STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00385996 and IN00388228. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00385996 - Substantiated. Federal/State Deficiencies related to the allegations are cited at F580. Complaint IN00388228 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F656, and F689. Survey dates: August 23, 24, and 25, 2022 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 25 Total: 25 Census Payor Type: Medicaid: 19 Other: 6 Total: 25 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/29/22.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to ensure a resident's Guardian was notified in a timely manner of an elopement and the return of the resident to the facility after the elopement, for 1 of 5 residents reviewed for family notification. (Resident C) Finding includes: A reported incident to the Indiana Department of Health (IDOH), indicated Resident C had been found missing from the facility on 8/16/22 at 3:05 a.m. and the police were notified. Resident C's record was reviewed on 8/23/22 at 11:36 a.m. The diagnoses included, but were not limited to, dementia and psychotic disorder with behaviors. A Social Service Note, dated 8/16/22 at 9:29 a.m., indicated the Guardian had been notified of the elopement. A Nurse's Progress Note, dated 8/16/22 at 11:41 p.m., indicated the resident was transferred from the hospital to the facility at 9:25 p.m. A Social Service Progress Note, dated 8/17/22 at 9:01 a.m., indicated the Guardian was notified the resident had been found at the hospital and had returned to the facility.	F 0580	**F580** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident C – unable to correct past occurrence. There have been no new accidents, significant changes in health status, or need to alter treatment that would have required the resident's guardian be notified. 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. **Corrective Action(s) for Other Residents Potentially Affected** All residents who experience accidents, significant changes in health status, or a need to alter treatment are potentially affected. Two of two residents have had emergent changes in health status since 8/25/22 requiring transfer to	09/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview on 8/23/22 at 11:05 a.m., the Social Service Director indicated RN 1 had not notified the resident's Guardian due to not having the number. He was notified by her the morning on 8/16/22. Cross reference F689 for additional information regarding Resident C. An undated facility policy, titled, "Elopements", received from the RN Nurse Consultant as current on 8/23/22 at 10:03 a.m., indicated the resident's representative was to be notified of the elopement. This Federal tag relates to Complaints IN00385996 and IN00388228. 3.1-5(a)(1)		an acute care facility for evaluation. There is documentation of timely family notification for both residents. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. **Measures to Ensure the Deficient Practice Does Not Recur** 24-hour reports available in Point Click Care are reviewed daily Monday through Friday by the Nurse Supervisor and daily by the Nurse Consultant during visits to the facility. The DON and/or Nurse Consultant review the 24-hour reports daily on weekends. The nursing progress notes of any resident with changes are reviewed to ensure timely family notification. Licensed nursing staff have been re-educated on the facility policy related to family notification of resident changes. Disciplinary actions will be taken if infractions to facility policy are identified. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Monitoring Process to Ensure the Deficient Practice Does Not Recur The DON or designee will monitor family notification of resident changes through 24-hr report review daily on-going. Resident changes will be documented on a Quality-of-Care Audit Form; compliance in family notification will be determined weekly for 4 weeks, every 2 weeks for 4 weeks, and monthly for 3 months. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. 5. Completion Date: 9/23/22	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure Care Plans were developed for residents who were assessed as a wandering/ exit seeking/ and or elopement risks, for 3 of 10 residents reviewed for Care Plan development. (Residents C, G, and H) Findings include: 1. Resident C's record was reviewed on 8/23/22 at 11:36 a.m. The diagnoses included, but were not limited to, dementia and psychotic disorder with behaviors.	F 0656	**F656** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident C – The care plan for wandering/elopement risk was developed 8/18/22. It will be reviewed quarterly or with a	09/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An Admission Minimum Data Set (MDS) assessment, dated 5/17/22, indicated a severely impaired cognitive status, had behaviors of physical, verbal, other, rejection of care, and wandering 1-3 days. The Wander Risk Assessments, dated 5/10/22 and 6/12/22, indicated he was a high risk for wandering/elopement related to a history of wandering. A Care Plan, dated 5/30/22, indicated verbal outbursts, wandering, combativeness, and refused care frequently. The interventions included medications as ordered, needs were to be anticipated and met, positive interactions were to be provided, and he was to be praised with progress or improvement in behavior. There was no Care Plan implemented for exit seeking and risk for elopement. During an interview on 8/23/22 at 2:22 p.m., the RN Nurse Consultant indicated there was no Care Plan for exit seeking/elopement risk. Cross Reference F689 for additional information regarding Resident C. 2. Resident G's record was reviewed on 8/24/22 at 1:23 p.m. The diagnoses included, but were not limited to, dementia. An Admission MDS assessment, dated 6/21/22, indicated a moderately impaired cognitive status and no behaviors. A Wandering Risk Assessment, dated 7/17/22, indicated a high risk for wandering due to a history of wandering.		significant change. Resident G - The care plan for wandering/elopement risk was developed 8/24/22. It will be reviewed quarterly or with a significant change. Resident H- The care plan for wandering/elopement risk was developed 8/24/22. It will be reviewed quarterly or with a significant change. 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. **Corrective Action(s) for Other Residents Potentially Affected** All residents assessed to be at risk for wandering are potentially affected. Wandering Risk Score assessments were updated for all residents as of 8/25/22. Care plans of residents assessed to be at risk were updated as of 8/25/22. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. **Measures to Ensure the Deficient Practice Does Not Recur** Wandering Risk Score assessments will continue to be completed upon admission and updated at 72 hours post	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	There was no Care Plan for the risk of wandering/elopement risk. During an interview on 8/24/22 at 1:49 p.m., the RN Consultant indicated the Wandering Risk Assessment is the assessment the facility used to assess for elopement and exit seeking risks. 3. Resident H's record was reviewed on 8/24/22 at 2:08 p.m. The diagnoses included, but were not limited to, schizophrenia. A Quarterly MDS assessment, dated 6/30/22, indicated a severely impaired cognitive status and wandering behavior 1-3 days. A Wander Risk Assessment, dated 7/31/22, indicated a high risk for wandering/elopement. There was no Care Plan for the wandering/elopement risk. An undated facility policy, titled, "Elopements", received from the RN Nurse Consultant as current on 8/23/22 at 10:03 a.m., indicated all residents would be assessed for safety concerns and precautions. A Care Plan would be developed for residents who are at risk for elopement. This Federal tag relates to Complaint IN00388228. 3.1-35(a)		admission, quarterly or with significant change. Care plans will be developed and/or updated for any resident who scores at risk for unsafe wandering or exit seeking. Licensed staff have been re-educated on the care planning process for residents who trigger at risk for unsafe wandering/elopement. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Wandering Risk Scores will be reviewed once every 2 weeks for 2 months, then monthly for 4 months per DON or designee. The reviews will be documented on audit forms. Any increase in scores will be reported immediately to the DON or Administrator, and care plan interventions reviewed and revised, if needed, to ensure safety. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. Completion Date: 9/23/22	
F 0689 SS=J	483.25(d)(1)(2) Free of Accident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, record review and interview, the facility failed to provide adequate supervision and follow protocols to prevent elopement of a cognitively and mentally impaired resident, who was assessed as an elopement risk, and had a history of exit seeking for 1 of 9 residents reviewed for supervision. The facility was unaware of the resident's whereabouts and the exit alarm had been shut off. The time of the elopement and the area in which the resident was found and had been wandering was unable to be determined. The resident was missing from the building for at least 17 hours and was found wandering the city by the local Fire Department, who transported him to the Emergency Room. (Resident C) The Immediate Jeopardy began on 8/16/22 when the facility was unaware the resident had exited the facility without supervision. The resident walked independently and was found wandering the city by the local Fire Department, who transported him to the Emergency Room. The Emergency Room was able able to identify the resident through a Silver Alert and notified the facility. The Administrator was notified of the immediate jeopardy on 8/23/22 at 2:51 p.m. The Immediate Jeopardy was removed on 8/25/22, but noncompliance remained at the lower scope and severity level of no actual harm, with potential for	F 0689	**F689** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? **Corrective Action(s) for Residents Affected by the Deficient Practice** 8/16/22 Resident C was assessed for injury immediately upon return to facility at 9:25pm. There was no evidence of injury. Resident C was unable to state where he had been due to cognitive impairment. Staff gave the resident food and medications that were due. Resident C received bedtime care and was placed in bed. DON began monitoring the evening and night shift at 8:00pm by calling the facility every two hours requesting a report on the resident's location and the status of all residents. This monitoring is documented on an audit form and will be continued every night until mag locks are installed on the east and west hallway doors.	09/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	more than minimal harm that is not Immediate Jeopardy. Finding includes: During an observation on 8/23/22 at 8:32 a.m., the Nursing Supervisor was walking from door to door to check the door alarms. The doors were opened, the alarm sounded, and a key had to be used to turn the alarm on and off. A reported incident to the Indiana Department of Health (IDOH), indicated the date of the incident was 8/16/22 at 3:05 a.m. Resident C had eloped from the facility through an exit door. RN 1 (no longer employed at the facility) notified the Police and left a voicemail for the Director of Nursing (DON) and the Nursing Supervisor. A search of the area had been completed and the Police had been contacted. The hospital notified the facility the resident was in the Emergency Room on 8/16/22 at 8:15 p.m. Resident C's record was reviewed on 8/23/22 at 11:36 a.m. The diagnoses included, but were not limited to, dementia and psychotic disorder with behaviors. An Admission Minimum Data Set assessment, dated 5/17/22, indicated a severely impaired cognitive status, had behaviors of physical, verbal, other, rejection of care, and wandering 1-3 days, required supervision for bed mobility, transfers and ambulation occurred 1-2 times. The ambulation was not steady, but was able to stabilize himself without staff assistance, had no impairments of the upper and lower extremities, and had no falls. A Care Plan, dated 5/30/22, indicated verbal		8/17/22 Resident C was placed on safety checks every thirty minutes around the clock. The 30-minute checks will continue until mag locks are installed on the east and west hallway doors. Thirty-minute checks on door alarm activation and security was implanted and will continue mag locks are installed on the east and west hallway doors. Staff on duty were in serviced in both processes and documentation of same. The DON suspended the licensed nurse and certified nursing assistant who were on duty during the night shift 8/16/22 pending investigation. 8/18/22 Staff on duty were in serviced in both processes and documentation of same. The Wander Risk Score for Resident C was updated. A problem of exit seeking behavior was added to the care plan with safety interventions. 8/19/22 Staff on duty were in serviced on facility Elopement policy. Staff on duty the night of the incident were suspended and both employees quit their positions during investigation, causing an incomplete investigation. A truthful accounting of what happened will never be able to be determined due to previous staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	outbursts, wandering, combativeness, and refused care frequently. The interventions included medications as ordered, needs were to be anticipated and met, positive interactions were to be provided, and he was to be praised with progress or improvement in behavior. The Wander Risk Assessments, dated 5/10/22 and 6/12/22, indicated he was a high risk for wandering/elopement related to a history of wandering. The Wander Risk Assessment, dated 8/18/22, indicated a high risk for wandering/elopement and he had a successful exit off the facility premises on 8/16/22. The Admission Summary, dated 5/10/22 at 4:05 p.m., indicated he had full range of motion to all extremities, ambulated independently, was a fall and elopement risk, and required to be closely monitored by the staff. The Nursing Progress Notes indicated the resident was exit seeking, attempted to exit, and/or set off the door alarms on 5/13/22 at 4:49 a.m., 5/14/22 at 4:04 p.m., 5/17/22 at 1:05 p.m., 5/18/22 at 8:23 p.m., 5/22/22 at 3:48 p.m., 5/23/22 at 11:38 p.m., 5/25/22 at 6:30 a.m., 5/26/22 at 12:58 a.m., 5/28/22 at 3:08 p.m., 5/30/22 at 11:55 p.m., 5/31/22 at 5:56 a.m., 5/31/22 at 11:11 p.m., 6/2/22 at 9:18 p.m., 6/10/22 at 10:17 p.m., 6/12/22 at 7:24 a.m., 7/10/22 at 8:08 a.m., 7/12/22 at 12:04 a.m., 7/13/22 at 8:14 a.m., 7/14/22 at 8:35 p.m., 7/16/22 at 7:43 p.m., 7/17/22 at 6:54 p.m., 7/18/22 at 7:40 a.m., 7/19/22 at 10:17 a.m., 7/23/22 at 3:26 p.m., 7/26/22 at 9:55 p.m., and 8/14/22 at 6:22 a.m. The Nursing Progress Notes indicated the resident had exited the building on 5/16/22 at 6:55		unwillingness to cooperate. A motion sensor was placed at the bedside of Resident C. 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. **Corrective Action(s) for Other Residents Potentially Affected** All residents assessed to be at risk for wandering are potentially affected. Wandering Risk Score assessments were updated for all residents as of 8/25/22. Care plans of residents assessed to be at risk were updated as of 8/25/22. Wandering Risk Score assessments will continue to be completed upon admission and updated at 72 hours post admission, quarterly or with significant change. Care plans will be developed and/or updated for any resident who scores at risk for unsafe wandering or exit seeking. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. **Measures to Ensure the Deficient Practice Does Not Recur** Staff on duty were in serviced on Elopement policy on 8/18/22. All remaining staff was in-serviced on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	a.m., 5/18/22 at 6 23 a.m. (twice), 5/24/22 at 7:14 a.m., and 5/29/22 at 10:14 p.m. There were no Nursing Progress Notes dated 8/16/22 until 11:41 p.m. The Social Service Director Notes, dated 8/16/22, indicated the following: At 9:29 a.m., the Social Worker contacted the Guardian for Resident C and notified him the resident had eloped from the facility. At 9:31 a.m., Social Service was notified of the elopement by the Maintenance Man, who indicated the resident had exited the building the past night. The DON was then notified of the elopement and discussed the incident with RN 1. RN 1 had indicated she had attempted to notify the DON a, "couple times" with a message. The DON denied the messages were received. A note was written by RN 1, which indicated CNA 2 (no longer employed at the facility) had notified her the resident was not in his bed or in the room. The facility was searched and the resident was not located. RN 1 had indicated this was at 3 a.m. RN 1 indicated the door alarm to the West Wing Door was unlocked and the alarm had been turned off and this was why nobody was notified that a resident had tried to elope. The Social Service director was notified approximately at 8:45 a.m. and had continued to follow up with the Police Department, the Guardian, and the Emergency Rooms in the area. At 10:07 a.m., the Guardian had called the facility and indicated a missing person report had never been filed with the local Police Department and requested a Silver Alert be issued. At 10:59 a.m., the Local Police Department was		8/24/22. Nurses will report any exit-seeking behaviors to the DON after ensuring the resident's safety. CNAs will report any exit-seeking or potentially unsafe behaviors to the charge nurse. Nursing staff will continue to receive education and instruction related to safety interventions. New hires in the nursing department will receive orientation to the facility Elopement Plan. The DON and Nurse Consultant will be responsible for ensuring education is provided as planned. The Nurse Supervisor will be responsible for ensuring orientation is completed as planned. These same three persons will be conducting the education, training, and/or orientation. Emergency Information Files have been printed with resident demographic information, code status, hospital preference, allergies, photograph if available, and the contact information of legally appointed representatives and/or family members. The files have been placed in a binder labeled Emergency Information Files. The binder is located at the nursing station; it will be updated with each new admission, transfer, or discharge. A policy and procedure was developed, adopted, and all nursing staff were in serviced on the policy. A quote was requested for 15-second egress delay bars and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	contacted and a full report was given to them and the Silver Alert was to be issued. The Police arrived at the facility and information about the resident was given. At 1:17 p.m., the Police Department was contacted and was informed the Silver Alert had not gone out yet and it could take 2-3 hours to go through. At 1:49 p.m., a Police Officer arrived at the facility and a photograph of the resident and contact information was given to the Officer from the DON. The Silver Alert would be initiated. A Nurse's Progress Note, dated 8/16/22 at 11:41 p.m., indicated the resident was transferred from the hospital to the facility at 9:25 p.m. He was verbally responsive. A full body assessment was completed and the skin was intact. He had indicated he had not eaten all day and was hungry. Food was given and he consumed 100%. A Social Service Progress Note, dated 8/17/22 at 9:01 a.m., indicated the Guardian was notified the resident had been found at the hospital and had returned to the facility. An undated note, identified by the Social Service Director as written by RN 1, indicated CNA 2 had alerted her the resident was not in the bed or in the room at 3 a.m.. They had searched the inside and outside of the facility and he was not located. The alarm to the West Wing exit door was observed to be off. A telephone call was placed approximately at 3:15 a.m. to the Nurse Supervisor and the DON. There had been no answer from either and a message was left. The Local Police were notified and an Officer arrived at the facility at 3:30 a.m. The computer was offline for maintenance so no information could be given to		mag locks to be added to the east and west outer hallway doors on 8/18/22 with GoKeyless Company. On 8/19/22 a response from GoKeyless was received and a review of what potential products would work, but local fire marshal would have to be contacted. Q.A.A. Committee consulted and it was determined to contact Safecare since they maintained our smoke and fire alarm system. was contacted on 8/23/22 and requested to schedule a visit to look at the exit doors and provide specific information on the type of products that can be mounted on these doors. Safecare visited the facility on 8/30/22 to determine what type of delayed egress device would work on the doors. On 9/1/22 quote was received from Safecare and work order signed. Electrician was contacted to install new outlets by the east and west end doors which is scheduled for installation on 9/12/22. Safecare has ordered the equipment for the delayed egress but has not received the items, they will notify administration when the parts arrive and schedule installation. Alarms were added to the exterior west and east hallway doors on 8/25/22, which makes the exits with 2 alarms exit one on each door. One alarm on the glass panel door and one alarm on the steel exit door. The pre-admission screening	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Police Officer about the resident and his family. She was only able to inform the Officer of the resident's race. The Police Officer had wanted the facility to call back with the information when the computer was back on line. A typed note, identified by the Social Service Director as her statement, indicated she had been notified on 8/16/22 at 8:30 a.m. about the elopement. She then contacted the DON, who indicated she had never received a call or message in regards to the elopement and had been completely unaware of the situation. The Nursing Supervisor had indicated when she left the building on 8/15/22 at 8 p.m., all the doors were locked, the alarms were all on, and the resident was in his bed. When the Nursing Supervisor arrived at the facility on 8/16/22, she observed the doors were unlocked and the alarms were disabled. The Police were notified at 8:45 a.m. and a full report on the elopement was given. An Officer arrived at the facility at 10 a.m. and finalized the report so a Silver Alert could be initiated. After the call to the Police Department, the Guardian was notified and indicated he was unaware the resident had eloped and no one had notified him earlier. Several calls were made to the Police and hospitals in the area. At 8:15 p.m. on 8/16/22, the resident was found at the hospital and returned to the facility at 9:25 p.m. A Missing Person Police Report, dated 8/16/22, indicated they were notified on 8/16/22 at 10:10 a.m. of the elopement by the Social Service Director. The resident suffered from dementia with psychotic disorder and violent behaviors. He could not speak in proper sentences. He was last seen wearing gray pants, no shirt, socks, or shoes. A Silver Alert was requested.		process has been revised to ensure any history of wandering or exit seeking is identified prior to admission and to ensure adequate safety measures are implemented upon admission. An admission review team has been implemented; this team includes the DON, Social Services, Nurse Supervisor, and Nurse Consultant. The team will be responsible for review of all information disclosures prior to making recommendations for accepting prospective residents for admission. The new process was implemented 8/30/22. The Administrator will be physically present in the facility 4 days per week. The DON will physically be present in the facility 3 days per week plus week-ends. The Nurse Supervisor will be physically present in the facility on day shift Monday through Friday unless she is ill or has an emergent situation. The Nurse Consultant will be physically present in the facility 2 to 3 days per week unless she is ill or has an emergent situation. The sequence of management staff to call when facility staff need to report significant events is: Administrator, then DON, then Nurse Supervisor, and if not able to reach any of these, they call the Maintenance Director. This will be put in writing and placed in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Emergency Room Note indicated the date and time of service was 8/16/22 at 6:58 p.m. The Triage Notes indicated the local Fire Department brought the resident to the Emergency Room after he had been found wandering in the city. During a phone interview on 8/23/22 at 10:47 a.m., the responding Police Officer indicated the first time he responded at the facility was 8/16/22 at 10:10 a.m. He responded to the facility and took the report. He had continually checked with the hospitals for, "John Doe's", all day and none were reported. During a phone interview on 8/23/22 at 11 a.m., an Officer at the local Police Department indicated there had been no record of anyone notifying them about a missing resident on 8/16/22 until about 10 a.m. He indicated a family member had notified them and wanted a missing person report filed and they explained to him that the facility would need to file the report. The facility then called after the family member had called to file the report. The Department had no record of another call prior to this call. During an interview on 8/23/22 at 11:05 a.m., the Social Service Director indicated she had told the Guardian the nurse had not had the information to notify him due to the computers being down. The Social Service Director indicated there was a hard copy of the face sheet with all the numbers in the resident's file and the nurse had access to the file, she had not utilized the hard files to get the information. During an interview on 8/23/22 at 2:22 p.m., the RN Nurse Consultant was unsure why the alarm to the West Unit door had been turned off and who had turned the alarm off.		Nursing Staff Schedule binder. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Nursing progress notes will be monitored daily Monday through Friday per the Nurse Supervisor on day shift, and by the RN staff nurse on weekend night shifts. All facility staff are responsible for monitoring that residents are in a safe location at all times around the clock. Any residents with observed exit seeking behaviors or increased unsafe wandering that may place the resident at risk will be reported to the DON or Administrator and care plan interventions reviewed and updated, if needed, to ensure safety. This process will be on-going. The DON, Nurse Supervisor, Social Services, and the Nurse Consultant will be responsible for ensuring that Wandering Risk Scores are completed, updated when needed, and that the corresponding care plans reflect current risk status and appropriate interventions. Once the mag locks are installed, licensed staff will monitor that battery-operated door alarms are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 8/23/22 at 2:23 p.m., a copy of the undated summary of the investigation of the incident was received from the RN Nurse Consultant. The summary indicated RN 1 had not informed the Administrator and/or Director of Nursing of the elopement, rounds every two hours had not been completed, she had not ensured the doors were locked and alarmed at all times, and had not called the Officer back to give a full report after the computers were available. RN 1 had refused to meet with the facility and had resigned her position. CNA 2 was interviewed and indicated the doors were not opened and were locked. She had not observed the alarms to ensure the alarms were on. She was unable to explain why she had not heard the door alarm. She resigned her position after the interview. During an interview on 8/24/22 at 8:18 a.m., the Nursing Supervisor indicated she looked at her phone at around 8 a.m. on 8/16/22 and noticed she had missed a cell phone call at approximately 2:45 a.m. and 3 a.m. on 8/16/22, while she had been asleep. A voicemail was left after the call at 3 a.m. RN 1 had indicated Resident C could not be located in the building and she (RN 1) was going to notify the DON. During a phone interview on 8/24/22 at 9:23 a.m., a Dispatcher for the Cities of the county and the County Police Department indicated a 911 call had been received on 8/16/22 at 3:08 a.m. and a City Police Officer was dispatched to the facility. The Officer had indicated the nurse at the facility was unable to provide information about the resident due to the computers being down and the officer was to be notified and given the information when the computers were available.		active on all doors so equipped and mag locks on exit doors are functional during shift-to-shift changeover every day of the week. The Administrator, DON, and Nurse Consultant will monitor that shift-to-shift checks are conducted when they are physically present in the facility. The DON will continue to monitor the night shift activity after the mag locks are installed on exit doorways by calling in twice during the night shift tour of duty for 2 weeks, then once during the night shift for 2 weeks. The monitoring will be documented on audit forms and submitted to the QAA Committee for review and further actions as deemed necessary. Wandering Risk Scores will be reviewed once every 2 weeks for 2 months, then monthly for 4 months per DON or designee. The reviews will be documented on audit forms. Any increase in scores will be reported immediately to the DON or Administrator, and care plan interventions reviewed and revised, if needed, to ensure safety. Audit results will be reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. All battery-operated exit door alarms and door locking mechanisms will be inspected weekly for 2 months, every 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 DON was interviewed by phone on 8/24/22 at 2:23 p.m. and indicated she had a voicemail dated 8/16/22 at 3:05 a.m. She indicated she had not heard the phone ring. The voicemail indicated Resident C was not located inside the facility, the West Wing door alarm had been found shut off, the Nursing Supervisor was called with no answer and voicemail had been left for her, and the Police were going to be notified.. The DON had found the voicemail at 8:30 a.m. on 8/16/22 after the Social Service Director had called her and informed her of the missing resident. During the investigation she had received conflicting stories from RN 1 and CNA 2. She was unsure who had turned the West Wing door alarm off. During an interview on 8/25/22 at 9;45 a.m., the RN Nurse Consultant indicated a binder was available at the Nurses' Station, labeled Evacuation Information, which had information on all residents in the facility and this could have been used to give the Police Officer the information. An undated facility policy, titled, "Elopements", received from the RN Nurse Consultant as current on 8/23/22 at 10:03 a.m., indicated the door alarm was never to be turned off without continual supervision of the exit. The person who had turned the alarm off was responsible for resetting the alarm. Residents who were at risk for elopement would have a safety precaution placed, which may have included a door alarm on the facility exits, a personal safety device, and staff supervision. The procedures of a missing resident indicated the Administrator and DON were to be immediately notified. A message was not to be left and calls were to be continued until they had been answered. (telephone numbers were listed in the policy for both home and cell phones). A sequence of events was to be documented with		weeks for 2 months, and monthly on-going per the Maintenance Director. Any malfunction will be immediately reported to the Administrator. Inspection results will be documented and reviewed per the QAA Committee with further revisions or actions implemented as deemed necessary. Completion Date: 9/23/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	specific times of each notification and procedure. A complete description of the resident, which included height, weight, hair color, eye color, what they were last seen wearing, and a photo was to be provided. The resident's representative was to be contacted. The Immediate Jeopardy that began on 8/16/22 was removed on 8/25/22 when the facility had inserviced 17 of 21 staff members on the facility resident at risk for elopement, elopement, and missing resident policy and procedures. Staff were interviewed and indicated alarms on the exit doors were to be on and checked every 30 minutes, residents who were at risk were identified by a list at the station and their location was to be monitored every 30 minutes. If the alarm was activated, the staff were to respond immediately and if there was no resident at the door, an outside search and inside resident count was to be completed. If a resident was deemed missing from the facility, the Administrator and DON were to be notified. The Police and Responsible Party were to be notified and a full description of the resident was to be given to the Police. Hard files with resident information were located in the cabinet at the Nurses' Station. All staff who had not yet been educated, will be educated prior to working. The binder with the resident information will be updated and all resident were re-assessed for risk with care plans updated. The non-compliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility still needs to educate the rest of the staff who work in the facility. The facility will monitor the door alarms and residents who were deemed a risk for elopement/wandering every 30 minutes. The Nursing Progress Notes will be monitored by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	08/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	DON or designee. New locks are ordered for the exit doors and once they are initiated, the doors are to be monitored during the shift-to-shift checks. Any changes in the wandering/elopement risk assessments will be reported immediately to the DON or designee and care plan interventions will be updated. All findings of the audits will be documented and reviewed by the Quality Assurance Committee for further revisions or actions that may need initiated. This Federal tag relates to Complaint IN00388228. 3.1-45(a)(2)			