| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155845 | A. BUILDING 00<br>B. WING | 10/06/2022 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00385996 and IN00388228 completed on August 25, 2022.<br><br>This visit was in conjunction with the Recertification and State Licensure Survey.<br><br>Complaint IN00385996 - Corrected.<br><br>Complaint IN00388228 - Not Corrected.<br><br>Survey dates: October 3, 4, 5, and 6, 2022.<br><br>Facility number: 000368<br>Provider number: 155845<br>AIM number: 100275220<br><br>Census Bed Type:<br>SNF/NF: 22<br>Total: 22<br><br>Census Payor Type:<br>Medicaid: 17<br>Other: 5<br>Total: 22<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 10/11/22. | F 0000 | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment | | | |

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

RAENITA DUMAS | RNDON | 10/31/2022

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

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| | remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to ensure post fall interventions were in place for a resident with a history of falls with a fracture related to a floor mat beside the bed and wearing non skid socks for 1 of 2 residents reviewed for falls. (Resident B)<br><br>Finding includes:<br><br>On 10/3/22 at 9:22 a.m., Resident B was observed sitting in a wheelchair at table by himself in the main dining room. The resident's wheelchair brakes were locked and he started moving the table to the left, right, and forward. The resident was agitated and was speaking nonsensical. He pushed the table forward and the front of his wheelchair popped up leaving him sitting in the chair only on back wheels. He continued to do this until the nurse was summoned immediately into the dining room as there was no other staff around. There were no anti-tippers on the back of his wheelchair to prevent him from tipping backwards.<br><br>On 10/4/22 at 10:40 a.m. until 12:55 p.m., the resident was observed in bed. He was dressed in street clothes,with no shoes on, and wearing just plain socks to both of his feet. The 1/4 side rail was observed in the upright position. There was no floor mat beside the bed and the bed was not in the lowest position.<br><br>On 10/4/22 at 3:00 p.m., to 3:30 p.m., the resident was observed in bed, a floor mat was placed | F 0689 | **F689**<br>**Corrective Action(s) for Residents Affected by the Deficient Practice**<br>Resident B. The resident was moved to a low bed on 10/6/22. The resident's wheelchair is now equipped with anti-tipper bars. Staff ensure the resident has non-skid footwear in place when he is in the wheelchair. A motion sensor is at the bedside to alert staff if the resident attempts to exit the low bed. The care plan has been reviewed and updated.<br><br>**Corrective Action(s) for Other Residents Potentially Affected**<br>All residents at risk of falling have the potential to be affected. Residents are assessed upon admission, quarterly and with significant change for the risk of falling. Individualized fall prevention interventions are implemented as deemed appropriate. Care plans are reviewed and updated as needed after each fall and each assessment. Incident reports will continue to be completed in PCC after any fall has occurred.<br><br>**Measures to Ensure the Deficient Practice Does Not** | 11/01/2022 |

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| | beside the bed, however, the bed was not in the lowest position. The resident was wearing plain black socks to both feet.<br><br>The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia.<br><br>The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident needed supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked.<br><br>A Care Plan, revised on 7/7/22, indicated the resident was at risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was wearing appropriate footwear (non-skid shoes/socks) when ambulating or mobilizing in the wheelchair.<br><br>Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff the resident was on the floor. The resident had a bruise on the upper lip and slight bleeding from the nostril. The lower eyelid was swollen and dark. 911 was notified and the resident was sent to the emergency room.<br><br>A Cat Scan (CT) of the face, neck and head, dated 6/26/22, indicated the resident had an acute left zygomaticomaxillary complex fracture of the left zygomatic arch, left inferior and lateral orbital wall | | **Recur**<br>Staff have been in-serviced on facility policy related to fall prevention.<br><br>**The Monitoring Process to Ensure the Deficient Practice Does Not Recur**<br>Charge nurses on each shift are responsible for monitoring that fall prevention interventions are in place as planned. The monitoring is documented on a daily Nurse Rounds Sheet and will continue on-going. The DON or designee will continue to review all Incident/Accident Reports and will investigate any incidents related to falls to determine root causes and potential need for new interventions. The investigation results will be documented and will be reviewed per the<br><br>QAA Committee with further revisions or actions implemented as deemed necessary.<br><br>DATE: 11/1/22 | |

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| | and the left maxillary sinus (this type of fracture was a result from blunt trauma to the periorbital area).<br><br>Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated the resident was being transferred to another hospital due to a fracture of the facial bones. The resident returned on 6/28/22.<br><br>Nurses' Notes, dated 7/7/22 at 1:37 a.m., indicated the resident was observed on the floor mat next to his bed at 7:00 p.m. The resident was assisted back to the bed and the Director of Nursing (DON) was notified who instructed the writer to send the resident to the emergency room for an evaluation. 911 was called and the paramedic indicated the hospital was full and there was no bed available. The DON was notified again regarding the hospital status and the resident was left at the facility for close observation.<br><br>A Nurses' Note, dated 7/11/22 at 4:48 p.m., indicated the resident was alert and verbally responsive. He had continued to have pain to the right leg and hip and was unable to bear weight. An x-ray was performed which was negative for a fracture, but indicated degenerative changes. The resident had complaints of pain when attempting to bear weight. A CT scan was ordered and performed at the hospital and results were still pending. Will continue to monitor for any changes.<br><br>Nurses' Notes, dated 7/11/22 at 7:38 p.m., indicated the Physician had called and indicated the resident had an impacted fracture to the right hip. Naproxen (an anti-inflammatory medication) 500 milligrams (mg) twice a day was ordered for pain. | | | |

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| | A CT scan of the right hip, dated 7/11/22, indicated an impacted fracture of the femoral neck.<br><br>Physician's Orders, dated 6/28/22, indicated fall and safety precautions. Place floor mat at bedside when resident was in bed. Alarm sensor in room to alert staff of transfers.<br><br>Interview with the Director of Nursing (DON) on 10/5/22 at 1:30 p.m., indicated the floor mat should have been on the floor next to the bed at all times and the bed should be in the lowest position. They have a low bed in the facility and were going to change out his bed but that had not been done.<br><br>This deficiency was cited on 8/25/22. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-45(a)(2) | | | |