| 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 05/04/2023 | | | |
|--|--|--|------|---------------------------------------|---|-----|------------|
| | PROVIDER OR SUPPLIER | | | 700 E 2 | ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | 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 APPROPRI | ATE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| E 0000 Bldg | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. | | E 00 | 000 | | | |
| | Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found not 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 05/08/23 | | | | | | |
| E 0006 SS=F Bldg | (1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), | | | | | | |

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

TITLE (X6) DATE

Kathy Jones Interim Administrator 06/21/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 127T21 Facility ID: 000368 If continuation sheet Page 1 of 21

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE | | | LETED | | |
|---|---|--|------|--|--|--------|--------------------|
| | | 155845 | B. W | ING | | 05/04/ | 2023 |
| | PROVIDER OR SUPPLIER | | | 700 E 2 | ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION DD FETY (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| mo | | | | mo | | | DITTE |
| | develop and maining preparedness plant and updated at lear must do the follow (1) Be based on a facility-based and assessment, utilizing approach.* (2) Include strategemergency events assessment. * [For Hospices at Plan. The Hospice maintain an emergency every 2 years. The following: (1) Be based on a facility-based and assessment, utilizing approach. (2) Include strategemergency events assessment, incluithe consequences disasters, and other affect the hospice of the following: *[For LTC facilities are genergency Plan. develop and mains and the following are genergency Plan. develop and mains are genergency Plan. develop and mains are genergency plan. develop and mains are genergency plan. | lan. The [facility] must tain an emergency In that must be reviewed, last every 2 years. The plan ving:] Ind include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk It §418.113(a):] Emergency It must develop and gency preparedness plan lewed, and updated at least it plan must do the Ind include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk ding the management of is of power failures, natural er emergencies that would is ability to provide care. | | | | | |
| | and updated at lead do the following: | ast annually. The plan must | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 2 of 21

| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | (X3) DATE SURVEY | |
|-----------------------------|---|------------------------------------|---|---|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | A. BUILDING COMPL | | |
| | | 155845 | B. WING | | 05/04/2023 | |
| | | | CTREE | ADDRESS SITE OF THE SOR | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | ADDRESS, CITY, STATE, ZIP COD 21ST AVE | | |
| SIMMON | | JENI TH ENCILITY | | , IN 46407 | | |
| SIMIMON | SIMMONS LOVING CARE HEALTH FACILITY | | | , 111 40407 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | 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 | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | (1) Be based on and include a documented, | | | | | |
| | | community-based risk | | | | |
| | | ing an all-hazards | | | | |
| | | ng missing residents. | | | | |
| | | gies for addressing | | | | |
| | | s identified by the risk | | | | |
| | assessment. | | | | | |
| | *[For ICF/IIDs at §483.475(a):] Emergency | | | | | |
| | | | | | | |
| | Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must | | | | | |
| | be reviewed, and updated at least every 2 | | | | | |
| | years. The plan must do the following: | | | | | |
| | years. The plantin | dot do the following. | | | | |
| | (1) Be based on a | ind include a documented, | | | | |
| | ' ' | community-based risk | | | | |
| | | ing an all-hazards | | | | |
| | approach, includir | _ | | | | |
| | (2) Include strateg | jies for addressing | | | | |
| | emergency events | s identified by the risk | | | | |
| | assessment. | | | | | |
| | | view and interview, the facility | E 0006 | 1. What corrective action(s) w | | |
| | | n Emergency Preparedness | | accomplished for those reside | | |
| | | s (1) based on and includes a | | found to have been affected b | y the | |
| | | y-based and community-based | | deficient practice; | | |
| | | lizing an all-hazards approach, | | No residents were found to I | oe e | |
| | | esidents and (2) included | | affected by the deficient | | |
| | _ | ssing emergency events | | practice; however, all reside | nts | |
| | - | k assessment in accordance | | had the potential to be | | |
| | | 3(a) (1) and 42 CFR 483.73(a) (2). | | affected. The risk assessme | ent | |
| | inis dencient pract | ice could affect all occupants. | | was completed by the QA committee on 6/21/2023 usin | | |
| | Findings include: | | | | | |
| | 1 manigs include: | | | the Indiana LTC form "hazar vulnerability". | u [| |
| | Based on records re | eview with the Director of | | 2. how other residents having | the | |
| | Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. | | | potential to be affected by the | | |
| | and 11:32 a.m., no documentation could be found | | | same deficient practice will be | | |
| | regarding a documented facility-based and | | | identified and what corrective | | |
| | | isk assessment utilizing an | | action(s) will be taken; | | |
| | _ | h. Based on interview at the | | All residents were identified | as | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet Page 3 of 21

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | | | |
|--|---|--|---|-------------------------------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155845 | A. BUILDING COMPLETED B. WING 05/04/2023 | | | | |
| | | 133043 | b. WIN | | | 03/04/2 | 2023 |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| CINANACNI | IO I OVINIO GARE I | IEAL THEACH ITY | | | 21ST AVE | | |
| SIMMON | IS LOVING CARE H | HEALTH FACILITY | | GARY, | IN 46407 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| time of record review, the DON stated the facility has a documented risk assessment that is with the | | | | being potentially affected by | | | |
| | | edness Plan, but was unable to | | | the deficient practice. The Hazard Vulnerability Risk | | |
| | be located at the tin | | | | Assessment was placed in the | 10 | |
| | | | | | emergency preparedness | | |
| | This finding was re | viewed with the DON during | | | binder and reviewed by the (| QA AC | |
| | the exit conference. | | | | team on 6/21/2023. | | |
| | | | | | 3. what measures will be put | into | |
| | | | | | place and what systemic chan | | |
| | | | | | will be made to ensure that the | е | |
| | | | | | deficient practice does not rec | ur; | |
| | | | | | The custodians and | | |
| | | | | | administration were educate | d | |
| | | | | | by the interim administrator | | |
| | | | | | including the placement of the risk assessment as well as the | I | |
| | | | | | need to update it with any | ie | |
| | | | | | changes or at least every 2 | | |
| | | | | | years. The administrator and | d l | |
| | | | | | or designee will ensure that | | |
| | | | | | the Hazard Vulnerability Risk | ζ | |
| | | | | | Assessment is located in the | , | |
| | | | | | emergency preparedness | | |
| | | | | | binder at the nurse's station | | |
| | | | | | 4. how the corrective action(s | a) will | |
| | | | | | be monitored to ensure the | ´ | |
| | | | | | deficient practice will not recui | ſ, | |
| | | | | | i.e., what quality assurance | | |
| | | | | | program will be put into place; | 1 | |
| | | | | | The Administrator or design | | |
| | | | | | will conduct a monthly audit | 1 | |
| | | | | | for 6 months to ensure that t | | |
| | | | | | be located in the emergency | | |
| | | | | | preparedness binder at the | | |
| | | | | | nurse's station. The | | |
| | | | | | Administrator will present | | |
| | | | | | findings to the QA committee | e | |

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155845 | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION | (X3) DATE COMPI 05/04 | LETED | | | |
|---|--|--|--|--|---------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | | | | each month to ensure continued compliance | | | | |
| E 0022 SS=F Bldg | 441.184(b)(4), 483.73(b)(4), 485.485.727(b)(2), 484.494.62(b)(3) Policies/Procedure \$403.748(b)(4), \$4(4), \$483.73(b)(4) (2), \$485.625(b)(4) \$485.920(b)(3), \$4(5) Policies and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication place to the enviewed and upersection. The policies existence in the policies and procedure for patients, remain in the [faction of the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. The policies address the following a for hospice-operation only. | dept. 12(b)(2), §494.62(b)(3). Focedures. The [facilities] Implement emergency cies and procedures, based In plan set forth in paragraph risk assessment at In this section, and the In at paragraph (c) of this It is and procedures must Indiated at least every 2 In LTC facilities]. At a It is and procedures must Indiated at least every 2 In LTC facilities]. At a It is and procedures must In this is and procedures who It is a spices at §418.113(b): It is a spices at §418.113(b): It is a spices at §418.113(b): It is and procedures must It is and procedures must It is and procedures must It is a spice at §418.113(b): It is a spice a | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 5 of 21

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845 | ľ | UILDING | ONSTRUCTION | COMP | E SURVEY PLETED 4/2023 |
|--------------------------|--|--|--|---------------------|--|--|------------------------------|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | TION D BE OPRIATE | (X5) COMPLETION DATE |
| | hospice. Based on record revision failed to ensure that documented in eme accordance to 42 C practice could imparative could imparative could imparative could imparative properties. Based on record revision for the place policy design preparedness plans, time of record revisa forementioned documents that the place policy design preparedness plans, time of record revisa forementioned documents that the place policy design preparedness plans, time of record revisa forementioned documents that the place policy design preparedness plans, time of record revisa forementioned documents that the place policy design preparedness plans, time of record revisa forementioned documents that the place policy design preparedness plans, time of record revisa forements and the place policy design preparedness plans. | view with the Director of 05/04/23 between 09:18 a.m. facility did not have a shelter in | E 0 | 022 | 1. what corrective action(accomplished for those refound to have been affected deficient practice; No residents were found affected by the deficient practice; however, all reshad the potential to be affected. The shelter in I Policy and procedures wereviewed by the QA com on 6/21/2023 and placed emergency preparedness binder at the nurses state. 2. how other residents hapotential to be affected by same deficient practice will identified and what correct action(s) will be taken; No residents were found affected by the deficient practice; however, all reshad the potential to be affected. The shelter in I Policy and procedures were reviewed by the QA com on 6/21/2023 and placed emergency preparedness binder at the nurses state. 3. what measures will be place and what systemic of will be made to ensure the deficient practice does not the maintenance/custod staff were educated on the requirement to ensure the require | sidents ed by the to be sidents Place ere mittee in the sion. aving the the tl be tive to be sidents Place ere mittee in the sion. put into changes at the t recur; ial ne | 06/23/2023 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 6 of 21

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845 | | | A. BUILDING B. WING | onstruction | COMPLETED 05/04/2023 |
|--|---|--|---------------------|---|--------------------------------------|
| | ROVIDER OR SUPPLIER S LOVING CARE H | | 700 E 2 | ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE 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 APPROPRIATE DEFICIENCY) | |
| | | | | facility has a Shelter In Place Policy and Procedure as par their emergency preparedne binder by the interim administrator on 6/21/2023. 4. how the corrective action(s be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place. The administrator or designe will conduct monthly audits 6 months as part of the mon environmental rounds to ensure the Shelter In Place Policy and Procedures continue to be placed in the emergency preparedness binder. The Administrator we present the findings of the rounds to the QA committee monthly to ensure continue compliance. | t of ss s) will r, ; and ee for thly |
| K 0000 | | | | | |
| Bldg. 01 | Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/04 Facility Number: 06 Provider Number: 1002 At this Life Safety C | 00368 155845 | K 0000 | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 7 of 21

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 COMPLETED | | | | |
|---|---|--|--|---|-----------------------|--|
| | | 155845 | B. WING 05/04/2023 | | | |
| | PROVIDER OR SUPPLIER S LOVING CARE H | | STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | | (X5) COMPLETION DATE | |
| K 0291 | with Requirements and Medicaid, 42 C Safety from Fire and National Fire Protect Life Safety Code (L Health Care Occupation of the Company of the Construction and was facility has a monitor smoke detection in the corridor. The power protection. The power protection. The facility has the census of 20 at the total All areas accessible | to residents and areas ervices were sprinklered. | TAG | | DATE | |
| SS=F Bldg. 01 | Emergency Lightir Emergency Lightir | ng g of at least 1-1/2-hour ed automatically in | | | | |
| | 1. Based on records facility failed to ens lights were tested m requires functional monthly, with a min maximum of 5 weel than 30 seconds and inspections and test for inspection by the | review and interview, the ure 10 of 10 battery backup conthly. Section 7.9.3.1.1 (1) testing shall be conducted animum of 3 weeks and a cas between tests, for not less 1 (5) Written records of visual as shall be kept by the owner e authority having efficient practice could affect all | K 0291 | what corrective action(s) was accomplished for those reside found to have been affected the deficient practice; No residents were affected this deficient practice. The defective battery-operated emergency lights were replaced by 5/11/2023. April documentation was noted of | ents Dy Dy 2 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet Page 8 of 21

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|--|-----------------------------------|---------------------------------|--------------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPLETED | | | ETED | |
| | | 155845 | B. W | ING | | 05/04/ | /2023 |
| | | l . | | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | 8 | | | 21ST AVE | | |
| SIMMON | S LOVING CARE H | HEΔI TH FΔCII ITV | | | IN 46407 | | |
| SIIVIIVIOIN | O LOVING CARE F | ILALIIII AOILII I | | GART, | 114 7040 7 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | 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 | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | ~ . | when work is needed in the | | | the inspection logs | | |
| | transfer switch roor | n during a power outage. | | | immediately when the | | |
| | | | | | Maintenance Director was | | |
| | Findings include: | | | | notified. | | |
| | | | | | | | |
| | | view during a tour of the | | | 2. how other residents having | | |
| | • | rector of Nursing (DON) on | | | potential to be affected by the | | |
| | | 9:18 a.m., documentation of a | | | same deficient practice will be | ! | |
| | , | test for the battery powered | | | identified and what corrective | | |
| | | s provided, but there was no | | | action(s) will be taken; | | |
| | information provided that indicated a monthly | | | | All residents had the potenti | | |
| 30-second inspection for April 2023 was | | | | to be affected by the deficier | | | |
| | conducted. Based on an interview at the time of record review, the DON stated they were in touch | | | | practice; however, none wer | е | |
| | | - | | | affected. The 2 | | |
| | - | ersonnel and was told the | | | battery-operated emergency | | |
| | - | one, but did not get signed off | | | lights were replaced by | | |
| | on the inspection lo | g. | | | 5/11/2023. | | |
| | This finding was re | viewed with the DON during | | | 3. what measures will be put | into | |
| | the exit conference. | _ | | | place and what systemic chan | | |
| | | | | | will be made to ensure that | _ | |
| | 3.1-19(b) | | | | deficient practice does not rec | | |
| | () | | | | Maintenance/custodial staff | · · · · · · | |
| | 2. Based on observa | ation and interview, the facility | | | were educated by the interim | 1 | |
| | | f 10 battery powered | | | administrator on 6/21/2023 | | |
| | | ere maintained in accordance | | | related to monthly | | |
| | | 27.9.2.6 states battery operated | | | documentation of all | | |
| | | nall use only reliable types of | | | battery-operated emergency | | |
| | | ies provided with suitable | | | lighting that must be routine | | |
| | - | ining them in properly charged | | | checked per the NFPA 101 | - | |
| | condition. Batteries | s used in such lights or units | | | regulations. The education | | |
| | shall be approved for | or their intended use and shall | | | includes proper documentat | ion | |
| | comply with NFPA | 70 National Electric Code. LSC | | | and record keeping to ensur | е | |
| | 7.9.2.7 states the en | nergency lighting system shall | | | life safety documentation is | | |
| | | sly in operation or shall be | | | available upon request. | | |
| | capable of repeated | automatic operation without | | | | | |
| | manual intervention | n. This deficient practice could | | | 4. how the corrective action(s | s) will | |
| | affect approximatel | y 20 residents and staff. | | | be monitored to ensure the | | |
| | | | | | deficient practice will not recui | r, | |
| | Findings include: | | | | i.e., what quality assurance | | |

| 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 05/04/2023 | | |
|--|--|---|--|---|-------------------------------------|--|
| | ROVIDER OR SUPPLIER S LOVING CARE H | | STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE 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) | DATE | |
| | Nursing (DON) on and 12:55 p.m., the lights in the dining a entrance/exit doors Based on interview observations, the Dobattery-operated emfunction when its repushed and stated the replaced later this was a state of the state o | ON agreed the ergency lights failed to spective test button was see emergency lights will be | | program will be put into place The administrator or designe will audit the life safety bind documentation monthly for 0 months to ensure the routine monthly inspections of the 1 battery-operated Emergency lighting are documented tim and accurately. The administrator will present findings of these audits to th QA committee monthly to ensure continued compliance for at least 6 months. | ee er 6 e 0 v ely | |
| K 0300 SS=C Bldg. 01 | Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included Based on record revolution, the fact documentation for the of 20 of 20 battery of resident rooms was 4.6.12.3 states exist to the public, if not maintained. NFPA Tests. Fire-warning and tested in according published instruction | are not addressed by the ut are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. iew, interview, and | K 0300 | 1. what corrective action(s) wi accomplished for those reside found to have been affected by deficient practice; No residents were found to affected by the deficient practice; however, all residents, staff and visitors the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheef | ents by the had | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 10 of 21

| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (XX) ID SUMMARY STATISHATO OF DETICINCIE TAG REGILATORY OR LISE INSTITUTIVES INTORMATION Testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 99:18 a.m. and 11:32 a.m., done commentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the mouthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 (X3) DROWNERS AND OF COMPLETION OCCUMENTATION | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|---|--|---|---|------|-----|-----------------------------------|-------------------|
| SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (LACH DEPICIENCY MIST IN EPRICEDED BY PRIL. TAG REQUIRENCY MIST IN EPRICEDED BY PRIL. TAG REQUIRENCY MIST IN EPRICEDED BY PRIL. TAG REQUIRENCE MISTORY MIST AND A COMPLETION DATE testing, and maintenance programs shall suitsfy the equipment manufacturer's published instructions. This deficient practice could affect all residents, salif, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09-18 a.m. und 11-32 a.m., accumentation for monthly inspection for April 20-3 was not documented based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection of swa sable contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection for swa sable contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection of swa sable contact maintenance director when made aware. 3.1-19(b) | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | COMPLETED |
| SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SIMMARY STATEMENT OF DEPICIENCE (IJCACI DEPICIENCY MIST BE PERCEIDED BY BELL TAG REGILLATORY OR LSC IDENTIFYING INFORMATION Lesting, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment maunifecturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3.1-19(b) 3.4-19(c) 3.5-10-19(c) 3.5-10-19(c) 4.5-10-19-19-19-19-19-19-19-19-19-19-19-19-19- | | | 100840 | B. W | | | 05/04/2023 |
| SIMMONS LOVING CARE HEALTH FACILITY GARY, IN 46407 | NAME OF P | PROVIDER OR SUPPLIER | | | | | |
| X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCE PREFIX TAG PREFIX PRECEDED BY FULL. TAG PREFIX PRECEDED BY FULL. TAG PREFIX PRECEDED BY FULL. PROVIDENT FLANGE FOR PROPERTION TAG PREFIX PR | SIMMON | IS LOVING CARE L | ΙΕΔΙ ΤΗ ΕΔΟΙΙ ΙΤΥ | | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION Requirements and instance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) PREFIX TAG TO ACM CONCENTION ACCOUNTS AND TAG OF THE PROPERTIES AND TAG | _ | I | - | | | IIN 70701 | |
| testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detectors used to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. | | | | | | PROVIDER'S PLAN OF CORRECTION | |
| testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) In addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 2. 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 residents were found to be affected by the deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were rotested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | ` | | | | CROSS-REFERENCED TO THE APPROPRIA | |
| the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m., and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personanel who stated the checks were done, but did not document the checks were done, but did not document the conference. 3.1-19(b) 3.1-19(b) 3.1-19(b) 4. how the corrective action(s) will be manufactor of smoke detector testing on 6/21/2023. 4. how the orrective action(s) will be monitored to ensure the deficient practice will not recur, The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | TAG | | | + | IAU | | DATE |
| cequipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) the maintenance director when made aware. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be monthly to be affected by the deficient practice of the practice, however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | _ | | | | I - | bv |
| staff, and visitors. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks were done, but did not document the conference. 3.1-19(b) 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the lintorim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | _ | - |
| Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the reresidents having the potential to be affected by the identified and what corrective action(s) will be taken; No residents serf and visitors had the potential to be affected by the deficient practice in when and the potential to be affected by the caption of the port of the part of the potential to be affected by the caption of the potential to be affected by the caption of the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3. What measures will be put into place and what systemic changes will be made to easure that the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | This deficient pract | ice could affect all residents, | | | made aware. | |
| Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3.1-19(b) 3.1-19(b) Dotential to be affected by the same deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | staff, and visitors. | | | | | |
| Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) Same deficient practice will be identified and what corrective action(s) will be taken; No residents were found to be affected by the deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 4. how the corrective action(s) will be bed action(s) will be bed action(s) will be bed action(s) will be made to ensure the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be mediant what corrective action(s) will be medicient machinal to be affected by the deficient practice. However, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) | | Findings include: | | | | 1 . | |
| Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be affected by the deficient practice and importance of documentation of the monthly inspection of smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. | | Rased on records | wiew with the Director of | | | · - | ; |
| and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) No residents were found to be affected by the deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detectors testing on 6/2/1/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. 3.1-19(b) 3. 1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | . , | be |
| detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. 3.1-19(b) Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | 1 | |
| time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | 1 · · | had |
| contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b) 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | was not documented. Based on interview at the | | | | the potential to be affected. | |
| checks were done, but did not document the checks on the monthly inspection sheets. Comparison of the monthly inspection sheets of the conference of the monthly inspection sheets of the maintenance director when made aware. Comparison of the monthly inspection of the monthly inspection of smoke detector testing on 6/21/2023. | | | | | | | |
| checks on the monthly inspection sheets. In addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | - | | | | |
| Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | is |
| Findings were discussed with the DON at the exit conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | checks on the mont | nly inspection sneets. | | | | by |
| conference. 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | Findings were discu | ussed with the DON at the exit | | | _ | - |
| 3.1-19(b) 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | _ | issed with the Bolv at the exit | | | | |
| place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| will be made to ensure that the deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | 3.1-19(b) | | | | 3. what measures will be put | into |
| deficient practice does not recur; The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | 1 * | - |
| The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | 1 | |
| interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | _ | "' ' 9 |
| of the monthly inspection of smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | - | n |
| smoke detector testing on 6/21/2023. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | I - | |
| 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | | | | | | | |
| be monitored to ensure the deficient practice will not recur, | | | | | | 6/21/2023. | |
| be monitored to ensure the deficient practice will not recur, | | | | | | A boundhouse of the following | V |
| deficient practice will not recur, | | | | | | | s) WIII |
| | | | | | | | r |
| | | | | | | i.e., what quality assurance | ', |

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845 | | A. BUILDING B. WING | 01 | COMPLETED 05/04/2023 | |
|--|--|---|---------------------|---|------------------------------------|
| | ROVIDER OR SUPPLIER S LOVING CARE H | | 700 E 2 | ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE 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) | (X5) COMPLETION DATE |
| K 0321 SS=D Bldg. 01 | barrier having 1-he (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be selfautomatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 | - Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of hat are deficient in | | program will be put into place The administrator or design will audit the life safety bind documentation monthly for months to ensure the routin monthly testing of all battery-operated smoke detectors are documented timely. The administrator w present findings of these au to the QA committee monthl to ensure continued compliance for at least 6 months. | eee er 6 e ill dits |
| | | Automatic Sprinkler N/A | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet Page 12 of 21

06/26/2023 PRINTED:

| | T OF HEALTH AND HU | | | | | | RM APPROVED |
|--|--|-----------------------------------|----------------------------------|--------------------------|--|-----------|-----------------|
| | R MEDICARE & MEDIC | X1) PROVIDER/SUPPLIER/CLIA | (V2) M | III TIDI E C | ONICTRICTION | (X3) DATE | IB NO. 0938-039 |
| | NT OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPI | | | | |
| ANDILAN | OF CORRECTION | 155845 | | | | | /2023 |
| | | 133643 | Б. W | | | 03/04 | 12023 |
| NAME OF I | PROVIDER OR SUPPLIEI | 3 | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| TOTAL OF I | NO VIDER OR SOLVER | | | 700 E 2 | 21ST AVE | | |
| SIMMON | IS LOVING CARE I | HEALTH FACILITY | | GARY, | , IN 46407 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX (EACH DEFICIENCY MUST BE PR | | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | a. Boiler and Fue | l-Fired Heater Rooms | | | | | |
| | b. Laundries (larg | er than 100 square feet) | | | | | |
| | c. Repair, Maintei | nance, and Paint Shops | | | | | |
| | d. Soiled Linen Re | ooms (exceeding 64 | | | | | |
| | gallons) | | | | | | |
| | e. Trash Collectio | n Rooms | | | | | |
| | (exceeding 64 ga | llons) | | | | | |
| | | orage Rooms/Spaces | | | | | |
| | (over 50 square fe | eet) | | | | | |
| | g. Laboratories (if classified as Severe Hazard - see K322) | | | | | | |
| | | | | | | | |
| | | on and interview, the facility | K 0 | 321 | 1. what corrective action(s) v | vill be | 06/23/2023 |
| | failed to ensure the | corridor doors to 1 of 4 | | | accomplished for those reside | | |
| | hazardous rooms w | vere provided with a | | | found to have been affected by | | |
| | | which would cause the door to | | | deficient practice; | , | |
| | | and latch into the door frame. | | | No residents were found to | be | |
| | | tice could affect approximately | | | affected by the deficient | | |
| | | own amount of residents. | practice; however, all residents | | ents | | |
| | | | | | could have been affected. | | |
| | Findings include: | | | | New spring hinges were | | |
| | | | | | purchased and installed by | | |
| | Based on observati | ons during a tour of the facility | | | 6/5/2023 to ensure the stora | ae | |
| | | f Nursing (DON) on 05/04/23 | | | room corridor door met the | 90 | |
| | | and 12:55 p.m., the corridor | | | hazardous area Enclosure | | |
| | | room in the basement across | | | guidelines. | | |
| | _ | ry room did not self-close. The | | | 2. how other residents having | a the | |
| | _ | proximately 60 square feet, had | | | potential to be affected by the | - | |
| | | boxes of PPE and patient care | | | same deficient practice will be | | |
| | items. Based on interview at the time of | | 1 | | identified and what corrective | | |
| observation, the DON acknowledged the amount | | | | action(s) will be taken; | | | |
| | | erial within the room; that room | | | A round of all potential area | as | |
| | | re feet; and the door did not | | | needing self closure | | |
| | self close. | | | | mechanism was conducted | by | |
| | 3311 37030 | | 1 | | the interim administrator on | - | |
| | This finding was re | eviewed with the DON during | | | 6/21/2023 and list given to | | |
| | the exit conference | | | | ownership in QA meeting. | | |
| | and exit conference | • | | | More spring hinges will be | | |
| | | | 1 | | I more spring inniges will be | | 1 |

FORM CMS-2567(02-99) Previous Versions Obsolete

3.1-19(b)

Event ID:

127T21

Facility ID: 000368

ordered for other doors needing a self-closure mechanism to be installed

If continuation sheet

Page 13 of 21

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| CENTERS FOR | R MEDICARE & MEDIC | AID SERVICES | | | OMB NO. 0938-039 | |
|----------------------------|--|--|---------------------|---|--|--|
| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 01 | COMPLETED | |
| | | 155845 | B. WING | | 05/04/2023 | |
| | | | STREET 2 700 E 2 | ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| TAG | , | LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| | | | | upon delivery. 3. what measures will be put place and what systemic chan will be made to ensure that the deficient practice does not reconstructed and maintenance/custodial staff were educated on 6/21/2023 regarding the use of self closure mechanisms in hazardous areas. New maintenance staff will be educated as well upon hire during emergency preparedness rounds with administrator or designee. 4. how the corrective action(she monitored to ensure the deficient practice will not recurred. I.e., what quality assurance program will be put into place. The maintenance director or designee will conduct month checks on doors leading to hazardous areas and supply storage closets and docume according. The administrator or designee will check month documentation to ensure it is completed timely for 6 month Findings will be presented to the QA committee monthly to ensure continued compliance. | into nges e cur; nly nt or hly s hs. | |
| K 0353 SS=F Bldg. 01 | Sprinkler System | - Maintenance and Testing - Maintenance and Testing er and standpipe systems | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

are inspected, tested, and maintained in

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 14 of 21

| AND PLAN OF CORRECTION IDE | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845 | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 05/04/2023 | | |
|---|--|---|---|--------------------|--|------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY | | | - | 700 E 2 | .DDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PR | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Inspection, Testin Water-based Fire Records of syster inspection and test secure location at a) Date sprinkled. b) Who provided b) Who provided coverage for any automatic sprinkled 9.7.5, 9.7.7, 9.7.8 Based on record refailed to provide we evidence the sprink been inspected and 4.6.12.1 requires at required for complimaintained in according requirements. Sprimaintained in according for the Inspection, Water-Based Fire Idea. 1.3.1 requires recording performed (e.g., instead of the Inspections, tests, a components and shauthority having jurequires that recording performed (e.g., instead of the Inspections) waterflow alarm dequarterly to verify damage. NFPA 25 waterflow alarm degree | supply source RKS information on non-required or partial er system. | K 035 | 33 | 1. what corrective action(s) waccomplished for those reside found to have been affected be deficient practice; No resident found to be affected; The quarterly sprinkler test was conducted 5/1/2023 and is scheduled to conducted again before the end of June for quarter 2. 2. how other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents were potential affected. The quarterly sprinkler test was conducted 5/1/2023 with no abnormal findings and is scheduled to conducted again by the end June to stay on schedule for Q2. 3. what measures will be put | ents by the d on be g the e | 06/23/2023 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845 | | JILDING | nstruction <u>01</u> | (X3) DATE COMPL 05/04 / | ETED | | |
|--|--|--|--|--------------------------------------|--|--|----------------------------|
| | NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (X4) ID. SUMMARY STATEMENT OF DEFICIENCIE | | | 700 E 2 | NDDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407 | | |
| | (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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) | ΓE | (X5) COMPLETION DATE |
| | | tested semiannually affect all residents, facility. Findings include: Based on review of inspection records v (DON) on 05/04/23 a.m., there was no conspection report av (January, February interview at the time acknowledged there documentation avait system had been insof 2023 and stated to company did not document and was goint inspections during semissed inspection. | the quarterly sprinkler system with the Director of Nursing between 09:18 a.m. and 11:32 quarterly sprinkler system with the Director of Director of Nursing between 19:18 a.m. and 11:32 quarterly sprinkler system will be for the first quarter and March) of 2023. During an e of record review, the DON | | place and what systemic chan will be made to ensure that the deficient practice does not recommendate the system of the Interim administrator and Owner spoke with Safecare and set up a portal access to ensure improved communication ongoing to ensure all inspections were scheduled and completed timely. Interim administrator educated maintenance direct and designee of importance differed and designee of importance of life safety required documentation requested up entrance be made available. Life Safety binder reorganize on 6/21/2023 for a better filling system to ensure timeliness. Maintenance director educated on 6/21/2023 on the processes and portal access. 4. how the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator will include the quarterly documentation on monthly audits to ensure that the sprinkler inspections are included and discussed in Quas well. Quarterly inspection to be audited for completion monthly for 6 months to include through December inspections. Administrator will present findings of monthly audits to the QA committee to the quarterly for the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of monthly audits to the QA committee to the quarterly documentation or present findings of the quarterly d | e cor or of on d g ese) will , and e t | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 16 of 21

| CENTERS FOR | MEDICARE & MEDIC | AID SERVICES | | | ONIB NO. 0938-039 | |
|--------------------------------|---|----------------------------------|--|--|-------------------|--|
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (3) DATE SURVEY | |
| AND PLAN OF CORRECTION IDENTIF | | IDENTIFICATION NUMBER | A. BUILDING | 01 | COMPLETED | |
| | | 155845 | B. WING | | 05/04/2023 | |
| | | <u> </u> | CTREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | R | | 21ST AVE | | |
| SIMMON | S LOVING CARE H | HEALTH FACILITY | | IN 46407 | | |
| OlivilviOliv | C LOVING OAKL I | TEACTITI AOIEITT | OAKT, | 111 10107 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | | | | ensure continued compliance | | |
| | | | | through the remainder of the | | |
| | | | | year. | | |
| | | | | - | | |
| | | | | | | |
| K 0500 | NFPA 101 | | | | | |
| SS=C | Building Services | | | | | |
| Bldg. 01 | Building Services | | | | | |
| | | RKS section any LSC | | | | |
| | | 19.5 Building Services | | | | |
| | - | 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 record review, observation, and | | | | | |
| | | | K 0500 | what corrective action(s) will | | |
| | | ty failed to ensure 1 of 1 water | | accomplished for those resident | | |
| | | inspection certificates to | | found to have been affected by | the | |
| | | aters were in safe operating | | deficient practice; | | |
| | | 01, Section 19.1.1.3.1 requires | | No residents were found to be | 9 | |
| | | to be designed constructed, | | affected by the deficient | | |
| | _ | erated to minimize the | | practice; The facility is workin | g | |
| | possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect approximately 10 staff and an | | | with the insurance company | | |
| | | | | and other appropriate parties | | |
| | unknown number o | - | | to schedule the inspections ar | | |
| | unknown number o | i residents. | | gain the certificates as soon a | | |
| | Eindings in aluda. | | | inspected. Insurance compan | У | |
| | Findings include: | | | was contacted and they will | | |
| | Raced on observation | on during a tour of the facility | | make arrangements for the | | |
| | | f Nursing (DON) on 05/04/23 | | boiler inspections then ownership can renew the | | |
| | | and 12:55 p.m., one water | | certification online. | | |
| | | e basement did not have a | | Certification offilite. | | |
| | | n the water heater. Based on | | how other residents having t | he | |
| | | een 09:18 a.m. and 11:32 a.m., a | | potential to be affected by the | | |
| | | tion certificate was available | | same deficient practice will be | | |
| | | expiration date was dated | | identified and what corrective | | |
| | | interview at the time of record | | action(s) will be taken; | | |
| | | tion, the DON stated that the | | No residents were found to be | | |
| | | used to do inspections, but | | affected by the deficient | - | |
| I | I mourance company | asea to ao mspections, out | 1 | anecieu by the delicient | I | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet

Page 17 of 21

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction 01 | (X3) DATE SURVEY COMPLETED 05/04/2023 |
|--------------------------|---|---|-------------------------------------|--|---|
| | PROVIDER OR SUPPLIEI | R HEALTH FACILITY | 700 E | ADDRESS, CITY, STATE, ZIP COI 21ST AVE , IN 46407 | D |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE COMPLETION PROPRIATE DATE |
| | to get inspections s expiration date. | ed inspections and was unable cheduled before the indicated ewed with the DON at exit | | practice; however, all rehad the potential to be affected. The facility is working with the insural company and other appropriate parties to so the inspections and gai certificates as soon as inspected. Insurance of was contacted and they make arrangements for boiler inspections then ownership can renew the certification online. 3. what measures will be place and what systemic will be made to ensure the deficient practice does in Owner and maintenance ducated on the process water heater/boiler inspection or before 6/21/2023 interim administrator. Owner will continue to be contact with the insurance company daily with folling requested by interim administrator to ensure scheduling of the inspecion or before to ensure the deficient practice will not incompany will be put into program will followed the inspection completed and inspectio | chedule in the company y will the he e put into c changes hat the ot recur; ce staff ss for pections by the The be in nce ow up ction sible. ction(s) will the t recur, nce place |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

127T21

Facility ID: 000368

If continuation sheet Page 18 of 21

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 2 01 | X3) DATE SURVEY COMPLETED 05/04/2023 |
|--|--|--|---|---|--|
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE DEFINITION OF A CHARGE STATEMENT OF DEFICIENCY OF A CHARGE STATEMENT OF THE PROPERTY OF A CHARGE STATEMENT OF THE PROPERTY OF TH | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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 |
| | | | | certificates placed in life safet binder. Once the inspection is completed, the administrator will include the water heater inspections documentation or the monthly environmental round audit form. The administrator will present findings to the QA committee monthly for 6 months to ensur compliance. The inspection due date will be placed also of the inspection log tool notifying the maintenance director whe each inspection is due next. | re n |
| K 0511 SS=D Bldg. 01 | complies with NF Code, electrical w complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.1 Based on observati failed to ensure ele Closet was protecte Article 406.5 (F) E shall be enclosed s | d Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility etrical wiring in 1 of 1 Janitor's ed. NFPA 70, 2011 Edition. xposed Terminals, Receptacles to that live wiring terminals are tact. This deficient practice | K 0511 | what corrective action(s) will accomplished for those residen found to have been affected by deficient practice; No residents were found to be affected by the deficient practice. A new light fixture was purchased and installed | ts the |
| | with the Director o | on during a tour of the facility f Nursing on 05/04/23 between 55 p.m., in the Janitor closet next | | immediately on or before 5/11by the maintenance director.2. how other residents having t potential to be affected by the | |

FORM CMS-2567(02-99) Previous Versions Obsolete

to resident room 108 had a broken light fixture.

Event ID:

127T21

Facility ID: 000368

If continuation sheet

same deficient practice will be

Page 19 of 21

| | MENT OF DEFICIENCIES AN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>01</u> | (X3) DATE SURVEY COMPLETED 05/04/2023 |
|-------------------------|---|--|-------------------------------------|---|--|
| | OF PROVIDER OR SUPPLIE | | 700 E | ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407 | |
| SIMM (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIENT REGULATORY OF The light bulb was wiring exposed with the mount used to be time of observation unaware of the definition process to repair the summary of the definition | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION hanging off of the wall and had ring coming from the wall where be. Based on interview at the n, the DON stated they were ficiency and would start the | | | DATE COMPLETION DATE Ve Do be acility 123 by Dut into nanges the recur; y the he nding fe for aff 023 out d for ental n(s) will cur, ce e will f the |
| | 1 | | - 1 | safety binder for 6 months | s to |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/26/2023
FORM APPROVED
OMP NO. 0038 030

| CENTERS FOR | R MEDICARE & MEDIC | AID SERVICES | | | OM | 1B NO. 0938-039 |
|--|---|-------------------------------|--|---|------------------|-----------------|
| STATEMEN | MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 01 | | COMPLETED | |
| | | 155845 | B. WING | | 05/04 | /2023 |
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY | | | STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | | | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | | | DATE |
| | | | | include work orders and tim | iely | |
| | | | | completion especially when | 1 | |
| | | | | causing a risk to residents a | and | |
| | | | | staff. Work orders will be | | |
| | | | | discussed with owners daily | • | |
| | | | | as needed. Administrator w | | |
| | | | | discuss findings in QA mee | • | |
| | | | | monthly for 6 months to ens | sure | |
| | | | 1 | continued compliance | | 1 |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 127T21 Facility ID: 000368 If continuation sheet Page 21 of 21