PRINTED: 12/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
155845		155845	B. WING		12/06/2021	
NAME OF F	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE		
				21ST AVE		
SIMMON	S LOVING CARE H	IEALTH FACILITY	GARY	IN 46407		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
E 0000	REGUERTORT OR	ESC IDENTIFY THAT IN CRAIM THORY	1710		DATE	
L 0000						
Dida						
Bldg	, F B	1 0	F 0000			
		paredness Survey was	E 0000			
		diana Department of Health				
	in accordance with	42 CFR 483.73.				
	Survey Date: 12/06	5/21				
	Facility Number: 0					
	Provider Number:	155845				
	AIM Number: 1002	275220				
	At this Emergency	Preparedness survey,				
	Simmons Loving C	are Health Facility was found				
	_	Emergency Preparedness				
		ledicare and Medicaid				
		lers and Suppliers, 42 CFR				
	483.73	icis and Suppliers, 12 Cr R				
	103.73					
	The facility has 16 (certified beds. At the time of				
	the survey, the cens					
	the survey, the cens	us was 10.				
	Quality Review con	mulated an 12/09/21				
	Quality Review con	npieted on 12/08/21			!	
K 0000						
K 0000						
DId~ 04						
Bldg. 01	A T 10 0 0 1 0 1	D. C. C. C. LOV.			l I	
		Recertification and State	K 0000			
		as conducted by the Indiana				
	_	th in accordance with 42				
	CFR 483.90(a).					
	Survey Date: 12/06	6/21				
	Facility Number: 0	00368				
	Provider Number:	155845				
	AIM Number: 1002	275220				
	At this Life Safety (Code survey, Simmons				

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

TITLE

000368

(X6) DATE

Any defiency statement 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.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845 A. BUILDING B. WING O1 COMPLETED 12/06/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE 700 F 21ST AVE GARY, IN 46407 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETED 12/06/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (SACH CORRECTION SHOULD BE COMPLETION) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FILL IN PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE GARY, IN 46407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION).	
SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES Deficiency Must be preceded by full 1 prefix (Fach correction should be completion). (X5)	
PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (FACH DEFICIENCY MILST BE PRECEDED BY FILL I PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPLETION	
PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMPLETION	
	N
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
Loving Care Health Facility was found not in	
compliance with Requirements for Participation	
in Medicare and Medicaid, 42 CFR Subpart	
483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection	
Association (NFPA) 101, Life Safety Code	
(LSC), Chapter 19, Existing Health Care	
Occupancies and 410 IAC 16.2.	
This one-story facility with a partial basement,	
built in 1967, 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. The facility has no emergency power	
protection. Twenty resident rooms were provided	
with battery operated smoke detectors. The facility has the capacity for 46 and had a census	
of 18 at the time of this survey.	
of 16 at the time of this survey.	
All areas accessible to residents and areas	
providing facility services were sprinklered.	
Quality Review completed on 12/08/21	
K 0511 NFPA 101	
SS=E Utilities - Gas and Electric	
Bldg. 01 Utilities - Gas and Electric	
Equipment using gas or related gas piping	
complies with NFPA 54, National Fuel Gas	
Code, electrical wiring and equipment	
complies with NFPA 70, National Electric	
Code. Existing installations can continue in service provided no hazard to life.	
18.5.1.1, 19.5.1.1, 9.1.2	
Based on observation and interview, the facility $K 0511$ WE are asking for a paper $12/07/202$	21
failed to ensure 1 of 1 main entry door set was The discussion of the paper The discussion of the paper	~ 1
maintained in a safe operating condition. LSC K511	
19.5.1 requires utilities comply with Section 9.1. Based on observation and	
LSC 9.1.2 requires electrical wiring and interview, the facility failed to	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED		
		155845	B. W	B. WING		12/06/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	₹					
				1	21ST AVE		
SIMMON	S LOVING CARE I	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	equipment to comp	ly with NFPA 70, National			ensure 1 of 1 main entry door	set	
		11 Edition. NFPA 70, 2011			was maintained in a safe		
		4.28(c) requires all junction			operating condition. LSC 19.5	.1	
		ided with covers compatible			requires utilities comply with		
	_	deficient practice could affect			Section 9.1. LSC 9.1.2 require	s	
		ents, 4 employees, and 1			electrical wiring and equipmen	it to	
	visitor in the main				comply with NFPA 70, Nationa		
		-			Electrical Code, 2011 Edition.		
	Findings include:				NFPA 70, 2011 Edition, Article)	
					314.28(c) requires all junction		
	Based on observation	on with the Director of			boxes shall be provided with		
	Nursing (DON) and	d the Custodial / Maintenance			covers compatible with the box	x.	
	Man during the tour of the facility on 12/06/21				This deficient practice could		
	from 12:20 a.m. to 2: p.m., the following was				affect as many as 2 residents,	4	
	noted:				employees, and 1 visitor in the		
	a) there was conduit that housed wiring used to				main lobby.		
	operate the main entry door automatically. This				,		
	function of the door was disabled for the				1. What corrective action will b	e	
	pandemic to limit access to the facility. There				accomplished for those reside	nts	
	_	g coming from the conduit that			found to have been affected by		
	was not protected.				the deficient practice?		
	b) there was a conduit that led to an outlet box				·		
		main entry doors to the			The low voltage electrical wire	was	
		of the outlet box had an			immediately taped with electric	cal	
	1	exposed wire that extended			tape on 12/6/21. All areas in t	he	
	from the box was p				front entrances and office area		
		ned items were acknowledged			were immediately checked for		
		e Custodial / Maintenance			loose wires.		
	· ·	ey were observed on the tour					
		DON added that she would			2. How other residents having	the	
	1	/ Maintenance Man take care		potential to be affected by the			
	of the exposed wires as soon as he was able to				same deficient practice will be		
	attend to them. During the exit conference with			identified and what corrective			
	the DON at 2:15 p.m., no additional information				action will be taken.		
	_	pe provided contrary to this					
	deficient finding.	, J ==			No resident affected and no of	her	
	8				loose wires found.		
	3.1-19(b)				3. What measures will be put i	nto	
	(-)				place or what systemic change		
					will be made to ensure that the		

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		DNSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPL	
		155845	B. W	ING		12/06/	2021
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PROVIDER OR SUPPLIER			700 E 2	1ST AVE			
SIMMON	S LOVING CARE H	IEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID	NEOVIDERIC N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
					deficient practice does not rec	ur.	
					D.O.N. in-serviced all		
					maintenance staff on continuir	ng	
					monitoring for loose wiring in		
					facility.		
					D.O.N. in-serviced all		
					maintenance staff on Monthly		
					Monitor for Loose Wiring.		
					Maintenance Staff monitor ent		
					facility on 12/7/21 for loose wi	-	
					and completed log sheets. No)	
					other areas noted.		
					D.O.N. will review log sheets		
					monthly to ensure compliance		
					4. Describe who will be the		
					person(s) responsible for		
					implementing and monitoring plan for future compliance with		
					regulations.	i uie	
					regulations.		
					D.O.N. will submit log sheets t		
					Administrator and Q.A. Comm	ittee	
					for review monthly to ensure		
					compliance.		
					E Commission D-1- 40/7/00/	,	
					5. Completion Date: 12/7/202	۱ ا ا	
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens						
		ent - Power Cords and					
	Extension Cords						
	Power strips in a p	patient care vicinity are					
					1		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155845	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/06/2021	
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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure in 1 of 1 main entry foyer flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect as many as 2 residents, 4 employees, and 1 visitor in the main entry / foyer area. Findings include: Based on observation with the Director of Nursing (DON) and the Custodial / Maintenance	K 0920	We are asking for a paper compliance review. K920 Based on observation with the Director of Nursing (DON) and Custodial / Maintenance Man during the tour of the facility of 12/06/21 at 1:50 p.m., an extension cord was plugged ir wall mounted electrical socket This extension cord then had a vaporizer and a toy soldier Christmas decoration plugged it. Based on interview at the tir of the observation the DON st that they were using the vapor to spread sanitizer in the area	I the n nto a a into me ated rizer	

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	OF CORRECTION OF CORRECTION 155845	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/06/2021
	PROVIDER OR SUPPLIER IS LOVING CARE HEALTH FACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP CODE 21ST AVE 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 APPROPRIA DEFICIENCY)	DATE
	Man during the tour of the facility on 12/06/21 at 1:50 p.m., an extension cord was plugged into a wall mounted electrical socket. This extension cord then had a vaporizer and a toy soldier Christmas decoration plugged into it. Based on interview at the time of the observation the DON stated that they were using the vaporizer to spread sanitizer in the area as they had recently done COVID-19 testing and they wanted to keep the area clean. The DON then immediately unplugged the extension cord and removed it from the area. During the exit conference with the DON at 2:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		they had recently done COVII testing and they wanted to kee the area clean. The DON thei immediately unplugged the extension cord and removed if from the area. During the exit conference with the DON at 2:15p.m., no additional information or evidence could provided contrary to this deficit finding. 1. What corrective action will be accomplished for those reside found to have been affected be the deficient practice? The extension cord was immediately removed by D.O. on 12/6/21. All areas in the freentrances and office area wer immediately checked for extension cords. 2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No resident affected and no or extension cords were found. 3. What measures will be put place or what systemic chang will be made to ensure that the deficient practice does not recomply the same deficient practice does	be dent description of the second of the sec

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155845	B. WING		12/06/2021
			CTD FET	ADDRESS OF A STATE OF SORE	
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
				21ST AVE	
SIMMON	S LOVING CARE	HEALTH FACILITY	GARY	, IN 46407	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROWIDER'S BLANCE CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				facility.	
				D.O.N. in-serviced all	
				maintenance staff on Monthly	
				Monitor for Loose Wiring &	
				Extension Cords.	
				Maintenance Staff monitor en	tire
				facility on 12/7/21 for extension	on
				cords and completed log shee	
				No other areas noted.	
				D.O.N. will review log sheets	
				monthly to ensure compliance	_
				mentally to officer of compliance	
				4. Describe who will be the	
				person(s) responsible for	
				implementing and monitoring	the
				plan for future compliance wit	
				regulations.	ii tiie
				regulations.	
				DON will submit log shoots	to
				D.O.N. will submit log sheets Administrator and Q.A. Comm	
					IIIIEE
				for review monthly to ensure	
				compliance.	
				E Commission Date: 40/7/00	24
				5. Completion Date: 12/7/20	۷۱
			1	1	I

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