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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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	This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/3/12, which resulted in immediate jeopardy. This visit included PSR to the Investigation of Complaint IN00116865 completed on 12/3/12. Complaint IN00116865-Corrected. Survey Dates: January 23 and 24, 2013 Facility Number: 000368 Provider Number: 15E187 AIM Number: 100275220 Survey Team: Heather Tuttle, R.N.- T.C. Lara Richards, R.N. Census Bed Type: NF: 25 Total: 25 Census Payor Type: Medicaid: 24 Other: 1 Total: 25 These deficiencies reflect state findings cited in accordance with 410	F0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
	IAC 16.2. Quality review completed on January 25, 2013, by Janelyn Kulik, RN.			

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
		F0157	F 157 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; It is the practice of Simmons Loving Care to promptly consult	02/08/2013

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 01/24/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			with the resident's physician; and if known, notify the resident's legal representative or an interested family member when 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). After further investigation of Resident's 16 medical record and speaking with the nurse which worked that shift. It was learned by the D.O.N. that she had given Insta-Glucose to the resident after talking to the physician this was verified by checking the EDK box and requisition use; however the nurse failed to properly record all activity and follow up protocol. This nurse is no longer employed by the facility. No other diabetic resident was affected all blood sugars were above 60. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All diabetic resident's accu-check readings were reviewed and all were above 60 and not higher than 400. 3. What measures will be put into place or what systemic changes will be made to ensure that the	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			deficient practice does not recur; Meeting with the physician, pharmacist, D.O.N. was held to review blood sugar protocol and a new policy protocol was developed. The new protocol made the policy according to universal practices in long-term care facilities seen by the pharmacist and physician at other facilities. The policy was changed to the following: BLOOD SUGAR POLICY Physician Order For Treatment Of HYPOGLYCEMIA BLOOD SUGAR BELOW 60 Treatment for ALERT residents if blood sugar reading is BELOW 60: 1. Administer 1 Insta-Glucose tube (1.09 oz. = 31gms) by mouth. 2. Retake blood sugar in 10 minutes. 3. If blood sugar is above 70 notify M.D. for further interventions. 4. Monitor resident's status and recheck blood sugar in 1 hour to ensure success of treatment. 5. If blood sugar remains below 60 after 10 minutes. 6. Repeat administration of Insta - Glucose (1.09 oz. = 31gms) by mouth. 7. Recheck blood sugar in 10 minutes if not above 70. 8. Notify M.D. and monitor resident's status until paramedics arrive. 9. Call 911 for hospital transport. 10. Notify responsible party of resident's condition. 11. Document all interventions and outcome in resident's nurses notes. Treatment for Unresponsive residents if blood	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			sugar reading is BELOW 60: 1. Administer Glucagen (glucagon) Hypo Kit 1mg I.M. 2. Retake blood sugar in 10 minutes. 3. If blood sugar is above 70 notify M.D. for further interventions. 4. Monitor resident's status and recheck blood sugar in 1 hour to ensure success of treatment. 5. If blood sugar remains below 60 after 10 minutes. 6. Repeat administration of Glucagen (glucagon) Hypo Kit 1mg I.M. 7. Recheck blood sugar in 10 minutes if not above 70. 8. Notify M.D. and monitor resident's status until paramedics arrive. 9. Call 911 for hospital transport. 10. Notify responsible party of resident's condition. 11. Document all interventions and outcome in resident's nurses notes. Physician Order For Treatment Of HYPERGLYCEMIA BLOOD SUGAR 400 OR ABOVE HYPERGLYCEMIA: BLOOD SUGAR 400 OR ABOVE 1. Administer regular dose of insulin prescribed. 2. Recheck Accu-Check in 1 hour to ensure blood sugar is lowering. 3. Notify M.D. for further interventions. 4. Monitor resident's status, if change noted recheck Accu-Check. 5. Notify physician and call 911 for hospital transport for resident. 3. Notify responsible party of resident's condition. 4. Document all interventions and outcome in resident's nurses notes. Dr. David	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			E. Ross, Jr. Medical Director 1/30/13 An in-service was held with all licensed nurses about the blood sugar protocol and their responsibility to look at every resident's blood sugar each day for each shift. The nurse is to record the blood sugar on the MAR and the report sheet for shift to shift report. If a blood sugar is below 60 or above 400 the accu-check log sheet will be filled out indicating date, blood sugar, nurse action and nurse signature. ACCU-CHECK LOG DATE BLOOD SUGAR NURSE ACTION NURSE SIGNATURE RESIDENT NAME: The blood sugar protocol will also be completed for internal control and reviewed by D.O.N. and/or Designee as each incidence of blood sugar reading being below 60 or above 400. **BLOOD SUGAR PROTOCOL LOG FOR BS BELOW 60 AND BS 400 OR ABOVE** DATE TIME BS NURSE SIGNATURE NAME OF PHYSICIAN CONTACTED PHYSICIAN ORDER FOLLOW UP BS TIME D.O.N./DESIGNEE NOTIFIED DON/DESIGNEE REVIEW DATE 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			i.e., what quality assurance program will be put into place; The D.O.N. and/or designee will monitor all diabetic resident's accu-checks daily. The licensed nurses will monitor resident's blood sugar each shift and report the levels to the oncoming nurse during shift to shift report. If a resident has a blood sugar is below 60 or above 400 the Blood Sugar Protocol Log and Accu-Check will be completed and reviewed by the D.O.N. and/or designee. Blood sugars will be reviewed daily times 2 weeks, then 3 times a week for 2 weeks, then weekly for 3 months then ongoing monthly by D.O.N. and/or designee. Q.A. Committee will review the findings in 3 months to determine the success of the new system of monitoring blood sugars, if no deficient practices are found the frequency of review will be monthly ongoing. 5. 2/8/13	
	Based on record review and interview, the facility failed to promptly notify the resident's Physician related to low blood sugars for 1 of 3 residents reviewed for notification of change. (Resident #16) Findings include:			

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
	The record for Resident #16 was reviewed on 1/24/13, at 11:45 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus (Iddm). Review of Physician Orders dated 1/5/13, indicated Lantus insulin 20 units every evening. Review of the Medication Administration Record (MAR) for the month of 1/13, indicated the Lantus insulin was signed out as being administered to the resident from 1/5-1/23/13. Further review of Physician Orders dated 10/4/12, indicated the resident was to receive glucometer checks (to check the blood sugar) twice a day at 7 a.m. and 10 p.m. Review of Nurse's Notes dated 1/17/13, at 6:10 a.m., indicated the resident's blood sugar was 43. The Physician was notified and no new orders were given. The next documented entry in Nurse's Notes was on 1/17/13, at 7:00 a.m., which indicated the resident's blood sugar was rechecked 30 minutes later and now was 47. The nurse indicated			

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
	the resident's blood sugar was slowly rising. The nurse then indicated the shift report will be passed onto the day nurse to continue to monitor the resident and to continue to the check the blood sugars for any increase. The next documented entry was 1/17/13, at 8:00 p.m., and there was no information regarding the resident's blood sugars or Physician notification of the low blood sugar of 47 from the morning glucometer. Review of the current 12/12 Physician Notification for Resident Blood Sugar provided by LPN #1 indicated the resident's Physician was to be notified when the resident's blood sugar reading was 60 or below. For a Hypoglycemia reaction (a blood sugar 60 or below) the following was to be completed by nursing staff: 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. The resident's blood sugar was to be rechecked in 1 hour and the Physician was to be notified for further treatment. Interview with LPN #1 on 1/24/13, at 1:10 p.m., indicated the nurse that			

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
	took care of the resident at that time, no longer worked at the facility. She further indicated the Physician was to be notified when a resident's blood sugar was less than 60 and she personally had inserviced staff nurses regarding this issue. This deficiency was cited on 12/3/12. The facility failed to implement a systemic plan of correction to prevent recurrence. *3.1-5(a)(3)*			

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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	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. Based on observation, record review and interview, the facility failed to provide the necessary treatment and services related to low blood sugars for 1 of 3 residents reviewed for quality of care. (Resident #16) Findings include: The record for Resident #16 was reviewed on 1/24/13, at 11:45 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus (Iddm). Review of Physician Orders dated 1/5/13, indicated Lantus insulin 20 units every evening. Review of the Medication Administration Record (MAR) for the month of 1/13, indicated the Lantus insulin was signed out as being administered to the resident from 1/5-1/23/13. Further review of Physician Orders	F0309	F 309 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; It is the practice of Simmons Loving Care to 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. After further investigation of Resident's 16 medical record and speaking with the nurse which worked that shift. It was learned by the D.O.N. that she had given Insta-Glucose to the resident after talking to the physician this was verified by checking the EDK box and requisition use; however the nurse failed to properly record all activity and follow up protocol. This nurse is no longer employed by the facility. No other diabetic resident was affected all blood sugars were above 60. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/08/2013

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 01/24/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 10/4/12, indicated the resident was to receive glucometer checks (to check the blood sugar) twice a day at 7 a.m. and 10 p.m. Review of Nurses Notes dated 1/17/13, at 6:10 a.m., indicated the resident's blood sugar was 43. The Physician was notified and no new orders were given. The nurse then administered insta glucose (a medication used to increase a blood sugar)sublingual to the resident to increase her blood sugar. The next documented entry in Nurse's Notes was on 1/17/13, at 7:00 a.m., which indicated the resident's blood sugar was rechecked 30 minutes later and now was 47. The nurse indicated the resident's blood sugar was slowly rising. The nurse then indicated the shift report will be passed onto the day nurse to continue to monitor the resident and to continue to the check the blood sugars for any increase. The next documented entry was 1/17/13, at 8:00 p.m., and there was no information regarding the resident's blood sugars. There was no assessment or evidence of any documentation the resident's blood sugar was being closely monitored.		action(s) will be taken: All diabetic resident's accu-check readings were reviewed and all were above 60 and not higher than 400. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Meeting with the physician, pharmacist, D.O.N. was held to review blood sugar protocol and a new policy protocol was developed. The new protocol made the policy according to universal practices in long-term care facilities seen by the pharmacist and physician at other facilities. The policy was changed to the following: BLOOD SUGAR POLICY Physician Order For Treatment Of HYPOGLYCEMIA BLOOD SUGAR BELOW 60 Treatment for ALERT residents if blood sugar reading is BELOW 60: 1. Administer 1 Insta-Glucose tube (1.09 oz. = 31gms) by mouth. 2. Retake blood sugar in 10 minutes. 3. If blood sugar is above 70 notify M.D. for further interventions. 4. Monitor resident's status and recheck blood sugar in 1 hour to ensure success of treatment. 5. If blood sugar remains below 60 after 10 minutes. 6. Repeat administration of Insta - Glucose (1.09 oz. = 31gms) by mouth. 7. Recheck blood sugar in 10 minutes if not above 70. 8. Notify M.D. and monitor resident's status until paramedics arrive.	

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 01/24/2013
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Physician Orders dated 1/17/13, indicated there was no order to administer the insta glucose medication. Review of the 1/13 MAR, indicated there was no documentation of any as needed (prn) order for insta glucose if a resident's blood sugar was below 60. Review of the current 12/12 Physician Notification for Resident Blood Sugar provided by LPN #1 indicated the resident's Physician was to be notified when the resident's blood sugar reading was 60 or below. For a Hypoglycemia reaction (a blood sugar 60 or below) the following was to be completed by nursing staff: 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. The resident's blood sugar was to be rechecked in 1 hour and the Physician was to be notified for further treatment. Interview with LPN #1 on 1/24/13, at 1:10 p.m., indicated the nurse that took care of the resident at that time, no longer worked at the facility. She further indicated the Physician was to be notified when a resident's blood sugar was less than 60 and she		9. Call 911 for hospital transport. 10. Notify responsible party of resident's condition. 11. Document all interventions and outcome in resident's nurses notes. Treatment for Unresponsive residents if blood sugar reading is BELOW 60: 1. Administer Glucagen (glucagon) Hypo Kit 1mg I.M. 2. Retake blood sugar in 10 minutes. 3. If blood sugar is above 70 notify M.D. for further interventions. 4. Monitor resident's status and recheck blood sugar in 1 hour to ensure success of treatment. 5. If blood sugar remains below 60 after 10 minutes. 6. Repeat administration of Glucagen (glucagon) Hypo Kit 1mg I.M. 7. Recheck blood sugar in 10 minutes if not above 70. 8. Notify M.D. and monitor resident's status until paramedics arrive. 9. Call 911 for hospital transport. 10. Notify responsible party of resident's condition. 11. Document all interventions and outcome in resident's nurses notes. Physician Order For Treatment Of HYPERGLYCEMIA BLOOD SUGAR 400 OR ABOVE HYPERGLYCEMIA: BLOOD SUGAR 400 OR ABOVE 1. Administer regular dose of insulin prescribed. 2. Recheck Accu-Check in 1 hour to ensure blood sugar is lowering. 3. Notify M.D. for further interventions. 4. Monitor resident's status, if change noted	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
	personally had inserviced staff nurses regarding this issue. LPN #1 further indicated there was no evidence of any follow up documentation or assessment of the resident and/or the resident's blood sugar on 1/17/13. Interview with RN #1 on 1/24/13, at 1:17 p.m., indicated she was the nurse who worked the day shift on 1/17/13. Further interview indicated she really did not remember the incident when the resident's blood sugar was low. This deficiency was cited on 12/3/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)		recheck Accu-Check. 5. Notify physician and call 911 for hospital transport for resident. 3. Notify responsible party of resident's condition. 4. Document all interventions and outcome in resident's nurses notes. Dr. David E. Ross, Jr. Medical Director 1/30/13 An in-service was held with all licensed nurses about the blood sugar protocol and their responsibility to look at every resident's blood sugar each day for each shift. The nurse is to record the blood sugar on the MAR and the report sheet for shift to shift report. If a blood sugar is below 60 or above 400 the accu-check log sheet will be filled out indicating date, blood sugar, nurse action and nurse signature. ACCU-CHECK LOG DATE BLOOD SUGAR NURSE ACTION NURSE SIGNATURE RESIDENT NAME: The blood sugar protocol will also be completed for internal control and reviewed by D.O.N. and/or Designee as each incidence of blood sugar reading being below 60 or above 400. **BLOOD SUGAR PROTOCOL LOG FOR BS BELOW 60 AND BS 400 OR ABOVE** DATE TIME BS NURSE SIGNATURE NAME OF PHYSICIAN CONTACTED	

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 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			PHYSICIAN ORDER FOLLOW UP BS TIME D.O.N./DESIGNEE NOTIFIED DON/DESIGNEE REVIEW DATE 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The D.O.N. and/or designee will monitor all diabetic resident's accu-checks daily. The licensed nurses will monitor resident's blood sugar each shift and report the levels to the oncoming nurse during shift to shift report. If a resident has a blood sugar is below 60 or above 400 the Blood Sugar Protocol Log and Accu-Check will be completed and reviewed by the D.O.N. and/or designee. Blood sugars will be reviewed daily times 2 weeks, then 3 times a week for 2 weeks, then weekly for 3 months then ongoing monthly by D.O.N. and/or designee. Q.A. Committee will review the findings in 3 months to determine the success of the new system of monitoring blood sugars, if no deficient practices are found the frequency of review will be monthly ongoing. 5. 2/8/13	