

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2014
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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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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/22/14</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 100275220</p> <p>Surveyors: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Simmons Loving Care Health Facility was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement 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 in spaces open to the corridor. Twenty resident rooms were</p>	K010000	Simmons Loving Care would like to ask for a desk review for the following 4 deficiencies cited.	
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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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K010038 SS=E	<p>provided with battery operated smoke detectors. The facility has a capacity of 46 and had a census of 26 at the time of this survey.</p> <p>All areas accessible to residents and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure a handrail was provided for 1 of 2 exits with a ramp. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4 Exception #3 allows existing ramps shall be permitted to have handrails on one side only. This deficient practice could affect 6 staff, visitors and</p>	K010038	<p>1 The facility was required to install exit ramps over 3 years ago At that time handrails were not required to be installed with the ramps, so the facility was unaware of this regulation</p> <p>2 No one was harmed by the lack of handrails</p> <p>3 The handrails will be installed on the ramp where the rise is greater than 6 inches The hand rails will be ordered and installed by a contractor when handrails are received</p>	05/22/2014

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	<p>any resident in the east wing smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 04/21/14 at 1:35 p.m. with Maintenance # 1, the east exit from the east sleeping room corridor had a twelve foot long ramp with a grade change of at least eight inches from top to bottom. The ramp was not provided with a handrail. Maintenance # 1 acknowledged at the time of observation, the drop off from the side of the ramp could be unsafe.</p> <p>3.1-19(b)</p>		<p>4 Handrails will me monitored for stability quarterly and inspections will be logged on a log sheet</p>				
K010064 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to provide 2 of 10 portable fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each</p>	K010064	<p>1a. Facility was unaware of the height requirements for the fire extinguisher of 40 pounds or less be placed no more than 5 feet above the floor and those over 40 pounds placed 3 1/2 feet off the floor.</p>	05/08/2014			

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	<p>extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating the date of 6 year maintenance. This deficient practice could affect visitors, staff and 26 residents in the dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with maintenance # 1 on 04/22/14 between 11:30 a.m. and 1:00 p.m., manufacture dates for the portable ABC fire extinguisher in the kitchen and in the basement near the fire panel could not be found. The fire</p>		<p>1 b. Fire Science was contacted which is the company which services our fire extinguishers The facility had not been asked about the verification of service on our portable fire extinguishers before Fire Science provided the facility with a Portable Fire Extinguishers Inspection Report 2 a & b No one was harmed by the verification of service collar not being on 2 fire extinguishers or wrong height for extinguishers. 3a 2 Fire Extinguishers were relocated to the right height 3b The Portable Fire Extinguishers Inspection Report included the following: Unit Size Agent Six Year Date Mfr Date or Hydro Date 1 5 ABC 2015 2009 2 5 ABC 2015 2009 3 5 ABC 2015 2009 4 10 ABC 2009 n/a to this rule they were hydro tested 09 5 10 ABC 2020 2014 was replaced 6 5 ABC 2014 2007 6 CLASS K 2009 n/a to this rule they were hydro tested 09 8 10 ABC 2016 2010 9 5 CO2 2008 n/a to this rule they were hydro tested 08 10 5 ABC 2020 2014 was replaced 4 Portable Fire Extinguishers Inspection Report is the facility's verification of service This report will be kept in the Life Safety Log Book and reviewed annually by maintenance personnel and fire science</p>				

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	<p>extinguishers had no verification of service collars. No documentation for the manufacture dates was included in the fire extinguisher records provided for review on 04/22/14 at 2:15 p.m. Maintenance # 1 said at the time of record review, he didn't know anything about the manufacture dates.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 14 portable fire extinguishers were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with Maintenance # 1 on 04/22/14 between 11:30 a.m. and 11:50 a.m., portable fire extinguishers were located immediately east and west of the smoke barrier door near room 101. The fire extinguisher was located 69 inches above the finished floor on the</p>						

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K010074 SS=E	<p>east side of the smoke barrier. The fire extinguisher on the west side of the smoke barrier hung 66 inches above the floor. Maintenance # 1 acknowledged at the time of observations, the fire extinguishers were located above the maximum height of 60 inches.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the</p>	K010074	1 Plastic Film was removed off of the window 2 No one was harmed	04/22/2014			

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	<p>facility failed to ensure a loosely hanging film in 1 of 3 smoke compartments was flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires loosely hanging furnishings to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 11 residents in the West wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance # 1 on 04/22/14 at 1:30 p.m., a 108 inch by 48 inch clear plastic sheet hung over the window in resident room 118 and it was secured with duct tape The film had no flame resistance labeling and Maintenance # 1 said at the time of observation, he didn't think it was flame resistant.</p> <p>3.1-19(b)</p>		<p>by the plastic film on the window 3 Maintenance staff will monitor rooms to ensure all loosely hanging furnishings to have flame resistance tag present for inspection 4 Maintenance Supervisor is responsible for applying flame retardant on items as needed and applying tags Log book is updated on items which require flame retardant and reviewed by administrator or designee semi-annually</p>		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, and 2 or more staff accessing storage rooms and the laundry located in the basement.</p> <p>Findings include:</p> <p>Based on observation with Maintenance # 1 on 04/22/14 at 2:00 p.m., two ceiling junction boxes in the common area housing the fire panel were left uncovered with multiple wires exposed. Maintenance # 1 acknowledged at the time of observation, the boxes should have been covered.</p> <p>3.1-19(b)</p>	K010147	<p>1 Two ceiling junction boxes were covered by outside contractor 2 No one was harmed by the 2 boxes being uncovered 3 Maintenance Supervisor inspected all electrical plates in the building and all plates were covered 4 Facility will monitor for loose wire exposer monthly and log sheet will be completed by maintenance staff and reviewed quarterly by administrator or designee</p>	04/23/2014			

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

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