PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 05/03/2021	
	PROVIDER OR SUPPLIEF	HEALTH FACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP CODE 11ST AVE IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
E 0000		·			
Bldg	conducted by the Ir in accordance with Survey Date: 05/03 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Simmons Loving C in compliance with Requirements for M Participating Provided 483.73	3/2021 000368 155845 2752200 Preparedness survey, Pare Health Facility was found Emergency Preparedness Medicare and Medicaid Elers and Suppliers, 42 CFR	E 0000		
K 0000 Bldg. 01	the survey, the cens Quality Review con A Life Safety Code Licensure Survey w	Recertification and State was conducted by the Indiana lth in accordance with 42 8/2021 900368 155845	K 0000		
		Code survey, Simmons			

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

TITLE

(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.

Facility ID:

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	01	COMPL	
		155845	B. WING			05/03/	/2021
			ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		70	0 E 21	IST AVE		
SIMMON	S LOVING CARE H	IEALTH FACILITY	G/	ARY, I	N 46407		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	-	Facility was found not in					
	-	equirements for Participation					
		edicaid, 42 CFR Subpart					
		ety from Fire and the 2012					
	edition of the Nation	nal Fire Protection					
) 101, Life Safety Code					
		Existing Health Care					
	Occupancies and 41	0 IAC 16.2.					
	This one story facili	ity with a partial basement,					
	built in 1967, was d	etermined to be of Type II					
	(111) construction a	and was fully sprinklered.					
	The facility has a fir	re alarm system with smoke					
	detection in the corr	ridors and spaces open to the					
	corridor. The facilit	y has no emergency power					
	protection. Twenty	resident rooms were provided					
	with battery operate	ed smoke detectors. The					
	facility has the capa	city for 46 and had a census					
	of 20 at the time of	this survey.					
	All areas accessible	to residents and areas					
	providing facility se	ervices were sprinklered.					
	Quality Review con	npleted on 05/07/21					
K 0211	NFPA 101			İ			
SS=F	Means of Egress -	- General					
Bldg. 01	Means of Egress -	- General					
	Aisles, passagewa	ays, corridors, exit					
	discharges, exit lo	cations, and accesses are					
	in accordance with	n Chapter 7, and the					
	means of egress is	s continuously maintained					
	free of all obstruct	ions to full use in case of					
	emergency, unless	s modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1						
		riew, observation and	K 0211		1. What corrective action will be		06/02/2021
		ty failed to ensure 1 of 5			accomplished for those reside		
		s continuously maintained			found to have been affected by	y	
	free of all obstruction	ons or impediments to full			the deficient practice?		
	l		1				1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01	COMPLETED
155845	B. WING	05/03/2021
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845 NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility from the dining room. Findings include: Based on observation during a facility survey with the Unit Manager on 05/03/2021 at 12:52 p.m. a chair was obstructing the dining room east exit. Based on interview at the time of observation, the Unit Manager agreed the chair was obstructing the exit and moved it out of the	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP OF THE TRANSPORT OF	COMPLETED 05/03/2021 CODE RERECTION SHOULD BE APPROPRIATE Y removed To monitor and keep S.
path of egress. This deficient finding was reviewed with the Administrator at the time of exit.	potential to be affecte same deficient practice identified and what con action will be taken. No resident affected. 3. What measures will place or what systeming will be made to ensure deficient practice does. All staff in-serviced not any pathways of egrestime. Unit Manager will more pathways of egress day week times 3 weeks of Charge Nurse will more pathways of egress the each shift daily throug ongoing. Administrator/Designer monitoring weekly for then monthly x 3 mone quarterly ongoing.	d by the se will be sorrective I be put into a changes e that the sont recur. In to block so at any enter all aily 5 days a during day. In the formation into a formation in the formation in t

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	OF CORRECTION	IDENTIFICATION NUMBER: 155845	 JILDING	01	COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP CODE 21ST AVE IN 46407	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Q.A. Committee will review monitoring monthly times 3 months then semi-annually to ensure compliance. 4. Describe who will be the person(s) responsible for implementing and monitoring plan for future compliance with regulations. Staff in-serviced not to block a pathways of egress at any time will be performed upon hire are quarterly, thereafter ongoing. Unit Manager will monitor all pathways of egress daily 5 day week times 3 weeks during day Charge Nurse will monitor pathways of egress throughout each shift daily throughout shift ongoing. Administrator/Designee will remonitoring weekly for 3 weeks then monthly x 3 months then quarterly ongoing. Q.A. Committee will review monitoring monthly times 3	the h the any le and ys a ay. ut lift, eview s	DATE
				months then semi-annually to ensure compliance. 5. Completion Date: 6/2/21		
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lightii Emergency Lightii					

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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 COMPLETED 01 155845 B. WING 05/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 K 0291 what corrective action(s) will 06/02/2021 Based on observation and interview, the facility failed to ensure 2 of 22 battery powered be accomplished for those emergency lights were maintained in accordance residents found to have been affected by the deficient practice; with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with New emergency lights installed. suitable facilities for maintaining them in Staff will continue to test emergency lights monthly and properly charged condition. Batteries used in such lights or units shall be approved for their record results. intended use and shall comply with NFPA 70 how other residents having National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either the potential to be affected by the continuously in operation or shall be capable of same deficient practice will be identified and what corrective repeated automatic operation without manual action(s) will be taken; intervention. This deficient practice could affect 7 residents in the East Wing, staff and visitors in No one affected at this time. the facility. what measures will be put into place and what systemic changes will be made to ensure Findings include: that the deficient practice does During a tour of the facility with the Unit not recur; Manager on 05/03/2021 at 12:17 p.m. the Backup emergency light will be battery powered emergency light in the East kept on hand. Wing near room E105 failed to function when its Emergency light monthly testing will be ongoing by maintenance respective test button was pushed five times. Then, at 12:30 p.m. the battery powered staff. emergency light at the bottom of the stairwell Unit manager will monitor logs and failed to function when its respective test button emergency lights monthly. was pushed five times. Based on interview at the New maintenance staff will be in-serviced on emergency light time of the observations, the Unit Manager agreed that the lights did not operate when tested. testing ongoing. Administrator will monitor monthly This deficient finding was reviewed with the testing logs quarterly, ongoing. Administrator at the time of the exit. how the corrective action(s) will be monitored to ensure the 3.1-19(b) deficient practice will not recur,

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION ADDITION)) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION ADDITION) TAG COMPLETED TO THE APPROPRIATE DEFICIENCY) DATE i.e., what quality assurance	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845		CTION IDENTIFICATION NUMBER: 155845 A. BUILDING B. WING	COMPLETED 05/03/2021
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION ADDITION)) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION ADDITION) TAG COMPLETED TO THE APPROPRIATE DEFICIENCY) DATE i.e., what quality assurance			700 E 21ST AVE	
	PREFIX (EACH DI	DEFICIENCY MUST BE PRECEDED BY FULL	CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
K 0311 SS=E Bldg. 01 NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.	K 0311 NFPA 101 SS=E Vertical Ope 2012 EXIST Stairways, e ventilation s openings be construction at least 1 he accordance 19.3.1.1 thr If all vertica with constru fire resistan box. Based on ob- failed to ensi	1 Openings - Enclosure Openings - Enclosure Openings - Enclosure STING Side elevator shafts, light and In shafts, chutes, and other vertical Obetween floors are enclosed with It is in having a fire resistance rating of It hour. An atrium may be used in It is with 8.6. It is hough 19.3.1.6 It is call openings are properly enclosed It is truction providing at least a 2-hour It is an arrive in the facility It is observation and interview, the facility Insure the protection of 1 of 2	i.e., what quality assurance program will be put into place Emergency light monthly testivill be ongoing by maintenance staff. Unit manager will monitor loge emergency lights monthly. New maintenance staff will be in-serviced on emergency light testing ongoing. Administrator will monitor montesting logs quarterly, ongoing Q.A. Committee will review in-service and procedure logs quarterly for 3 months then semi-annually. - by what date the system changes will be completed. 6/2/21 IOPenings - Enclosure LISTING and the system changes will be completed. 6/2/21 In the system changes will be completed. 6/2/21	ing ce s and ent inthly g. s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/03/2021
	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)	(X5) COMPLETION DATE
	states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect 7 residents on the East Hall. Findings include: During a facility tour with the Unit Manager on 05/03/2021 at 1:15 p.m. two unsealed penetrations were found above the suspended ceiling tile in the corridor side of the stairwell. Based on interview at the time of observation, the Unit Manager agreed that the penetrations were not sealed. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		affected by the deficient practic Two areas were immediately sealed with 3M approved smoth barrier caulk product. Unit Manager will monitor repain building as repairs are done ensure not wall penetration or without being caulked, ongoin - how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be purinto place and what systemic changes will be made to ensure that the deficient practice does not recur; Unit Manager will monitor repain building as repairs are done ensure not wall penetration or without being caulked, ongoin Maintenance Staff will be responsible for filling areas wifire barrier caulking and record it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are performs how the corrective action will be monitored to ensure the deficient practice will not recurite, what quality assurance program will be put into place; Unit Manager will monitor repair logs.	ke airs to cours g

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155845		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/03/2021	
	ROVIDER OR SUPPLIER S LOVING CARE HEALTH F	ACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP CODE 11ST AVE IN 46407	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosu Hazardous Areas - Enclosu Hazardous Areas are protect barrier having 1-hour fire reservity (with 3/4 hour fire rated doo automatic fire extinguishing accordance with 8.7.1 or 19 approved automatic fire exti option is used, the areas sh from other spaces by smoke partitions and doors in acco Doors shall be self-closing of automatic-closing and perm nonrated or field-applied protect that do not exceed 48 inche of the door. Describe the floor and zone hazardous areas that are de REMARKS. 19.3.2.1, 19.3.5.9	ted by a fire sistance rating rs) or an system in .3.5.9. When the nguishing system all be separated e resisting rdance with 8.4. or itted to have otective plates s from the bottom		in building as repairs are done ensure not wall penetration or without being caulked, ongoing Maintenance Staff will be responsible for filling areas with fire barrier caulking and record it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are performed Q.A. Committee will review replogs and fire barrier caulking losemi-annually. - by what date the systemic changes will be completed. 6/2/21	curs g. th ding ed. pair

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED	
		155845	B. W	ING		05/03/	′2021
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					21ST AVE		
SIMMON	IS LOVING CARE I	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Area	Automatic Sprinkler					
	Separation	•					
		-Fired Heater Rooms					
		er than 100 square feet)					
	, -	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)	Johns (exceeding 04					
	e. Trash Collectio	n Booms					
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
		classified as Severe					
	Hazard - see K322)						
		on and interview, the facility	K 0	321	- what corrective action(s)	WIII	06/02/2021
		east 4 hazardous areas such as			be accomplished for those		
		rooms containing fuel fired			residents found to have been		
		parated from other spaces by			affected by the deficient practi	ce;	
	_	titions and doors. Doors					
		g or automatic closing in			a. Front office/conference		
		2.1.8. This deficient practice			room self-closure device adde	ed to	
		dents, staff and visitors in the			door.		
		ed Utility room near the North			b. Janitors room in baseme		
	Hall nurse's station				self-closure device added to d	oor.	
					c. Mrs. Miller's storage		
	Findings include:				deadbolt was removed and		
					replaced with a locking doorkr	nob.	
	During a tour of the	e facility with the Unit			d. Wire was removed and d	oor	
	Manager on 05/03/2	2021 from 12:10 p.m. to			self closes.		
	1:15 p.m., the follo	wing was observed:					
	a) The front office/	conference room contained a			- how other residents havi	ng	
	large amount of par	per in boxes. The corridor			the potential to be affected by	the	
	door did not self-cle	ose. Based on interview at			same deficient practice will be		
	the time of observa	tion, the Unit Manager agreed			identified and what corrective		
		hazardous area due to the			action(s) will be taken;		
	amount of paper.				No one affected at this time.		
		in the basement contained a			- what measures will be pu	ut	
		rage in boxes. The room was			into place and what systemic		
		f-closing device, however			changes will be made to ensu	re	
		or did not close at latch into			that the deficient practice does		
		n interview, the Unit Manager			not recur;		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155845	A. BUILDING 01 B. WING		COMPLETED 05/03/2021
	ROVIDER OR SUPPLIER S LOVING CARE H		700	ET ADDRESS, CITY, STATE, ZIP CODE E 21ST AVE RY, IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	into the frame when c) "Ms. Miller's" Ro contained storage. The equipped with a self door was only secur and did not positively Based on interview at the Unit Manager as positively latch into d) The laundry room equipment, had a coself-closed, however a wire. Based on introbservation, the Unit door was held open self-close.	om in the basement The corridor door was c-closing device, however the ed with a manual deadbolt y latch into the door frame. at the time of observation, greed that the door did not the frame. a, which contained fuel-fired rridor door which r, the door was held open by terview at the time of t Manager agreed that the by a wire and would not g was reviewed with the		Backup emergency light will be kept on hand. In-service held with custodial laundry staff about deficient practices. Unit manager will monitor prodoor closure logs monthly. Maintenance will be responsite for completing door closure logs monthly. Administrator will monitor logs monthly times 3 months then quarterly, ongoing. - how the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Unit manager will monitor prodoor closure logs monthly. Maintenance will be responsite for completing door closure logs monthly. Administrator will monitor logs monthly times 3 months then quarterly, ongoing. Q.A. Committee will review loguarterly for 3 months then semi-annually. by what date the system changes will be completed. 6/2/21	and per ple gs an(s) e r, ; and per ple gs
K 0511 SS=D	NFPA 101 Utilities - Gas and	Electric			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		01	COMPLETED	
		155845	B. WI	NG		05/03/2021	
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SIMMONS LOVING CARE HEALTH FACILITY				21ST AVE			
SIMIMON	S LOVING CARE H	IEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 01	Utilities - Gas and	Electric					
	Equipment using g	gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
	Code, electrical wi	ring and equipment					
	complies with NFF	PA 70, National Electric					
	Code. Existing ins	tallations can continue in					
	service provided n	o hazard to life.					
	18.5.1.1, 19.5.1.1,	9.1.1, 9.1.2					
		on, the facility failed to	K 0:	511	What corrective action will be		06/02/2021
		cal junction boxes observed			accomplished for those reside		
	were maintained in	a safe operating condition.			found to have been affected by	у	
	_	es utilities comply with			the deficient practice?		
		1.2 requires electrical wiring					
		omply with NFPA 70,			Electrical plate covers were		
		Code. NFPA 70, 2011			immediately purchased and		
		.28(3) (c) states junction			placed over junction boxes on		
	_	ded with covers compatible			east exit light and dining room		
		itable for the conditions of			emergency light.		
		netal covers shall comply with			2. How other residents having	the	
		rements of 250.110. This			potential to be affected by the		
	deficient practice co	ould affect staff only.			same deficient practice will be		
					identified and what corrective		
	Findings include:				action will be taken.		
	-	facility with the Unit			No resident affected.		
	-	21 from 12:10 p.m. to 1:15			3. What measures will be put i		
		conditions were found:			place or what systemic change		
		ergency light was missing a			will be made to ensure that the		
	cover plate.				deficient practice does not rec	ur.	
	· -	oom exit emergency light was			l., ., .,		
	missing a junction b	-			Unit Manager will assign mont	•	
	Based on interview				surveillance of all junction box		
		it Manager agreed that the			covers on emergency lights the	IS	
	electrical boxes wer	e missing cover plates.			will be added to the monthly	aal	
	This defines the tr				emergency light testing audit to	001.	
		ng was reviewed with the			Linit Managar will in asmits		
	Administrator at the	time of exit.			Unit Manager will in-service		
	2 1 10/1-)				maintenance staff to additiona	I	
	3.1-19(b)				monitoring on new audit tool.		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/03/2021
SIMMON	PROVIDER OR SUPPLIEF	HEALTH FACILITY	700 E : GARY,	ADDRESS, CITY, STATE, ZIP CODE 21ST AVE , IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				Administrator/Designee will rulog sheets monthly x 3 month then semi-annually, ongoing ensure compliance.	ns
				4. Describe who will be the person(s) responsible for implementing and monitoring plan for future compliance wiregulations.	
				Unit Manager will in-service maintenance staff to addition monitoring on new audit tool.	
				Administrator/Designee will re log sheets monthly x 3 month then semi-annually, ongoing ensure compliance.	ns
				Unit Manager will submit log sheets to Administrator and Committee for review monthl ensure compliance x 3 month months then semi-annually ongoing. 5. Completion Date: 6/2/21	y to
K 0712 SS=F Bldg. 01	alarm signal and s fire conditions. Fir expected and une varying conditions shift. The staff is f	the transmission of a fire simulation of emergency e drills are held at xpected times under s, at least quarterly on each amiliar with procedures drills are part of established		3,02	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155845		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/03/2021				
	PROVIDER OR SUPPLIEF		700 E	ADDRESS, CITY, STATE, ZIP CODE 21ST AVE , IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR routine. Where di 9:00 PM and 6:00 announcement maudible alarms. 19.7.1.4 through 1	ay be used instead of	ID PREFIX TAG K 0712	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) - What corrective action(s)	DATE	
	facility failed to confire drills during the period. LSC 19.7.1 conducted quarterly conditions. Due to Emergency, docum lieu of fire drills, as practice affects all surface affects affec	anduct 2 of 12 quarterly shift to most recent 12 month time and recent 12 month time and requires drills to be an each shift under varied the COVID-19 Public Health tented training may be used in allowed. This deficient staff and residents. The work with the Director of 1021 at 11:00 a.m., the to provide documentation of the draining for the third shift ter of 2020, or second shift of 1. Based on interview at the term, the Director of Nursing amentation could not be the same was reviewed with the		be accomplished for those residents found to have been affected by the deficient pract. Fire Drill held on the fourth she Fire Drill schedule reviewed was unit manager. - how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be pinto place and what systemic changes will be made to ensuthat the deficient practice does not recur; In-service held with Unit Manawho will be responsible for he fire drills according to fire drill schedule. Fire Drill logs will be revied by Administrator as they monthly occur. - how the corrective action will be monitored to ensure the deficient practice will not recurive, what quality assurance program will be put into place.	ice; ift. vith ing the e ut ure s ager olding / / n(s) e r,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845		ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE 21ST AVE	(X3) DATE SURVEY COMPLETED 05/03/2021
		HEALTH FACILITY	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) COMPLETIC DATE	
				In-service held with Unit Mana who will be responsible for ho fire drills according to fire drill schedule. Fire Drill logs will be revied by Administrator as they monthly occur. Q.A. Committee will review fir drills q 3 months and semi-annually thereafter. - by what date the system changes will be completed. 6/2/21	olding

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