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

FORM APPROVED
OMB NO. 0938-0391

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	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/16/22 Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 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 24. Quality Review completed on 05/18/22	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: 05/16/22 Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 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 24 at the time of this survey. All areas accessible to residents and areas providing facility services were sprinklered. Quality Review completed on 05/18/22			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting 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 over 10 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	K 0291	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The emergency light in the dining room was replaced with a new emergency light.	06/21/2022

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	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 be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect residents and staff in the dining room and staff in the boiler room. Findings include: Based on observations and interview during a tour of the facility with the Custodian / Maintenance Man on 05/16/22 between 2:40 p.m. and 3:23 p.m., a battery-operated emergency light in the dining room failed to function when its respective test button was pushed five times. Additionall, the battery operater emergency light in the basement boiler room failed to function when it's respective test button was pushed four times. Based on interview at the time of the observations, the Custodian / Maintenance Man stated battery operated lights in the facility are tested regularly and documentation provided during the record review indicated monthly testing, and confirmed the aforementioned battery operated emergency lights failed to function when its respective test button was pushed. This finding was reviewed with the Licensed Practical Nurse at the exit conference. 3.1-19(b)		The basement emergency light in the basement boiler room was replaced with a new emergency light. All emergency lights were tested, and all emergency lighting is operating correctively. 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 and all other emergency lighting is working properly. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. in-serviced all maintenance staff on continuing monitoring and recording testing of battery-operated emergency lights and exit signs. Maintenance Staff monitors emergency lights monthly and record on log sheet. D.O.N. will review log sheets monthly to ensure compliance. 4. Describe who will be the person(s) responsible for implementing and monitoring the	

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			plan for future compliance with the regulations. D.O.N. will submit log sheets to Administrator and Q.A. Committee for review monthly to ensure compliance. 5. Completion Date: 6/21/22	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace 3 of 20 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of Rooms 104, 105 and 109. Findings include: Based on observations with the Custodian / Maintenance Man from 2:40 p.m. to 3:23 p.m. on 05/16/22, manufacturer's documentation	K 0300	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All battery operated smoke detectors were replaced in all resident's rooms. 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 and all smoke detectors were working but were over 10 years old. 3. What measures will be put into	05/29/2022

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	affixed to the battery operated smoke alarms installed on the ceiling in resident sleeping Room 104 indicated the device was manufactured 08/2006. Manufacturer's documentation affixed to the battery operated smoke alarm installed on the ceiling in resident sleeping room 105 indicated the device was manufactured 07/08/2006. Manufacturer's documentation affixed to the battery operated smoke alarm installed on the ceiling in Physical Therapy, room 109, indicated the device was manufactured 09/10/2005. Based on interview at the time of the observations, the Custodian / Maintenance Man agreed the aforementioned smoke alarms were more than ten years old. These findings were reviewed with the Licensed Practical Nurse during the exit conference. 3.1-19(b)		place or what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. in-serviced all maintenance staff on new log sheet indicating the date of the new installation of smoke detectors to be replaced every 10 years. D.O.N. in-serviced all maintenance staff on Monthly Monitor for testing cleaning log for smoke detectors. Maintenance Staff installed all new smoke detectors, tested them and recorded testing on log sheet. D.O.N. will review log sheets monthly to ensure compliance. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will submit log sheets to Administrator and Q.A. Committee for review monthly to ensure compliance. 5. Completion Date: 5/29/22	
K 0711 SS=F	NFPA 101 Evacuation and Relocation Plan			

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Bldg. 01	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			
	Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Preparedness Plan" documentation dated 06/01/2021 during record review from 11:43 a.m. to 2:40 p.m. on 05/16/22; the written fire safety plan, dated	K 0711	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The disaster preparedness plan and was updated to the staff response to the activation of battery-operated smoke detectors. 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. D.O.N. developed policy and	06/15/2022

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	10/2/2020, did not address staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Based on interview at the time of record review, the Custodian / Maintenance Man agreed the written fire safety plan did not address staff response to the activation of battery operated smoke detectors. Based on observations with the Custodian / Maintenance Man during a tour of the facility from 2:40 p.m. to 3:23 p.m. on 05/16/22, battery operated smoke detectors were installed in each resident sleeping room. This finding was reviewed with the Licensed Practical Nurse at the exit conference. 3.1-19(b)		procedure for staff action when battery smoke detectors are alarmed. In-service held with entire staff. Battery smoke detectors are monitored monthly by maintenance staff. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. in-serviced staff of policy and procedure for battery smoke detectors. Battery operated smoke detectors are checked monthly and written in logbook for review. Maintenance supervisor will review monitoring with Administrator and Q.A. Committee. Policy & Procedure Staff Response To Battery-Operated Smoke Detectors Policy: Battery-Operated Smoke detectors are required in every resident’s room. This facility is equipped with both smoke alarms that are hardwired with a battery backup, interconnected, and battery-operated smoke detectors all UL-listed. Battery-operated smoke alarms	

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			must contain a tamper-proof battery which last for 10 years, emit an audible and/or visual alarm when they detect smoke. Battery-operated smoke detectors are checked monthly by maintenance staff for proper functioning. Procedure: When you hear a smoke alarm, you must act immediately. Never assume that it could be a false alarm as the longer you wait after hearing an alarm the less time you will get to evacuate everyone from the affected premises. 1. All staff must immediately respond to an alarmed smoke detector. 2. Investigate area and see if you smell or see smoke. 3. If smoke is present you must follow fire alarm activation and evacuation protocol. 4. Call 911 5. Evacuate everyone to the outside and warn others of the fire on the way out. 6. Never re-enter the building. 7. Seek out the first arriving personnel, police officer, fire fighter, EMT, and give them the specific location of the fire or smoke. 8. If smoke detector false alarms notify administration immediately so replacement can be done by maintenance staff.	

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			5. Completion Date: 6/21/22 addendum	
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 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 ensure 6 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Monthly Fire Drill" with the Custodian / Maintenance Man on 05/16/22 from 11:43 a.m. to 2:40 p.m., the fire drill forms had a line stating "Fire Alarm System Activated: (Circle One) Yes / No". No was	K 0712	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? We have corrected this practice and will use the fire drill test button in the control panel to indicate when the fire alarm system is activated. All fire drills will include the verification transmission of a fire alarm signal to the monitoring company. 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.	06/15/2022

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	circled on the following monthly fire drills: 09/15/2021 at 10:00 a.m., 11/15/2021 at 3:00 a.m., 01/15/2022 at 4:00 p.m., 2/18/2022 at 8:00 a.m., 3/15/2022 at 2:00 p.m. and 04/20/2022 at 10:00 p.m. For each fire drill, an additional form titled 'Fire Alarm System Activation Report' was filled out. This form has areas stating 'Fire Alarm System Tested', 'Verified by', 'Monitoring Company received signal at:' 'Verified by:'; and each of the aforementioned fire drills has 'N/A or No' wrote next to the above areas. Based on interview at the time of record review, the Custodian / Maintenance Man stated the Administrator and the Director of Nursing are not at facility today and the documentation in the fire drill book is what is available to review at the time of the survey. This finding was reviewed with the Licensed Practical Nurse at the exit conference. 3.1-19(b) 3.1-51(c)		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. D.O.N. in-serviced all staff on fire drills. All fire drills are required to include the transmission of a fire alarm signal to the monitoring company. D.O.N. will monitor fire drills and fire alarm system activation during to ensure proper communication with monitoring service and ensure compliance. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will submit fire drills to Administrator and Q.A. Committee for review monthly to ensure compliance. 5. Completion Date: 6/15/22	