

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 03/07/2016
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194605.</p> <p>Complaint IN00194605- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: March 6 & 7, 2016</p> <p>Facility number: 000368 Provider number: 15E187 AIM number: 100275220</p> <p>Census bed type: NF: 18 Total: 18</p> <p>Census payor type: Medicaid: 17 Other: 1 Total: 18</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality Review completed by 32883 on March 11, 2016.</p>	F 0000		
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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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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision related to residents observed unsupervised on the floor, in the Kitchen, and in a dark Dining Room for 3 of 4 residents reviewed for accidents in a sample of 6. (Residents #C, #D, and #E)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 3/6/16 at 4:00 a.m., Resident #C was observed in bed.</p> <p>On 3/6/16 at 6:00 a.m., the resident was observed lying supine on the floor in the Dining Room next to a 1/2 circle round table. The resident's wheelchair was behind the table. The resident was awake and talking. No staff members were in the Dining Room at the time. The Director of Nursing entered the Dining room after seeing the resident's legs on</p>	F 0323	<p>F 323 Based on observation, record review, and interview, the facility failed to provide adequate supervision related to residents observed unsupervised on the floor, in the Kitchen, and in a dark Dining Room for 3 of 4 residents reviewed for accidents in a sample of 6. (Residents #C, #D, and #E) This Federal tag relates to Complaint IN00194605. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Stop Alarms have been placed on all exit doors: East Wing, West Wing, Front Entrance to Outer Door, Inside Double Doors, Dining Room Door, Kitchen Exit Door, Roof Top Door, Exit Door to Patio, 2 Basement Door. Signs have also been placed which state Stop Alarm Will Sound. Hours posted on Dining Room Door which states Dining Room Closed 9:30pm to 8:00am. Staff instructed not to allow anyone into the dining room unless staff is present. Resident's will wait in their rooms or by the</p>	03/29/2016

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	<p>the floor by the entrance to the Dining Room.</p> <p>On 3/6/16 at 6:25 a.m., the resident was observed propelling him self in his wheelchair down the hallway and into the Dining Room. The resident then stood up from his wheelchair and sat down in one of the Dining Room chairs. No staff members were present in the the Dining Room.</p> <p>On 3/6/16 at 6:30 a.m. the resident was not observed in his room or the Dining room. CNA #1 walked into the Dining Room and stated the resident should be in the Dining Room. CNA #1 opened the unlocked Kitchen door. The resident was observed in the Kitchen sitting in his wheelchair next to a small standing freezer. The freezer top was open and the resident was holding a large round barrel of frozen sherbet. No staff members were seen in the Kitchen at this time. CNA#1 took the container from the resident and assisted him out of the Kitchen. The Kitchen door was not locked when the CNA entered to look for the resident. RN #1 was present when the resident came out of the Kitchen with CNA#1.</p> <p>When interviewed at the above time both CNA #1 and RN #1 indicated the Kitchen</p>		<p>nurses station untildining room is opened so that proper supervision is available. 2. Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. Staff member was immediately placed in the diningroom to monitor residents. 3. Describe the steps or systemic changes thefacility has made or will make to ensure that the deficient practice does notrecur, including any in-services, but this also should include any systemchanges you made. Door Alarms installed on all listed above on exitdoors will be armed when staff is not in dining room during 9pm to 8am. Hours posted for dining room closure. All nursing staffin-serviced on alarm doors and dining room hours.</p> <p>1.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>Charge Nurse is responsible for ensuring all exit doors arelocked and door is alarmed. Dining Roomdoor will be alarmed from 9pm to 8am daily. Monitoring will be recorded on rounds sheet. D.O.N. will monitor rounds sheets anddoor alarm weekly times one month. Q.A. Committee will monitor rounds logsand determine if further monitoring is needed and if changes need to</p>				

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	<p>door should have been locked.</p> <p>The record for Resident #C was reviewed on 3/6/16 at 7:00 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral problems, major depressive disorder, anemia, end stage renal disease, anxiety disorder, and high blood pressure.</p> <p>Review of the 1/13/2016 Minimum Data Set (MDS) quarterly assessment indicted the residents BIMS (Brief Interview for Mental Status) score was (0). A score of (0) indicated the resident's cognitive patterns for daily decision making were severely impaired. The assessment indicated the resident usually made him self understood and usually was able to understand others. The assessment indicated the resident had behaviors 4-6 days of the reference period. The assessment indicated the resident was totally dependent on two staff members for transfers, bed mobility, personal hygiene, and bathing. The assessment indicated the resident displayed impairment in range of motion in both upper extremities.</p> <p>The resident's current Care Plans were reviewed. A Care Plan indicated the resident had a behavior problem as he would get out of bed and lay on the floor</p>		<p>be made todoor alarm system quarterly. ADDENDUM IN-SERVICE WAS HELD WITH ALL STAFF ABOUT RESIDENTSAFETY AND NEW MEASURES FOR DOOR ALARMS. DINING ROOM HOURS ARE FROM 8:00AM – 9:00PM. NO RESIDENTS ARE ALLOWED IN THE DINING ROOMUNLESS STAFF IS IN THAT AREA FOR SUPERVISION.</p>	

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	<p>throughout the facility. When in the wheelchair the resident would push and slide his body forward and then slide out of the wheelchair continuing throughout the day, evening and night shifts. Care plan interventions included, but were not limited to, anticipate and meet the resident's needs, monitor, and attempt to determine the underlying cause.</p> <p>The 2/2016 Nursing Progress Notes were reviewed. An entry made on 2/24/16 at 9:55 a.m., indicated the resident continuously attempted to go to the doorway and tried to slide to the floor. An entry made on 2/25/16 at 4:32 p.m. indicated the resident continuously attempted to go to the doorway. An entry made on 2/26/16 at 10:24 a.m. indicated the resident was continuously going to the door with exit seeking behavior exhibited. An entry made on 2/28/16 at 5:45 p.m. indicated the resident continued to have exit seeking behavior.</p> <p>When interviewed on 3/6/16 at 7:05 a.m., the Director of Nursing indicated the resident should not have been in the Kitchen unsupervised.</p> <p>2. During Orientation Tour on 3/6/16 at 4:00 a.m., Resident #E was observed in a speciality wheelchair in the Dining</p>						

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	<p>Room. The resident was dressed in pants, a shirt, shoes and socks. All the lights in the Dining Room were off. A TV was on in the Dining Room. Resident #E's back was to the TV. There was one other resident in the Dining Room. RN #1 entered the Dining Room during the Orientation Tour and walked towards the wall, opened an electrical box, and turned the lights on.</p> <p>The record for Resident #E was reviewed on 3/7/16 at 8:50 a.m. The resident's diagnoses included, but were not limited to, mental retardation, high blood pressure, cerebral palsy, and muscle weakness.</p> <p>Review of the 1/2/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive patterns for decision making were severely impaired. The assessment indicated the resident was dependent on staff for bed mobility, personal hygiene and bathing. The resident required extensive assistance of one staff member for locomotion on and off the unit. The assessment indicated the resident had impairment of range of motion in both upper and both lower extremities.</p> <p>A Care Plan initiated on 7/14/2014 indicated the resident had a</p>			

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	<p>communication problem related to cerebral palsy and aphasia (inability to speak). The care plan was last updated with a target goal date of 4/13/2016. Care Plan interventions included, but were not limited to, staff to assess and anticipate the resident's needs.</p> <p>A Care Plan initiated on 7/14/2014 indicated the resident had a behavior problem. The identified behaviors included yelling out and attention seeking. Care Plan interventions included, but were not limited to, staff to anticipate and meet the resident's needs and caregivers were to provided the opportunity for positive interactions and attention.</p> <p>A Fall Scale was completed on 1/2/16. The Fall Scale indicated the resident's gait was impaired and he overestimated or forgot his limits. No score was recorded on the assessment.</p> <p>When interviewed on 3/7/16 at 10:45 a.m., the Director of Nursing indicated the resident should not have been left unsupervised in the dark Dining Room.</p> <p>3. During Orientation Tour on 3/6/16 at 4:00 a.m., Resident #F was observed in a geri-chair in the Main Dining Room. The resident's geri-chair was in the reclined</p>			

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	<p>position. The resident was awake and dressed. No staff member or visitors were present in the Dining Room. No lights were on in the Dining Room. One other resident was observed in the Dining Room at this time. RN #1 entered the Dining Room during the Orientation Tour and walked towards the wall, opened an electrical box, and turned the lights on.</p> <p>The record for Resident #F was reviewed on 3/7/16 at 8:29 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, psychosis, and high blood pressure.</p> <p>Review of the 2/4/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (1). A score of (1) indicated the resident's cognitive patterns for decision making were severely impaired. The assessment indicated the resident transferred from surface to surface occurred only once or twice during the reference period and the resident required assistance of one staff member. The assessment indicated the resident was not steady moving from a seated to a standing position.</p> <p>A Fall Scale completed on 2/4/2016 indicated the resident had fallen in the</p>			

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	<p>past, had an impaired gait, and overestimated or forgot his ability to ambulate. The resident's score was (75). A score of (75) indicated the resident was at high risk for falling.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 2/23/2014 indicated the resident had a communication problem related to dementia. The Care Plan was last updated with a goal date of 5/18/2016. Care Plan interventions included, but were not limited to, anticipate and meet the resident's needs.</p> <p>When interviewed on 3/7/16 at 10:45 a.m., the Director of Nursing indicated the resident should not have been left unsupervised in the dark Dining Room.</p> <p>When interviewed on 3/6/16 at 4:15 a.m., RN #1 indicated the resident was up bathed and dressed earlier and placed in the Dining Room. The RN indicated the above residents were gotten up early because staff had to bathe all the residents on the hall before breakfast.</p> <p>This Federal tag relates to Complaint IN00194605.</p> <p>3.1-45(a)(2)</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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