice still occurs then the audits will be increased and other dietary staff hired. 5. Date completed: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review and interview, the facility failed to ensure dental services for ill-fitting dentures were provided for 1 of 3 residents reviewed of the 7 residents who met the criteria for dental services. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F was observed on 11/26/12 at 10:36 a.m. The resident was not wearing dentures. When interviewed at that time, he indicated he had dentures but they gave him problems. He indicated they did not stay in his mouth well. He stated they were not loose, but did not fit right.</p> <p>The record for Resident #F was reviewed on 11/29/12 at 9:19 a.m. The resident had diagnoses that included, but were not limited to,</p>	F0412	<p>F 412 1. Resident F will be scheduled for a dental exam. 2. No other residents noted to be affected at this time. 3. D.O.N and Social Service will be notified of all Dental referrals and schedule dental exams for the residents. 4. Nursing will assess do oral assessments of residents and if problems are noted with the oral cavity, dentures and dental complaints social service will be notified to schedule dental appointments. Dental exams will be done upon admission and then as needed. Q.A. Committee will monitor dental exams quarterly. 5. 1/2/12</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>diabetes and dysphagia (difficulty swallowing).</p> <p>The annual Minimum Data Set (MDS) assessment, dated 5/27/12, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. The MDS also indicated the resident had broken or loosely fitting dentures.</p> <p>The quarterly MDS assessment, dated 11/27/12, indicated the resident had a BIMS score of 15 and had broken or loosely fitting dentures.</p> <p>The Dental Treatment Plan, dated 7/5/11, signed by the Dentist, indicated upper and lower dentures were delivered and all was acceptable.</p> <p>On 3/11/12, the resident was seen by the dentist. The Dental Treatment Plan indicated the resident refused to wear his dentures. It did not indicate the reason for the refusal. It did not indicate that the fit of the dentures was evaluated by the Dentist at that time.</p> <p>The resident was interviewed on 11/29/12 at 2:19 p.m. He indicated he would like to wear his dentures,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>but they were too loose and he wanted to see the dentist.</p> <p>LPN #3 was interviewed on 11/29/12 at 3:15 p.m. She indicated the resident's dentures were loose and the staff offered adhesive denture cream for the resident to use and he had refused it. She indicated the dentist did not evaluate the dentures for fit.</p> <p>Interview on 11/29/12 at 3:10 p.m., with the Administrative Assistant/Social Service Director indicated the resident had been refusing to wear his dentures. She indicated the resident had Medicaid as a payor source.</p> <p>3.1-24(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure outdated insulin was not in use for 3 of 7 insulin dependent diabetics who resided in the facility. (Residents #2, #12 and #15)</p> <p>Findings include:</p> <p>Observation of the medication refrigerator on 12/3/12 at 8:50 a.m., indicated the "house stock" of Novolin Regular insulin was dated as opened 8/19/12.</p> <p>Interview with LPN #3 at the time, indicated the insulin was good for 21</p>	F0425	F 425 PHARMACEUTICAL 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Insulin for Resident 2, 15 and 12 were discarded and re-ordered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices noted at this time. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-services will be held for nursing staff to monitor	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>days once it had been opened.</p> <p>A vial of Lantus insulin for Resident #2 was dated as being opened on 10/20/12, the label on the vial indicated to discard after 28 days, review of the 12/12 Medication Administration Record (MAR), indicated the resident had received his Lantus insulin on 12/1 and 12/2/12.</p> <p>A vial of Humulin 70/30 insulin for Resident #15 was dated 10/20/12, the label on the vial indicated to discard after 28 days. Interview with LPN #3 at the time, indicated Resident #15 had just returned from the hospital and the vial of insulin should have been returned to pharmacy.</p> <p>A vial of Lantus insulin for Resident #12 was dated as opened 10/11/12, the label on the vial indicated to discard 28 days after opening. Review of the 12/12 MAR, indicated the resident had received her Lantus insulin on 12/1 and 12/2/12.</p> <p>Review of the facility policy titled "Preparation for Medication Administration" on 12/3/12 at 2:00 p.m., which was provided by LPN #3 and identified as current, indicated</p>		<p>refrigerator monthly and remove expired medication. Log sheet will be made to indicate when vials are opened and placed on the refrigerator door. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Charge nurse will label and date when medication vial is opened and place date on log sheet. One nurse will be assigned to monthly removal of expired medication. Pharmacist will monitor for expired medication monthly. D.O.N. and D.O.N. Designee will monitor monthly. QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>the following: "Medication in multidose vials may be used (for thirty days) if inspection reveals no problems during that time."</p> <p>3.1-25(o)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure multi-dose vials of medication were dated when opened for 2 of 7</p>	F0431	F Tag 431 Pharmacy Services 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>insulin dependent diabetics who resided in the facility, medications were stored correctly in 1 of 1 treatment carts, and an over the counter medication was labeled correctly for 1 of 10 residents observed for medication administration. (Residents #4, #5, and #15)</p> <p>Findings include:</p> <p>1. On 11/28/12 at 5:35 a.m., the treatment cart was observed in front of Room 106. The treatment cart was unlocked at this time. There were no staff members present in Room 106 nor around the treatment cart. A tube of Santyl ointment (a debriding ointment) was on top of the treatment cart as well as a can of Granulex spray which contained no lid, and a tube of A &amp; D ointment.</p> <p>Interview with LPN #4 on 11/28/12 at 5:55 a.m., indicated that she had finished with a treatment in Room 106 and got called away to do something else before she could put the medications away and lock the treatment cart.</p> <p>Interview with the Director of Nursing on 11/29/12 at 11:30 a.m., indicated the treatment cart should not have</p>		<p>expired insulin was removed and destroyed at the time of observation. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Nurses audited medication carts, treatment carts and refrigerate medication and remove any and all expired medication. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In-service will be presented to nurses which will include a review of drug destruction and properly labeling and storage of open medication policy and proper locking of refrigerator, medication cart and treatment carts. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The night nurse will be assigned to audit refrigerator medication daily and the day nurse will be assigned to audit treatment cart daily and the evening nurse will audit the medication carts daily. The pharmacy consultant will audit medication carts and refrigerator monthly and reports will be provided to the Director of Nursing. QA will review these reports quarterly and make recommendations as needed. 5. Date completed: 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>been unlocked and the medications should have been put away.</p> <p>2. On 11/30/12 at 8:48 a.m., Resident #5 received an Ocuville (a vitamin for eye health) tablet from LPN #1. Interview with LPN #1 at the time, indicated the medication was an over the counter medication and provided by the resident's family. The resident's name was listed on the box, however, the resident's Physician's name was not listed.</p> <p>Interview with LPN #3 on 12/3/12 at 11:00 a.m., indicated the name of the resident's Physician should have been listed on the box.</p> <p>3. On 12/3/12 at 8:50 a.m., in the medication refrigerator, the "house stock" Tuberculin Purified Protein was not dated when opened. A vial of Humulin 70/30 insulin for Resident #15 was delivered to facility on 11/13/12: however, the vial was not dated when opened. A vial of Lantus insulin for Resident #4 was delivered to the facility on 11/17/12, the vial of insulin was not dated when opened.</p> <p>Interview with LPN #3 at the time, indicated all multi-dose vials of medication were to be dated when opened.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Review of the facility policy titled, "Preparation for Medication Administration" on 12/3/12 at 2:00 p.m., provided by LPN #3 and identified as current, indicated the following: "The date opened and the initials of the first person to use the vial are recorded on multi-dose vials on the accessory label affixed for that purpose."</p> <p>Review of the facility policy titled "Medication Ordering and Receiving from Pharmacy," on 12/3/12 at 2:10 p.m., was provided by LPN #3 and identified as current, indicated the following: "Each prescription medication label includes the Physician's name."</p> <p>3.1-25(j) 3.1-25(k)(2) 3.1-25(m)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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			
F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F0441	F 441 INFECTION CONTROL 1. What corrective action will be	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>ensure a glucometer was cleansed with a germicidal wipe between resident contact for 2 of 2 glucometers observed. (Residents #2 and #F)</p> <p>Findings include:</p> <p>On 11/28/12 at 5:55 a.m., LPN #4 entered Resident #2's room to check the resident's blood sugar. The LPN was carrying an orange colored bag with Resident #16's name on it. The LPN removed the glucometer and checked Resident #2's blood sugar. She did not clean the glucometer prior to using it. The glucometer was placed on the resident's bed as she obtained a blood sample from the resident's finger.</p> <p>After obtaining the resident's blood sugar, she removed her gloves and washed her hands. She then proceeded to take the glucometer to Resident #F, who resided in the same room with Resident #2. The LPN applied a clean pair of gloves and walked over to Resident #F, as the LPN was getting ready to obtain a finger stick from Resident #F, she was asked how she cleans the glucometer. The LPN stopped and indicated that she cleans the glucometer with an alcohol wipe. She</p>		<p>accomplished for those residents found to have been affected by the deficient practice? LPN was provided with the Assure Platinum Blood Glucose Monitoring System procedure manual. A review of the Disinfecting Guidelines was discussed and she was able to perform the proper mixture of disinfecting solution and clean the accu-check machine after each use.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All licensed nurses who perform accu-checks were able to perform the skill task of properly Disinfecting Procedures of the Accu-Check Machine by return demonstration.</p> <p>No residents are exhibiting any signs of blood pathogen infections. .No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In-Service on Disinfecting Guidelines for Accu-Check machine was given to licensed nurses followed by return demonstration. A copy of the policy was given to each licensed nurse. Sani-Cloth Germicidal Disposable Wipes were purchased to ensure proper cleaning of the accu-check machine and bleach solution will be used if Sani-Cloth is unavailable.4. How the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>then proceeded to wipe down the glucometer with an alcohol wipe. After obtaining Resident #F's blood sugar, she wiped the glucometer with an alcohol wipe.</p> <p>At 7:30 a.m., observation of the medication room indicated a container of "medi-kill" bactericidal wipes were on top of the treatment cart. Interview with LPN #3 on 11/28/12 at 8:35 a.m., indicated each resident had their own glucometer. She indicated the glucometers were to be cleaned with the disposable germicidal wipes.</p> <p>Interview with the Director of Nursing on 11/29/12 at 1:30 p.m., indicated each resident had their own glucometer and the glucometer was to be cleaned before and after use with the germicidal wipes located in the med room.</p> <p>Review of the facility policy related to cleaning and disinfecting guidelines for the glucometer on 11/29/12 at 1:30 p.m., was provided by the Director of Nursing and identified as current, indicated Super Sani-Cloth and Sani-Cloth HB Germicidal Disposable Wipes were to be used when cleaning the glucometer. The policy also indicated the glucometer</p>		<p>corrective action will be monitored to ensure the deficient practice will not recur. All charge nurses doing accu-checks have done a return demonstration on properly cleaning the accu-check machine prior to 1/2/13.</p> <p>Sani-Cloth Germicidal Disposable Wipes will be used to clean accu-check machine and all charge nurses.</p> <p>D.O.N. assistant will monitor each charge nurse technique of germicidal cleaning of accu-check machine weekly times 1 month then quarterly for 6 months then as needed thereafter.Q.A. committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: 1/2/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>was to be cleansed and disinfected between each resident test to avoid cross-contamination issues.</p> <p>3.1-18(b)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0456 SS=A	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure essential kitchen equipment was operating, related to a broken ice machine and a broken walk-in freezer.</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Tour on 11/26/12 at 8:12 a.m., the following was observed:</p> <p>a. The ice machine in the kitchen was observed. The ice machine had no ice in the ice compartment. Interview with the Dietary Manager, at that time, indicated the ice machine was broken.</p> <p>b. The walk-in freezer was observed. The walk-in freezer did not function. There was no food in the walk-in freezer.</p> <p>Interview with the Dietary Manager on 11/30/12 at 9:22 a.m., indicated the walk-in freezer had been broken since 1/25/12, the food from the walk-in freezer was moved to the freezer in the basement. He also</p>	F0456	<p>F 04561. The walk-in freezer and ice machine has been fixed. The service company had been contacted and dye was placed in the machines to find the Freon leak. The Freon leaks were repaired and then Freon was replaced. 2. All other kitchen equipment is working properly.3. New dietary supervisor will be able to give accurate timelines of repairs and monitor proper functioning of dietary equipment.4. Dietary Staff is responsible for monitoring proper temperatures of the walk-in freezer and maintenance of the ice maker daily. They are to notify the Administrator of all problems with equipment. Administrative designee will place the service call. FSS will monitor proper function of dietary equipment weekly and Administrative designee will monitor log sheets bi-weekly times 1 month then quarterly for 6 months and report to administrator problems that occur. Q.A. committee will monitor service logs quarterly for 6 months.5. 1/2/13</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>indicated the ice machine had been broken for some time. The facility was buying ice and storing it in the freezer.</p> <p>3.1-19(bb)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred doors, chipped paint, dirty wall vents, dirty tables, and discolored base boards for 2 of 2 wings, 1 of 1 chapels, and for 1 of 1 dining rooms. The facility also failed to ensure the kitchen was in good repair related to burned out kitchen lights for 1 of 1 kitchens.</p> <p>In addition, the facility failed to ensure the call lights functioned in 1 of 13 rooms observed for call systems (Room 104). (The East Wing, the West Wing, the Main Dining Room, the Chapel, and the Main Kitchen)</p> <p>Finding include:</p> <p>1. During the environmental tour on 11/29/12 at 8:20 a.m., the following was observed in the Chapel and the Main Dining Room:</p> <p>A. The plastic cover that covered the tan carpet in the Chapel was dirty and torn in places. The plastic covering was also observed with</p>	F0465	<p>F 0465 1. Brown carpet in front of the nurses station. The rugs were removed and washed and other rugs placed in front of nures station. Room 120 door was recently painted but is continuously marred by residents wheelchair. Door was repainted by maintenance staf. Resident in room 120 goes to the bathroom independentl insite of staff asking her to let staff help her with her toileting needs. This resident had a bowel movement with left brown stain on toilet seat and floor. The resident was cleaned properly and toilet and floor in bathroom was cleaned by staff. Plastic cover over chapel carpet was replaced by custodial staff. Wall vent behind television was dirty and dusty it was cleaned by housekeeping staff. 4 vinyl cloth chairs dirty and discolored. All dining room chairs were cleaned and are cleaned daily after meals by custodial staff. Baseboard in dining room was cleaned by custodial staff. Table base paint chipped custodial supervisor is having the table bases paint stripped and revarnished. They will be cleaned weekly and put on their log sheet. Bathroom door frame in room 105 marred by residents wheelchair.</p>	01/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>food/beverage spillage. The television stand was dirty and dusty. The wall vent located behind the television was dirty and dusty. There were four vinyl cloth chairs that were dirty and discolored.</p> <p>B. The entire baseboard in the dining room was dirty and black stained. The round dining room table legs were dirty with food and/or beverage spillage noted. The bases of the regular tables were chipped and in need of painting.</p> <p>2. On 11/29/12 at 8:20 a.m., during the Environmental Tour the following was observed on West Wing:</p> <p>A. The brown carpet in the hallway in front of the nurses station was stained and dirty.</p> <p>B. The bathroom door in Room 120 was marred. There were also brown stains noted on the toilet seat as well as the floor. There were two residents who resided in this room.</p> <p>3. On 11/29/12 at 8:20 a.m., during the Environmental Tour the following was observed on East Wing:</p> <p>A. The bathroom door frame was marred and scraped in Room 105.</p>		<p>The door frame had been just painted 3 weeks ago. It was painted again by custodial staff. Dust on bed side table in room 107 was cleaned by housekeeper Call light resident E and resident 9 circuit was replaced and properly working. Two lights in the kitchen were replaced by custodial staff. 2. No other findings noted to affect residents. 3. Housekeeping, Custodian, Maintenance Supervisor will monitor log sheets and do facility rounds for repairs weekly. Log sheets and repairs will be reviewed by Administrator monthly. 4. Q.A. Committee will review departmental log sheets and discuss preventive maintenance timetable. 5. 1/2/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>There were two residents who resided in this room.</p> <p>B. There was dust on the bed side table in Room 107. There were two residents who resided in this room.</p> <p>Interview with the Administrative Assistant on 11/29/12 at that time, indicated all the above was in need of cleaning and/or repair.</p> <p>4. On 11/26/2012 at 1:51 p.m., the call lights for Resident #E and Resident #9 in Room 104 were not functioning. There were two residents who resided in this room. The light outside of the room and light inside the room on the wall did not light up when both call lights were pressed.</p> <p>On 11/30/12 at 8:40 a.m., during the Environmental Tour the call lights for both residents were still not functioning.</p> <p>Interview with Maintenance Employee #1 at that time, indicated the call lights for both bed one and two were not working.</p> <p>5. On 11/30/12 at 9:22 a.m., the Kitchen Tour was completed with the Dietary Manager. Two (2) of 4 ceiling</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
	lights in the kitchen did not function. Interview with the Dietary Manager, at that time, indicated the ceiling lights had been broken for some time and were in need of repair.  3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0490 SS=F	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interviews, the facility failed to maintain hot water temperatures between 100 and 120 degrees Fahrenheit, resulting in the risk for potential for serious harm and/or injury related to hot water temperatures ranging from 128 degrees to 166 degrees Fahrenheit for 20 of 23 residents who resided in the facility on the East and West Wings.</p> <p>Findings include:</p> <p>On 11/26/12 at 12:03 p.m., the hot water temperature in Room 110 was 155 degrees Fahrenheit.</p> <p>Interview with Maintenance Employee #1 on 11/26/12 at 12:35 p.m., indicated the mixing valve was broken and needed repaired. He further indicated this happened sometime last week and the part was on order.</p> <p>Interview with the Administrative</p>	F0490	<p>F Tag 490 Effective Administration/Resident Well-Being 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Water Report Status/ Plan of Action Taken--ASAP On Monday 11/26/2012 Alexandra, Maintenance/Contractor was contacted in regards to the water issues at Simmons Loving Care.</p> <p>1. Water test were done on 11/19/2012 by custodian the temps were with in limits. 2. On 11/20/2012 temps were done in the morning temps were registered at different values rates some as low as 101- - as high as 142. The plumber was contacted and came out for repair and temperature adjustment. The plumber stated that a mixing valve sometimes sticks when new parts are replaced. A water pump and igniter had been replaced. Alex stated he would order a mixing valve. 3. Water was re-tested that evening 11/20/2012 by myself at about 3:30pm the values were still holding and good within the limits of 100-120 degrees. 4. The plumber had</p>	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>Assistant on 11/26/12 at 12:35 p.m., indicated the plumbers had been called out to the facility on 11/19/12. She further indicated the problem was with the mixing valve, as it needed to be replaced. She also indicated all of the paper work the plumbers left was locked in the Administrator's office and she was not able to obtain it, as the Administrator was out of the facility and was not coming into the facility. She did indicate, the mixing valve was ordered at that time, and they were waiting on the part to come in.</p> <p>On 11/26/12 at 12:45 p.m., the hot water temperatures were taken in all of the rooms that were occupied with residents on the West Wing. The temperatures were as follows:</p> <p>Room 102: 166 degrees Fahrenheit two residents resided in this room Room 104: 162 degrees Fahrenheit two residents resided in this room Room 106: 158 degrees Fahrenheit two residents resided in this room Room 108: 148 degrees Fahrenheit two residents resided in this room Room 120: 162 degrees Fahrenheit two residents resided in this room West Shower Room: 160 degrees Fahrenheit</p>		<p>already contacted the supplier in Indiana and Illinois and no one had the Symmons thermostat mixing valve. No one had the part in stock and stated it would take 2 weeks for the part to come in. He ordered the part from a Plumbing Supply on 11/21/12. 5. Water test was done on 11/21/2012 in the evening the values were still within the limit range of 100-120 degrees. 6. Water test was done on 11/22/2012 in the evening a about 3:30 pm by myself the values were within the limits of 100-120 degrees. 7. Water test was done on 11/23/2012 in the afternoon evening about 3:30 pm by me the water values were still within the limits 100-120 degrees. 8. There was no water value test done by myself or any staff member to my knowledge on 11/24/2012 or 11/25/2012. 9. On Monday when the State Survey team was washing their hands they discover that the water temp was <b>HOT</b> was tested then and the reading was 160 degrees. 10. Water was SHUT OFF Alex was contacted and arrived between 9:30am and 10:00am. 11. Alex checked the water system and re-contacted the supplier where he had previous placed the order for part on 11/21/2012. He was told that they had not received the part due to the holiday. He reordered the part for express delivery and was to receive it in 3 days on 11/26/12. 12. Staff In-Service was done to show staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012	
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>On 11/26/12 at 12:55 p.m., the hot water temperatures were taken in all of the resident rooms that were occupied with residents on the East Wing as follows:</p> <p>Room 101: 129 degrees Fahrenheit two residents resided in this room Room 103: 134 degrees Fahrenheit two residents resided in this room Room 105: 129 degrees Fahrenheit two residents resided in this room Room 109: 130 degrees Fahrenheit one resident resided in this room Room 113: 130 degrees Fahrenheit two residents resided in this room Room 115: 128 degrees Fahrenheit one resident resided in this room</p> <p>East Shower Room: 140 degrees Fahrenheit</p> <p>Interview with the plumber on 11/27/12 at 10:06 a.m., indicated the Administrator had called him out to the facility on 11/19/12 to look at the hot water heater due to increasing hot water temperatures. At that time, he indicated he had tried to fix the problem, but informed the Administrator it may or may not work. The next day on 11/20/12, he came out again and looked at the hot water heater. He informed the Administrator the mixing valve was in</p>		<p>how to test the water temps, how to shut off the hot water supply, how to tag out the system with danger signs on the sink handle and shut off valve and to inform Ms. Adams. The thermometers were placed in every room along with the danger water sign instructions. Charge Nurse will record water temps on a temp log sheet during nurse rounds which occur at 12a, 3a, 5a, 8a, 11a, 2p, 4p, 6p, 9p. 13. The plumber contacted the vendor to see if the part had shipped and he was told it would take 14 days to get the part and then they would ship it express mail. The plumber then called some more vendors but no one had the part. Hessville Plumbing came out and stated they could not fix it because the part had to be ordered. 14. This is when the mix up was discovered and we had to do an alternate plan of action for replacing this part. 15. Ms. Adams located Miline Plumbing and Mrs. Dumas had the plumber to remove the mixing valve off the water heater and take it to Miline Plumbing Supply to see if they could find an equivalent replacement part. They found a part by Bradley and it was ordered and scheduled to arrive by 9am on 11/28/12 Alex pickup this part and arrived at Simmons Loving Care about 9:45am proceed to install said part. At 12:15 pm the water was restored and Alex and Ms. Adams,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>need of repair or needed to be replaced. The plumber then indicated he was told to try and find the part. He indicated the part was not ordered until 11/21/12 because he could not find it on the Internet. The Internet retail store indicated the part would arrive at the facility within three to five business days. During this time, the Administrator made no attempts to protect the residents from the scalding hot water. There was no evidence staff were informed how to take the water temperatures or what to do when the water felt like it was scalding. The part still had not come in for repair on 11/27/12.</p> <p>Interview with Administrator on 11/27/12 at 2:47 p.m., indicated she had finally called another plumbing company to see if they could help them get the part they needed to repair the mixing valve. She further indicated they were going to help her out, and reconstruct a mixing valve to fit her water heater, because her equipment was very old. The Administrator indicated the part would be ready for pick up on 11/28/12 by 7:00 a.m. Further interview with the Administrator indicated the facility had made no attempts to fix the mixing valve immediately when the temperatures were at scalding levels.</p>		<p>maintenance supervisor, proceeded to turn the water on in all rooms and check levels for temp. The water temps registered between 100-120 degrees. Entire staff was inserviced on how to take water temps, how to tag out valve and faucet if water temp is too hot and to report to the supervisor. The supervisor will notify the administrator immediately anytime water temps are not within proper range of 100-120 degrees. 16. State Surveyors informed that the water was fixed and staff to monitor temps. Staff instructed to monitor water temps every 2-3 hours. Water temp taken by maintenance at 12:45p.m. Temps were taken by the supervisor at 6:00p.m. Mrs. Dumas and Mrs. Miller called the facility throughout the night to check on the water temps and the charge nurse stated they were fine. 17. On 11/29/12 nurse rounds sheets were given to the surveyor and to our surprise the charge nurse for the evening and night shift had not recorded the temps on the west wing thinking the water was off. The D.O.N. spoke with the nurses involved and informed them to test all water in the building. Signs are posted in the nurses station stating the water is on test all temps until further notice. 18. D.O.N. will monitor water temps during nurse round times. A one to one in-service will be given to the evening and night</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
	3.1-13(q)		nurse by the D.O.N. upon their arrival to work and the D.O.N. will call during round times to check the water temps throughout the night. The D.O.N. will record the temps on a water temp log sheet when she calls to verify the water temps. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Water temps remain within normal limits of 100-120 degrees. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In Service held on water temps and proper reporting of too cold or too hot water temps to maintenance supervisor. Procedure for tagging out and cut off of water supply when water temp is too hot. Water temps were monitored during nurse rounds, then q shift, then daily and now two times weekly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Maintenance Supervisor staff will monitor water temps 2 weekly. D.O.N. designee will monitor weekly water temp sheets times one month and as needed. Maintenance staff will take over this practice after regulation of water temp. occurred. Director of Nursing and or designee will inservice new staff on water temp procedure. Q.A. Committee will determine		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
			effectiveness of the water temp. policy and procedures. 5. Completion Date: 1/2/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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	
F0520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of the use of physical restraints related to the reduction of a restraints and ensuring the Registered Dietitian's (RD) recommendations were followed in a timely manner through the quality assurance protocol.</p> <p>Findings include:  Interview with the Director of Nursing</p>	F0520	F 520 1. D.O.N. communication was misunderstood by surveyor. Restraints were reviewed with Q.A. committee. In prior survey all residents were restraints were reassessed by physical therapy. We also clarified the difference between safety belt and self release in September 2012. Restraint devices are assessed by nursing staff during nurse rounds. D.O.N. had discussed restraint reduction for resident 9 but nursing staff and physical therapy felt she still required the	01/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>(DoN) on 12/3/12 at 10:30 a.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Administrator, and department heads as well as the Medical Director. The DoN indicated at the time, that physical restraints has not been discussed, addressed or identified as being a problem in Quality Assurance. She further indicated there had been no action plan or system put into place to identify the problem of the use and the reduction of physical restraints.</p> <p>The DoN further indicated at the time, there was no action plan for the elimination or reduction of physical restraints. She indicated the facility's committee meets quite often and staff were to let herself know if the resident did not require the restraint or there was a possibility of reduction.</p> <p>Interview with the Director of Nursing on 12/3/12 at 10:00 a.m., indicated Resident #9 has had a decline in her physical condition and probably did not need the tray to be up in place across the geri chair. She further indicated there were no attempts made to reduce the restraint.</p> <p>The DoN also indicated at the time,</p>		<p>tray due to repositioning legs over the side of her geri-chair when agitated. All restraints have been evaluated and the least restrictive device is used. In September we had 6 residents in need of restraint use today we have 1 resident with a seat belt in his wheelchair for positioning, 1 resident with a geri-chair with tray used when she is not in her play pen, 1 resident in safety belt and Resident 9 geri-chair with lap tray. Resident 9 is in a recliner and in a reclined position therefore causing her not to need the lap tray. She will be re-evaluated by physical therapy. RD recommendation will be given to the D.O.N. and D.O.N. assistant. The D.O.N. designee will address all recommendations with the physician and dietary staff. After recommendations are completed they will be reviewed with D.O.N. and Q.A. committee on a semi-monthly basis. In the past the nurse recommendations were given to a specific L.P.N. to follow through on dietician recommendations this responsibility has been changed to the responsibility of the D.O.N. assistant. Diet orders had been reviewed but on the resident who was to have double portions it was misstated that it was double protein. Residents weights are monitored by D.O.N. and residents requiring weekly weights are monitored by D.O.N.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/03/2012
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>that she was unaware the RD's recommendations were not being followed. She indicated before the RD leaves the facility her recommendations were placed in her mailbox, and sometimes she goes over them with her. The DoN further indicated the staff nurse was responsible for getting a hold of the Physician and obtaining orders for the recommendations. She indicated the problem of not following or obtaining orders for the RD recommendations was not identified in the Quality Assurance meetings. The DoN indicated she was unaware there was a problem and therefore there was no action plan completed or system put into place by the way of the Quality Assurance Committee.</p> <p>Interview with the Administrator on 11/30/12 at 1:10 p.m., indicated the weekly nutrition meetings have not been held lately. She indicated there needed to be a closer watch on the dietary recommendations.</p> <p>3.1-52(b)(2)</p>		<p>Q.A. Committee meetings are held weekly addressing immediate concerns and progress in reaching goals. 2. No other residents were affected by this practice. 3. Ongoing committee meetings will be held weekly to address concerns noted by department heads. 4. Administrator will be given committee meeting reports for review and final action is reserved by the administrator.</p>		