STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING -- B. WING	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 46 certified beds. At the time of the survey, the census was 20. Quality Review completed on 05/07/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 At this Life Safety Code survey, Simmons	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement 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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	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 20 at the time of this survey. All areas accessible to residents and areas providing facility services were sprinklered. Quality Review completed on 05/07/21			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on record review, observation and interview; the facility failed to ensure 1 of 5 means of egress was continuously maintained free of all obstructions or impediments to full	K 0211	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	06/02/2021

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	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 path of egress. This deficient finding was reviewed with the Administrator at the time of exit.		Chair was immediately removed from path of egress. All staff made aware to monitor pathways of egress and keep them clear at all times. Nursing staff notified that when resident moves the furniture try to redirect him but place furniture where it does not block any pathways of egress. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No resident affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All staff in-serviced not to block any pathways of egress at any time. Unit Manager will monitor all pathways of egress daily 5 days a week times 3 weeks during day. Charge Nurse will monitor pathways of egress throughout each shift daily throughout shift, ongoing. Administrator/Designee will review monitoring weekly for 3 weeks then monthly x 3 months then quarterly ongoing.	

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			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 the plan for future compliance with the regulations. Staff in-serviced not to block any pathways of egress at any time will be performed upon hire and quarterly, thereafter ongoing. Unit Manager will monitor all pathways of egress daily 5 days a week times 3 weeks during day. Charge Nurse will monitor pathways of egress throughout each shift daily throughout shift, ongoing. Administrator/Designee will review monitoring weekly for 3 weeks then monthly x 3 months then quarterly ongoing. Q.A. Committee will review monitoring monthly times 3 months then semi-annually to ensure compliance. 5. Completion Date: 6/2/21	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting			

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	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 Based on observation and interview, the facility failed to ensure 2 of 22 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 7 residents in the East Wing, staff and visitors in the facility. Findings include: During a tour of the facility with the Unit Manager on 05/03/2021 at 12:17 p.m. the battery powered emergency light in the East Wing near room E105 failed to function when its respective test button was pushed five times. Then, at 12:30 p.m. the battery powered emergency light at the bottom of the stairwell failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, the Unit Manager agreed that the lights did not operate when tested. This deficient finding was reviewed with the Administrator at the time of the exit. 3.1-19(b)	K 0291	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New emergency lights installed. Staff will continue to test emergency lights monthly and record results. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Backup emergency light will be kept on hand. Emergency light monthly testing will be ongoing by maintenance staff. Unit manager will monitor logs and emergency lights monthly. New maintenance staff will be in-serviced on emergency light testing ongoing. Administrator will monitor monthly testing logs quarterly, ongoing. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	06/02/2021

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			i.e., what quality assurance program will be put into place; and Emergency light monthly testing will be ongoing by maintenance staff. Unit manager will monitor logs and emergency lights monthly. New maintenance staff will be in-serviced on emergency light testing ongoing. Administrator will monitor monthly testing logs quarterly, ongoing. Q.A. Committee will review in-service and procedure logs quarterly for 3 months then semi-annually. - by what date the systemic changes will be completed. 6/2/21	
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. Based on observation and interview, the facility failed to ensure the protection of 1 of 2 stairwells in accordance of 19.3.1. LSC 19.3.1.1	K 0311	- what corrective action(s) will be accomplished for those residents found to have been	06/02/2021

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	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 practice; Two areas were immediately sealed with 3M approved smoke barrier caulk product. Unit Manager will monitor repairs in building as repairs are done to ensure not wall penetration occurs without being caulked, ongoing. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Unit Manager will monitor repairs in building as repairs are done to ensure not wall penetration occurs without being caulked, ongoing. Maintenance Staff will be responsible for filling areas with fire barrier caulking and recording it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are performed. - 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; and Unit Manager will monitor repairs	

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			in building as repairs are done to ensure not wall penetration occurs without being caulked, ongoing. Maintenance Staff will be responsible for filling areas with fire barrier caulking and recording it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are performed. Q.A. Committee will review repair logs and fire barrier caulking log semi-annually. - by what date the systemic changes will be completed. 6/2/21	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure at least 4 hazardous areas such as storage rooms, and rooms containing fuel fired equipment were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors in the vicinity of the Soiled Utility room near the North Hall nurse's station. Findings include: During a tour of the facility with the Unit Manager on 05/03/2021 from 12:10 p.m. to 1:15 p.m., the following was observed: a) The front office/conference room contained a large amount of paper in boxes. The corridor door did not self-close. Based on interview at the time of observation, the Unit Manager agreed that the room was a hazardous area due to the amount of paper. b) The janitor room in the basement contained a large amount of storage in boxes. The room was equipped with a self-closing device, however when tested, the door did not close at latch into the frame. Based on interview, the Unit Manager	K 0321	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. Front office/conference room self-closure device added to door. b. Janitors room in basement self-closure device added to door. c. Mrs. Miller's storage deadbolt was removed and replaced with a locking doorknob. d. Wire was removed and door self closes. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	06/02/2021

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	agreed that the door did not fully close and latch into the frame when tested. c) "Ms. Miller's" Room in the basement contained storage. The corridor door was equipped with a self-closing device, however the door was only secured with a manual deadbolt and did not positively latch into the door frame. Based on interview at the time of observation, the Unit Manager agreed that the door did not positively latch into the frame. d) The laundry room, which contained fuel-fired equipment, had a corridor door which self-closed, however, the door was held open by a wire. Based on interview at the time of observation, the Unit Manager agreed that the door was held open by a wire and would not self-close. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		Backup emergency light will be kept on hand. In-service held with custodial and laundry staff about deficient practices. Unit manager will monitor proper door closure logs monthly. Maintenance will be responsible for completing door closure logs monthly. Administrator will monitor logs monthly times 3 months then quarterly, ongoing. - - 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; and Unit manager will monitor proper door closure logs monthly. Maintenance will be responsible for completing door closure logs monthly. Administrator will monitor logs monthly times 3 months then quarterly, ongoing. Q.A. Committee will review logs quarterly for 3 months then semi-annually. - by what date the systemic changes will be completed. 6/2/21	
K 0511 SS=D	NFPA 101 Utilities - Gas and Electric			

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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, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 2 of 2 electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff only. Findings include: During a tour of the facility with the Unit Manager on 5/3/2021 from 12:10 p.m. to 1:15 p.m., the following conditions were found: a) The east exit emergency light was missing a cover plate. b) The east dining room exit emergency light was missing a junction box coverplate. Based on interview at the time of each observation, the Unit Manager agreed that the electrical boxes were missing cover plates. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)	K 0511	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Electrical plate covers were immediately purchased and placed over junction boxes on the east exit light and dining room emergency light. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No resident affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Unit Manager will assign monthly surveillance of all junction box covers on emergency lights this will be added to the monthly emergency light testing audit tool. Unit Manager will in-service maintenance staff to additional monitoring on new audit tool.	06/02/2021

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			Administrator/Designee will review log sheets monthly x 3 months then semi-annually, ongoing to ensure compliance. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Unit Manager will in-service maintenance staff to additional monitoring on new audit tool. Administrator/Designee will review log sheets monthly x 3 months then semi-annually, ongoing to ensure compliance. Unit Manager will submit log sheets to Administrator and Q.A. Committee for review monthly to ensure compliance x 3 months x 3 months then semi-annually ongoing. 5. Completion Date: 6/2/21	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established			

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	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct 2 of 12 quarterly shift fire drills during the most recent 12 month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. Due to the COVID-19 Public Health Emergency, documented training may be used in lieu of fire drills, as allowed. This deficient practice affects all staff and residents. Findings include: During record review with the Director of Nursing on 05/03/2021 at 11:00 a.m., the facility was unable to provide documentation of fire drills or approved training for the third shift for the fourth quarter of 2020, or second shift of first quarter of 2021. Based on interview at the time of record review, the Director of Nursing agreed that the documentation could not be provided. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) 3.1-51(c)	K 0712	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire Drill held on the fourth shift. Fire Drill schedule reviewed with unit manager. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-service held with Unit Manager who will be responsible for holding fire drills according to fire drill schedule. Fire Drill logs will be revied by Administrator as they monthly occur. - 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; and	06/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 01 B. WING	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	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
			In-service held with Unit Manager who will be responsible for holding fire drills according to fire drill schedule. Fire Drill logs will be revied by Administrator as they monthly occur. Q.A. Committee will review fire drills q 3 months and semi-annually thereafter. - - by what date the systemic changes will be completed. 6/2/21	