

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/29/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/26/16</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 1002752200</p> <p>At this PSR survey, Simmons Loving Care Health Facility was found in substantial compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. Twenty resident rooms were provided</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0130 SS=C Bldg. 01	<p>with battery operated smoke detectors. The facility has the capacity for 46 and had a census of 18 at the time of this survey.</p> <p>All areas accessible to residents and areas providing facility services were sprinklered.</p> <p>Quality Review completed on 04/27/16 - DA</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier wall was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p>	K 0130	<p>F 130 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier wall was maintained to ensure the fire resistance of the barrier. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Area mentioned in previous addressed area in kitchen however upon revisit with the administrator area indicated was in the dining room. Administrative assistant was not aware of this previous citing so our attention went to the kitchen area. Maintenance man was not available during revisit and he did not remember the cited area. Area sculked with concrete 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct</p>	04/27/2016			

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	<p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff, visitors, and at least 9 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Administrative Assistant on 04/26/16 at 2:21 p.m., a two inch by three inch section of cement brick was missing from the barrier. Based on interview at the time of observation, the Administrative Assistant acknowledged the aforementioned condition and provided the measurements.</p> <p>This deficiency was cited on 02/29/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</p>		<p>the deficient practice for any client the facility identified as being affected. No other areas noted the facility has been checked continuously for areas that need fire caulking by life safety surveyors since 2013. The areas noted in this deficiency were not determined to be deficient in the past.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The fire caulking and/or concrete stays in the protected area when applied. The facility will monitor for openings that require fire caulking when repairs are done in the facility. 4. Describe 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.</p> <p>1. Maintenance will monitor for openings in walls and fire protected areas to prevent smoke penetrations monthly and caulk areas found.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-19(b)				