

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 07/10/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00151396 and IN00151901.</p> <p>Complaint IN00151396- Substantiated. Federal/State deficiencies related to the allegations are cited at F159 and F323.</p> <p>Complaint IN00151901- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: July 10, 2014</p> <p>Facility number: 000368 Provider number: 15E187 AIM number: 100275220</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: NF: 24 Total: 24</p> <p>Census payor type: Medicaid: 23 Other: 1 Total: 24</p> <p>Sample: 8</p>	F000000		
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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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F000159 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review on July 12, 2014, by Janelyn Kulik, RN.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each</p>			
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	<p>resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview the facility failed to ensure resident's personal funds were maintained in an interest bearing account for 1 of 3 residents reviewed for personal funds accounts in the sample of 8. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 7/10/14 at 9:35 a.m. The resident was admitted to the facility on 3/6/12. The resident's diagnoses included, but were not limited to, high blood pressure,</p>	F000159	<p>1. Resident D and her son were immediately informed of the regulation regarding funds over \$50. Resident had been informed of PR account but she did not want it in a interest bearing account she wanted to get the money when she wanted it. Son received the money and a receipt is available for review. 2. No one else was affected. 3. Addendum will be added to the admission agreement addressing regulation paragraphs (c)(3)-(8). The facility will continue to safeguard and manage residents PR funds if the money exceed \$50. The money will be maintained in an interest bearing account and if monies</p>	08/09/2014			

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	<p>arthritis, peripheral vascular disease, and anemia.</p> <p>A facility listing provided by the facility indicated there were (15) residents whom had their personal funds controlled by the facility in an interest bearing account. Resident #D's name was not on the above provided list.</p> <p>When interviewed on 7/10/14 at 9:40 a.m., the Director of Nursing indicated Resident #D was first admitted to the facility in March 2012. The Director of Nursing indicated the facility began holding \$350.00 of the resident's personal funds in August 2013. The Director of Nursing indicated the resident and her son did not want the above funds placed in the facility interest bearing account at that time. The Director of Nursing indicated the resident's funds were kept in an envelope in safe in the facility. The Director of Nursing indicated the resident's funds currently remained in the envelope at the facility and had not been in an interest bearing account since August 2013.</p> <p>This Federal tag relates to Complaint IN00151396.</p> <p>3.1-6(c)</p>		are under \$50 they will be held in petty cash. Resident PR ledgers are available for review. 4. The Administrator reviews PR statements monthly. Social Service maintains receipts and ledgers of PR accounts. The QA committee will monitor PR accounts semi-annually		

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F000323 SS=E	<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 provide supervision to prevent accidents related to not utilizing a gait belt during transfers for 2 of 3 residents observed for transfers in a sample of 8. (Residents #D and #G). The facility also failed to provide supervision to prevent accidents related to leaving a bathtub filled with water unattended in 1 of 2 Shower/Tub rooms. (The West Shower/Tub Room) The facility also failed to ensure the resident's environment remained free of hazards related to resident's medications being left unattended in the dining room, (Resident #H) and spray cologne bottles and razors left unsecured in 1 of 2 Shower/Tub rooms. (The West Shower/Tub Room)</p> <p>Findings include:</p> <p>1. On 7/10/14 at 8:35 a.m., the door to the Shower/Tub room on the West Unit was open with a door stop. There were</p>	F000323	<p>1 Staff was immediately informed to use gait belts during transfers for the safety of the resident and themselves Charge Nurses were informed of this deficient practice and transfer policy was given to all staff b. Door locks were immediately applied to tub areas on East and West wing and nursing staff was informed of the potential hazard of running water prior to bathing and leaving the area unsecured c. Charged Nurses were questioned about leaving medication unattended and after query it was miscommunication between them during the orientation of the new nurse She thought she was to watch the cart instead of the resident, however medication pass policy was given to both d. Nursing staff was immediately informed to keep all supplies secured in their carts and not on top for the safety each resident 2 No harm was caused by the transfer without gait belts, however their is potential for harm to the resident and to the staff. No residents have been injured</p>	08/09/2014

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	<p>no staff, residents, or visitors in the Shower/Tub room at this time. There were no staff or visitors in the hallway or in view of the Shower/Tub room at this time. There was a white bathtub in the room. The bathtub was filled with approximately (2) inches of water. There was a white step stool next to the tub on one side and a white shower bench next to the other side of the tub. There was a red plastic bin on top of a chest inside the entrance to the Shower/Tub Room. There were (4) plastic disposable razors and (2) bottles of spray cologne in the bin.</p> <p>At 8:47 a.m., Resident #J was observed propelling herself in a wheelchair down the hall. The resident passed the Shower/Tub room and continued down the hall. The Shower/Tub room remained unattended until 8:49 a.m. The room remained open and unattended from 8:35 a.m. until 8:49 a.m.</p> <p>At 8:49 a.m., CNA #1 was observed pushing Resident #G into the Shower/Tub in a geri-chair. The CNA and LPN #2 lifted the resident into the tub of water at this time.</p> <p>When interviewed on 7/10/14 at 8:50 a.m., CNA #1 indicated she had filled the tub before she brought Resident #G into</p>		<p>due to non use of gait belts. All nurses are required to use gait belts during transfers. b No harm was caused by tub room being unattended but the potential was noted and now staff will maintain the locking of the tub room areas at all times. c. No harm was caused by leaving the medication unattended with resident H she is orientated and counts her pills when she takes them her tablemate next to her is also orientated but the potential for harm was noted and addressed immediately. d. No harm was caused but nursing staff was informed to keep all supplies in the cart and not on top of the cart. 3 Transfer policy was given to all staff members and gait belts are used during all transfers. Charge nurse will monitor use of gait belts during all shifts. Inservice held with nursing staff on transfer policy b. Tub areas door passage locks were changed to key locked door knobs and doors will be locked at all times Nursing staff and custodial staff will be able to enter locked areas Doors will be only opened during bathing time for ventilation when staff is present New policy developed and given to all nursing staff c Medication Administration policy was given to charge nurses and staff re-inserviced on policy by D.O.N. d. Inservice held on keeping supplies in proper places and secured this is monitored by the</p>				

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	<p>the Shower/Tub room.</p> <p>When interviewed on 7/10/14 at 12:00 p.m., the Director of Nursing indicated staff should not have left the filled bathtub unattended. The Director of Nursing also indicated the razors and sprays should not have been left out unattended either.</p> <p>2. On 7/10/14 at 8:10 a.m., a small plastic medicine cup was sitting on one of the tables in the Dining Room. There were approximately 7-8 pills in the cup. There were a total of (6) female residents sitting at the table at this time. The cup of pills was placed between Resident #H and in reach of the tablemate to her side.</p> <p>At 8:15 a.m., LPN #1 left the Dining Room and the no staff members were present in view of the medications. At 8:18 a.m. a staff member was observed coming out of the Kitchen. This staff member was not in view of the medications.</p> <p>The record for Resident #H was reviewed on 7/10/14 at 2:40 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, glaucoma, and arthritis.</p> <p>The 7/2014 Medication Administration</p>		<p>charge nurses during bathing and nursing rounds. 4 Charge nurse will monitor for gait belt usage during all shifts. D.O.N. will monitor gait belt usage and proper transferring weekly times 4 weeks on each shift then quarterly thereafter. All deficient practices by any staff member will be reported to D.O.N. and disciplinary action will administered for this deficiency. Q.A. committee will monitor deficient practices quarterly. b.& d. Charge nurse will monitor locking of tub areas during nurse rounds and will monitor supplies being securely stored in tub area daily. D.O.N. will monitor all nursing staff during bathing periods 2 times a week for 4 weeks and monthly for 3 months then quarterly thereafter. Q.A. committee will review deficient practices quarterly c DON will monitor medication pass with all nurses times 1 week then monthly thereafter Pharmacy Consultant will monitor medication pass quarterly and all deficient practices will be reviewed by QA committee quarterly</p>				

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	<p>Record was reviewed. There were Physician orders for the resident to receive (9) oral medications at 9:00 a.m. daily. The (9) oral medications were signed out as given at 9:00 a.m. on 7/10/14.</p> <p>When interviewed on 7/10/14 at 12:05 p.m., LPN #1 indicated the medications should not have been left on the table unattended. The Director of Nursing was present at this time and indicated they did not have a policy related to leaving medications unattended though the Nurses know this was the practice to follow and the medications should not have been left out on the table unattended.</p> <p>3. On 7/10/14 at 2:10 p.m., LPN #1 and LPN #2 were observed transferring Resident #D from a wheelchair into another chair in her room. The LPN's placed their arms under the resident's underarms and assisted the resident to a standing position and then assisted the resident to pivot towards the chair. Neither of the LPN's utilized a gait or transfer belt during the transfer.</p> <p>The record for Resident #D was reviewed on 7/10/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, arthritis,</p>			

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	<p>peripheral vascular disease, and anemia.</p> <p>The 5/3/14 MDS (Minimum Data Set) Annual assessment indicated the resident required extensive assistance (resident involved in activity, staff provide guided maneuvering) of one staff person for transfers. The assessment also indicated the resident required extensive assistance of two staff persons for transfers from the wheelchair.</p> <p>4. On 7/10/14 at 9:05 a.m., CNA #1 and LPN #2 were observed transferring Resident #G from a geri-chair into the bathtub in the West Unit Shower/Tub room. CNA #1 placed the residents legs over the side of the tub. The two staff members then placed their arms under the resident's underarms and lifted the resident from the geri-chair and placed her in the bathtub. LPN #2 and CNA #1 did not use a gait or transfer belts during the transfer. At 8:19 a.m., the two staff members lifted the resident out of the bathtub with their arms under the resident's arm pits and placed her into the geri-chair. Neither of the above staff members utilized a gait or transfer belt during the transfer. CNA #1 pushed the resident in the geri-chair into her room. The CNA and the LPN then transferred the resident out of the geri-chair with their arms under the resident's arm pits</p>						

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	<p>and placed her into her bed . Neither staff member utilized a gait or transfer belt during the transfer. After dressing the resident the CNA and the LPN then placed their arms under the resident's arm pits and transferred her back into the geri-chair. Neither staff member utilized a gait or transfer belt during the transfer.</p> <p>The record for Resident #G was reviewed on 7/10/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, high blood pressure, arthritis, and coronary artery disease. The 4/17/14 MDS (Minimum Data Set) Annual assessment indicated the resident's cognitive skills for decision making were severely impaired. The Annual assessment also indicated the resident was totally dependent on staff for transfers and required two or more persons for transfers.</p> <p>5. The facility procedure titled "Transfer Activities" was received from the Director of Nursing on 7/10/14 at 1:50 p.m. There was no date on the Procedure. The Director of Nursing indicated the Procedure was current. The Transfer Activities Procedure indicated equipment for transfer use included a transfer belt.</p> <p>When interviewed on 7/10/14 at 12:05</p>			

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	<p>p.m., the Director of Nursing indicated gait/transfer belts are available for the staff and they should have been utilized for transfers.</p> <p>This Federal tag relates to Complaint IN00151396.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			