

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 09/07/2012
--	---	--	---

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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for the Investigation of Complaint IN00111130.</p> <p>Complaint IN00111130 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: September 7 and 10, 2012</p> <p>Facility number: 000368 Provider number: 15E187 Aim number: 100275220</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Heather Tuttle, RN (9/7/12)</p> <p>Census bed type: NF: 25 Total: 25</p> <p>Census payor type: Medicaid: 24 Other: 1 Total: 25</p> <p>Sample: 3</p> <p>These deficiencies reflect state</p>	F0000		
-------	---	-------	--	--

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.

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 09/07/2012
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	findings cited in accordance with 410 IAC 16.2. Quality review completed 9/11/12 Cathy Emswiler RN				

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 09/07/2012
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure the residents were free of physical restraints, related to an improperly applied self-release belt for 1 of 1 residents observed with a self-release belt in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B was observed on 9/7/12 at 8:40 a.m., seated in a wheelchair. There was a belt around his waist. The release buckle of the belt was observed in the center of the back of the wheelchair. The release buckle could not be reached by the resident.</p> <p>The resident was again observed on 9/7/12 at 9:20 a.m. and at 10:15 a.m. The resident had a belt on with the release buckle in the center of the back of the wheelchair, out of the resident's reach.</p> <p>Resident #B was observed on 9/7/12 at 1:10 a.m., coming out of the dining room after lunch in his wheelchair. The resident</p>	F0221	<p>1. Resident B self-release belt was immediately turned around and applied properly. An immediate inservice was given to the C.N.A.'s working on the day shift on proper restraint application of a self-release belt. Charge nurses were immediately notified of the deficient practice. Restraint Policy was given to the entire nursing staff. 2. No other residents were affected. 3. In-service was held with all shifts and Restraint Policy given to the entire nursing staff. Charge Nurses are required to complete Nurse Rounds Sheets and monitor proper restraint application at 12am, 3am, 5am, 8am, 11am, 2pm, 4pm, 6pm, 9pm. Clarification between a safety belt and self release belt restraint was done by the D.O.N. Physical Therapist will evaluate the 3 residents with self releasing belt restraints. 4. Charge Nurse will monitor proper restraint use according to nurse round sheet. Charge Nurse will notify P.T. of any new restraint orders and complete restraint assessments quarterly. D.O.N. will monitor proper restraint use daily Mon-Fri for 1 week. D.O.N.</p>	10/07/2012	

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 09/07/2012	
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>again had a belt in place around his waist that had the release buckle in the center of the back of the wheelchair.</p> <p>On 9/7/12 at 2:50 p.m., the resident was seated in his wheelchair in the hall. The resident had the belt around his waist. The belt was positioned under his seat, the release buckle was observed under the wheelchair seat. It was not within the resident's reach.</p> <p>Interview with LPN #1 on 9/7/12 at 2:55 p.m., indicated the self-release belt was not applied correctly. She indicated the resident could not reach the release buckle.</p> <p>Interview with CNA #1 on 9/7/12 at 3:00 p.m., indicated she was not aware the release buckle for Resident #B's belt was to be placed in front of his body so that he could release the belt. She indicated she thought it was to be positioned behind him so he could not reach it.</p> <p>The record for Resident #B was reviewed on 9/7/12 at 10:10 a.m. The resident had diagnoses that included, but were not limited to, Alzheimer's Disease and anxiety disorder.</p> <p>The resident had a fall on 5/1/12. The form titled, "Post Fall Preventions</p>		<p>will monitor nurse round sheet weekly times 1 month then monthly if no deficeint practice is noted. Physical Therapist will assess all new admissions if restraint devices are needed, new restraint device orders and update assessments for residents needing restraints quarterly. Q.A. Committee will monitor proper restraint usage quaterly. 5. 10/7/12</p>				

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 09/07/2012
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Assessment" dated 5/1/12, indicated the resident was confused and required staff assistance for transfers. Documentation on the form titled "Change in Condition" and dated 5/2/12, indicated the resident had generalized weakness and unsteady gait.</p> <p>There was a physician's order, dated 8/7/12, that indicated, "N.O. (new order) for self-release belt while in the w/c (wheelchair)." The indication for the use of the self-release belt was for, "fall risk."</p> <p>Interview with the Director of Nursing on 9/7/12 at 3:10 p.m., indicated the resident has a physician's order for a self-release belt. She indicated the release buckle on the belt was to be positioned so the resident could reach it and release it. She indicated the self-release belt had been applied incorrectly and the resident could not release the belt as it was applied.</p> <p>3.1-26(o)</p>				

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 09/07/2012	
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0323 SS=D	<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 ensure the residents' environment was free from hazards related to the use of side rails with an opening greater than 4 and 3/4 inches in size for 1 resident in a sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>Observation during orientation tour on 9/7/12 at 8:50 a.m., revealed 1 side rail was elevated on Resident #C's bed. The resident was not in the bed at the time of the tour. Interview with LPN #1, at the time of tour, indicated Resident #C had fallen in the past week while ambulating with her daughter. She also indicated the resident had cognitive impairment.</p> <p>On 9/7/12 at 9:30 a.m., the side rails on Resident C's bed were measured. One rail was elevated the second rail was not elevated. The side rails had two openings between the metal bars, the openings measured 5 inches in width by 30 inches in length.</p>	F0323	<p>1. Resident C side rails were immediately removed from her bed and new side rails applied. D.O.N. did an inventory on every bed in the facility and stored side rails. All side rails measuring over 4 3/4 were thrown away. 2. No other resident was affected. 3. All side rails measuring 4 3/4 rails have been discarded so this will never reoccur. 4. No other side rails will be purchased due to the high inventory of proper side rails and low side rail usage. This will never reoccur. 5. 9/10/12</p>	09/10/2012			

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 09/07/2012
--	---	--	---

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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued observations throughout the day on 9/7/12, indicated the resident was not in bed.</p> <p>The record for Resident #C was reviewed on 9/7/12 at 11:30 a.m. The resident had diagnoses that included, but were not limited to, dementia, agitation and arthritis.</p> <p>The Hospital History and Physical dated 5/3/12, indicated the resident had severe confusion and altered mental status. Therapy for Alzheimer's Disease was initiated at that time.</p> <p>The admission nursing notes, dated 5/7/12, indicated, the resident was confused and oriented to self only. The form titled, "Side Rail Assessment" and dated 5/7/12, indicated the resident had a cognitive deficit due to dementia with agitation.</p> <p>Information retrieved from the web site, "www.fda.gov/cdrh/beds" on 9/11/12, indicated the risks for body part entrapment related to bed rails were: "Within the Rail; Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size</p>			

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 09/07/2012
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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of the space. The HBSW (Hospital Bed Safety Workgroup) and IEC (International Electrotechnical Commission) recommend that the space be less than 120 mm(millimeters) (4 3/4 inches), representing head breath."</p> <p>Interview with the Director of Nursing on 9/7/12 at 2:40 p.m., indicated the side rails on Resident C's bed had openings that were greater than 4 and 3/4 inches. She indicated that she had worked the previous night. The Director of Nursing indicated she had moved the bed with the siderails, from an unoccupied room, so that the resident could use the side rails as enablers for positioning in the bed, during the previous night. She indicated the resident had that bed with those siderails for only one day.</p> <p>3.1-45(a)(1)</p>				