STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE A. BUILDING B. WING			
	PROVIDER OR SUPPLIE S LOVING CARE I	REALTH FACILITY	700 E	ET ADDRESS, CITY, STATE, ZIP COD E 21ST AVE Y, IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0000					
Bldg. 00	Licensure Survey. This visit was in corner Revisit (PSR) to the IN00385996 and In 25, 2022. Complaint IN0038. Complaint IN0038. Survey dates: Octor Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 22 Total: 22 Census Payor Type Medicaid: 17 Other: 5 Total: 22 These deficiencies accordance with 41	8228 - Not Corrected. ober 3, 4, 5, and 6, 2022. 00368 55845 75220 :: reflect State Findings cited in 0 IAC 16.2-3.1. upleted on 10/11/22.	F 0000		
SS=D Bldg. 00	Resident Rights/E §483.10(a) Resid	Exercise of Rights ent Rights. a right to a dignified			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

RAENITA DUMAS RNDON 12/02/2022

Any defiencystatement 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.

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DEPARTMEN CENTERS FO		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 <u>00</u>	(X3) DATE SURVEY COMPLETED 10/06/2022	
	PROVIDER OR SUPPLIE		700 E	ADDRESS, CITY, STATE, ZIP (21ST AVE , IN 46407	COD	
	1			, IIV 40407		
(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 CO. (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	communication wand services inside including those speaks \$483.10(a)(1) A foresident with respeach resident in a environment that enhancement of the recognizing each facility must protes the resident. §483.10(a)(2) The access to quality diagnosis, severit source. A facility maintain identical regarding transfer provision of service all residents as a resident can expect the resident can expect the resident can expect the service of interference or reprisal from the \$483.10(b)(2) The free of interference and reprisal from or her rights and the service in the region of the rights and the service in the resident can expect the service of the resident can expect the resident can expec	ith and access to persons de and outside the facility, pecified in this section. acility must treat each pect and dignity and care for a manner and in an promotes maintenance or nis or her quality of life, resident's individuality. The ect and promote the rights of er facility must provide equal care regardless of the condition, or payment must establish and a policies and practices r, discharge, and the ces under the State plan for rolless of payment source. ise of Rights. the right to exercise his or sident of the facility and as ent of the United States. er facility must ensure that exercise his or her rights ce, coercion, discrimination,				

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required under this subpart.

Based on observation, record review and

interview, the facility failed to ensure each

Event ID:

 $CWMF11 \quad {\it Facility ID:} \quad 000368$

F 0550

F550

Corrective Action(s) for

If continuation sheet

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11/01/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í				(3) DATE SURVEY COMPLETED	
		155845	B. W			10/06/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SIMMON	IS LOVING CARE I	HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		vas maintained related to being			Residents Affected by the		
	•	ng room and dining assistance			Deficient Practice		
	_	lents for 2 of 2 residents			Resident 4 – unable to correct		
	reviewed for dignity and for 2 of 6 meals				Resident's clothing position is		
	observed. (Residents 4, 1, and 22)				being and has been monitore	ed .	
	F' 1' ' 1 1				daily. His care plan has		
	Findings include:				addressed his repetitive beha	avior	
	1 0 10/2/22 4 1	2.54 P. 1. 44			of sticking hand in his pants.		
		2:54 p.m., Resident 4 was ing room seated in a chair.			Resident 1 – unable to correct		
		9			Resident's meal is being serv	/ea	
	_	ocks was exposed and visible e chair. Staff in the area did not			timely. Resident 22 – unable to corre	4	
	redirect him to pull up his pants.				We respectfully request IDR		
	redirect min to pair up his paires.				this citation. See Exhibit 1.	IOI	
	The record for Resident 4 was reviewed on 10/5/22				The resident's request for ice	ic	
		oses included, but were not			being and has been honored		
	_	ual disability, mood disorder,			Resident 22 had not receive		
	and brief psychotic	-			dialysis since Saturday due to		
	una orier psychotic	, disorder.			malfunctioning of his dialysis	,	
	The Ouarterly Min	imum Data Set (MDS)			access cite. He missed dialy	sis	
		22/22, was in progress. The			on	0.0	
		rately impaired for daily			Tuesday and Thursday which	ı was	
		nd required limited assistance			5 days since dialysis was		
	with dressing.				performed on Resident 22.		
	Interview with the	Director of Nursing on 10/6/22			Corrective Action(s) for Oth	er	
	at 10:15 a.m., indic	cated the resident should have			Residents Potentially Affect	ed	
	been told to pull up	his pants by staff. She also			All residents have the potenti	al to	
		ent needed some more clothes			be affected by this deficient		
		ght gain and some of his pants			practice.		
	were too small.2.	On 10/3/22 at 9:25 a.m., the			The resident's right to be trea	ited	
		started and NA 1 and CNA 1			with dignity and respect is		
	_	sing trays to the residents in			enforced daily through observ		
	_	om. Resident 1 was observed			and supervision by charge nu		
	sitting in a wheelchair at a table with Resident 4.				department managers, the D	ON	
	Meal service continued and Resident 1 still had				and the Administrator.		
	not received his food. All other residents had a						
		s well, however, the resident			Measures to Ensure the		
		k. Resident 4 received his			Deficient Practice Does Not		
food and started eating in front of Resident 1. At		1		Recur		1	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155845	B. W	ING		10/06	/2022
		1	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITT, STATE, ZIP COD		
SIMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
	C LOVING OAKLT	ILACITI AOILII I		5,4141,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY 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
	· ·	nt 1 received his breakfast and			All staff have been in-serviced		
		esidents were finished eating.			the resident's right to be treate		
	The Director of Nursing sat down to feed him.				with dignity and respect. They		
	O 10/2/22 -+ 2-00	I DN 1l			aware of their responsibility to		
		p.m., LPN 1 was observed			respond to and/or report any	_	
	passing out ice cream to the residents after lunch for dessert. Resident 1 was seated at one of the				observations of care or service		
	dining room tables and the LPN passed him up				provision that prevents the res		
	and he did not get any ice cream. At 2:30 p.m., the				from exercising his or her right Department managers are aw		
	resident still had not received any ice cream.				of their responsibility to report		
	resident still had not received any ice cream.				staff practice that fails to supp	-	
	On 10/4/22 at 12:55 p.m., Resident 1 was brought				the resident's right to be treate		
	to the dining room and placed at a table by				with dignity and respect.	Ju	
	himself. At 1:49 p.m., the resident received his				Disciplinary actions will be tak	en	
	•	down to feed him. At 2:05			per facility policy if repeated	OII	
		1 came out of the kitchen and			infractions are identified.		
		all of the residents. Resident 1					
	did not receive any				The Monitoring Process to		
	j				Ensure the Deficient Practice	•	
	On 10/5/22 at 8:50	a.m., LPN 1 started passing			Does Not Recur		
	coffee to the resider	nts in the dining room.			Charge nurses on each shift a	re	
	Resident 1 was seat	ted in his wheelchair at a table			responsible for monitoring digi	nity	
	by himself. The LF	PN passed out coffee to			related to how clothing is		
	everyone, however,	, the resident received nothing.			positioned to prevent exposure	e.	
		PN passed out bowls of hot and			The monitoring is documented	l on	
		esidents. At 9:12 a.m., the			a daily Nurse Rounds Sheet a	nd	
		ling out loud, as he did not get			will continue on-going. The DC	ON or	
		hortly after, NA 1 brought a			designee is responsible for		
		the resident and sat down to			reviewing the Nurse Rounds		
	feed him.				Sheets at least once per week		
					and for follow up to any identif		
		ident 1 was reviewed on 10/4/22			concerns. The DON will prepa		
	-	noses included, but were not			summary of dignity monitoring		
		ual disabilities, cerebral palsy,			review per the QAA Committe		
	aphasia, high blood	l pressure, and muscle spasms.			with further revisions or action	S	
	TI O (1 M) D (C (ATD))				implemented as deemed		
	The Quarterly Minimum Data Set (MDS)				necessary.		
	assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident was				DATE: 44/4/22		
					DATE: 11/1/22		
	totally dependent of	n staff with 2 person physical	1		Exhibit 1		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assist for transfers and needed extensive assist with 1 person physical assist for eating. We respectfully request this citation be struck from the record. Physician's Orders on the current 10/2022 order statement, indicated the resident was to receive a Resident 22 had been sent out for pureed diet with thickened liquids. dialysis on 10/4/22 but returned without receiving dialysis. Interview with the Director of Nursing on 10/5/22 According to the progress notes, at 1:30 p.m., indicated the resident was not the dialysis center called the supposed to be in the dining room until he was facility at 8:15am informing the ready to eat and he should have received the ice nurse that the dialysis could not cream and cake in pureed form. be performed due to malfunction of the AV fistula access site. NA 1 3. During a random observation on 10/4/22 at was informed of this, which was 10:13 a.m., Resident 22 was observed sitting in a why she did not respond to straight back chair in the dining room. The Resident 22's request for ice. She resident asked NA 1 for more milk. The NA provided the ice after checking indicated to the resident he could not have any with the charge nurse. The more milk. The resident then asked for a cup of resident has a history of ice. The NA stated, "Give me one minute." At requesting liquids or ice rather 10:15 a.m., NA 1 sat down at a table in the dining than eating the solid foods room and just watched the other residents. No prepared for him during meals. other staff were around. She stood up at 10:17 The care plan for Resident 22 a.m., and walked over to another table and cleared addresses the resident's potential the dishes and placed them in a tub by the kitchen nutritional problem related to End door. The resident asked NA 1 for ice again and Stage Renal Disease and dietary the NA stated, "Give me one minute [resident restrictions. The care plan name]." Another resident asked for an extra cup identifies that the resident of orange juice and the NA went into the kitchen becomes easily distracted during and brought out a cup of orange juice and handed meals and prefers soda pop, it to the resident. Another resident asked her for Kool-Aid or plain ice. An ice and she walked into the kitchen and brought intervention is to attempt to give out a bag of ice for the resident's water cup. the resident's tray before or after Resident 22 continued to ask for a cup of ice and other residents are served to NA 1 continued to state, "Give me one minute eliminate excess stimulation for [resident name]." At 10:27 a.m., NA 1 left the the resident and help him focus on dining room and asked LPN 1 if the resident could the meal. have more to drink. The NA came back into the dining room, walked into the kitchen and brought NA 1 is very familiar with this out a cup of ice for the resident and stated to the resident's history, his distraction

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-			
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155845	B. WING	·	10/06/2022	
			CTREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	₹		E 21ST AVE		
SIMMON	NS LOVING CARE H	HEALTH FACILITY		Y, IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1	(X5)	
PREFIX	1	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		nake sure you could have it."		during meals, and his frequer	nt	
		,		requests for liquids or ice. The		
	The record for Resi	dent 22 was reviewed on		charge nurse was completing		
		n. Diagnoses included, but		morning medication pass at tl		
		end stage renal disease,		time the requests were made		
		al dialysis, and dementia with		NA 1 waited until the nurse w		
	behaviors.			available to answer her quest		
				She did not feel it was emerg		
	Physician's Orders,	dated 6/7/22, indicated the		enough to distract the nurse f		
resident was to receive a no added salt diet,			passing medications. The del			
	regular texture, regular consistency, with no			responding to Resident 22's		
	bananas, tomatoes,	baked potatoes, or orange		requests for ice was directly		
	juice.			related to the fact that NA 1 w	/as	
				aware that the resident had n	ot	
	Interview with LPN	V 1 on 10/4/22 at 10:35 a.m.,		received dialysis that morning	յ, and	
	indicated the reside	nt was not on a fluid		she wanted direct instruction	from	
	restriction and coul	d drink whatever he wanted.		the nurse. The delay in respo	nse	
				was not at attempt to restrict	the	
		Director of Nursing on 10/5/22		resident's right to a dignified		
	_	ted the NA had told her she just		existence.		
		re the resident could have				
	1	drink, however, she should be				
		nt's diet and what he could				
	have to eat and drin	ık.				
	3.1-3(t)					
F 0638	483.20(c)					
SS=E	` '	at Least Every 3 Months				
Bldg. 00		erly Review Assessment				
Diag. 00	\ ′	sess a resident using the				
	1	nstrument specified by the				
	•	ed by CMS not less				
		nce every 3 months.				
		view and interview, the facility	F 0638	F638	11/11/2022	
		Quarterly Minimum Data Set	1 0030	Corrective Action(s) for	11/11/2022	
	1	timely for 6 of 17 residents		Residents Affected by the		
	1 '	ments were reviewed.		Deficient Practice		
	(Residents 4, 18, 20			Resident 4 – unable to correct	t.	

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MDS assessments are now in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: compliance. Resident 18 - unable to correct. 1. The record for Resident 4 was reviewed on MDS assessments are now in 10/5/22 at 9:35 a.m. compliance. Resident 20 – unable to correct. There was a Quarterly Minimum Data Set (MDS) MDS assessments are now in assessment, dated 5/22/22 and completed on compliance. 6/5/22. The Quarterly MDS assessment, dated Resident 6 – unable to correct. 8/22/22, indicated the MDS was in progress and MDS assessments are now in not completed. compliance. Resident 17 – unable to correct. Interview with the Director of Nursing on 10/5/22 MDS assessments are now in at 3:50 p.m., indicated the Quarterly MDS had not compliance. been completed timely and all of the MDS Resident 19 – unable to correct. MDS assessments are now in assessments were in the process of being completed and transmitted. 2. The record for compliance. Resident 18 was reviewed on 10/4/22 10:38 a.m. Corrective Action(s) for Other The Quarterly Minimum Data Set (MDS) **Residents Potentially Affected** assessment, dated 8/17/22, indicated it was still in All residents have the potential to progress. be affected by this deficient practice. 3. The record for Resident 20 was reviewed on Quarterly MDS assessments have 10/4/22 at 11:44 a.m. been audited for all current residents and are in compliance The Quarterly Minimum Data Set (MDS) with required completion dates. assessment, dated 8/20/22, indicated it was still in progress and not completed. Measures to Ensure the **Deficient Practice Does Not** Interview with the Director of Nursing on 10/4/22 Recur at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS DON will monitor MDS calendar assessments. She was aware the MDS weekly and address compliance at assessments were not completed timely.4. The morning meetings on record for Resident 6 was reviewed on 10/5/22 at Wednesday. MDS have been 11:51 a.m. outsourced but they will be done in-house until new MDS There was an Admission Minimum Data Set Coordinator is hired. (MDS) assessment completed on 6/1/22. MDS will be reviewed by DON and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
			A. BUILDING		COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		00	
		155845	B. WING		10/06/2022
NAME OF I	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP COD 21ST AVE	
SIMMON	S LOVING CARE I	HEALTH FACILITY	GARY,	IN 46407	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	A Quarterly MDS a	assessment, dated 8/26/22, was		Nurse Consultant weekly to	
	still in progress.			ensure compliance and trackir	ng
				log will be reviewed with	
	5. The record for R	esident 17 was reviewed on		Administrator and Q.A.	
	10/5/22 at 11:56 a.ı	m.		Committee.	
	There was a Quarterly Minimum Data Set (MDS) assessment completed on 5/10/22. The Monitoring Process to				
				_	
				Ensure the Deficient Practice	•
	A Quarterly MDS a	assessment, dated 8/10/22, was		Does Not Recur	
	still in progress.			The Director of Nursing or	
				designee will audit MDS	
	Interview with the Director of Nursing on 10/4/22 at 2:00 p.m., indicated the Nurse Consultant and herself were working on correcting all of the MDS			assessments for timely	
				completion twice a week for fo	ur
				weeks, then once every week	
	assessments. She v			on-going. Audit results will be	
		not completed timely.6. The		reviewed per the QAA Commit	
		19 was reviewed on 10/5/22 at		with further revisions or action	S
	11:32 a.m.			implemented as deemed	
	TI O	1 M' ' D (G (MDG)		necessary.	
		erly Minimum Data Set (MDS)		DATE: 44/44/00	
		5/3/22 and completed on		DATE: 11/11/22	
	5/17/22.				
	The following Quar	rterly MDS assessment was			
	dated 8/3/22 and wa				
		. 0			
	Interview with the	Director of Nursing on 10/4/22			
		ted the Nurse Consultant and			
	_	ng on correcting all of the MDS			
	assessments. She v	-			
	assessments were n	ot completed timely.			
	3.1-31(d)(3)				
	3.1-31(u)(3)				
F 0640	483.20(f)(1)-(4)				
SS=B	Encoding/Transm	itting Resident			
Bldg. 00	Assessments	•			
-		ated data processing			

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requirement-

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPI	LETED
		155845	B. W	ING _		10/06	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIEF	₹			21ST AVE		
SIMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
	Г		-				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	````	oding data. Within 7 days					
		npletes a resident's					
	assessment, a facility must encode the following information for each resident in the facility:  (i) Admission assessment.  (ii) Annual assessment updates.  (iii) Significant change in status						
	assessments.	ange in Status					
	(iv) Quarterly revi	aw assesments					
	1 ' '						
	<ul><li>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.</li><li>(vi) Background (face-sheet) information, if</li></ul>						
	there is no admission assessment.						
	§483.20(f)(2) Trar	nsmitting data. Within 7					
		y completes a resident's					
	1 -	cility must be capable of					
		CMS System information					
	for each resident	contained in the MDS in a					
	format that confor	ms to standard record					
	layouts and data	dictionaries, and that					
	passes standardiz	zed edits defined by CMS					
	and the State.						
	````	nsmittal requirements.					
	1	ter a facility completes a					
		ment, a facility must					
	1	smit encoded, accurate,					
	I	S data to the CMS System,					
	including the follo	-					
	(i)Admission asse						
	(ii) Annual assess						
	1 ' ' -	ange in status assessment.					
	1 ' ' -	rrection of prior full					
	assessment.						
	' ' -	rection of prior quarterly					
	assessment.	0144					
	(vii) Quarterly revie	ew. ems upon a resident's					
	I (VII) A SUDSEL OI ILE	ems upon a residents	ı		I		1

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155845	B. Wl	NG		10/06	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	₹	700 E 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 DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DEFICIENCY)		DATE
	transfer, reentry, (viii) Background an initial transmist resident that does assessment. §483.20(f)(4) Data transmit data in thor, for a State whi approved by CMS the State and app Based on record refailed to successful Set (MDS) assessm residents whose MI reviewed. (Resider Findings include: 1. The record for R 10/4/22 at 10:52 a.r. The Quarterly Mini assessment, dated 7 accepted but not ex completed on 7/21/ Interview with the lat 2:00 p.m., indica herself were working assessments. She wassessments had no	discharge, and death. (face-sheet) information, for sion of MDS data on a not have an admission a format. The facility must be format specified by CMS ch has an alternate RAI ch in the format specified by showed by CMS. Wiew and interview, the facility by export the Minimum Data lent in timely manner for 4 of 17 DS assessments were sents 1, 6, 23, and 5) Alteria and the man and the m	F 06		F640 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 1– unable to correct. MDS assessments are now in compliance. Resident 6 – unable to correct MDS assessments are now in compliance. Resident 23– unable to correct MDS assessments are now in compliance. Resident 25 – unable to correct MDS assessments are now in compliance. Resident 5 – unable to correct MDS assessments are now in compliance. Corrective Action(s) for Other Residents Potentially Affected. All residents have the potential be affected by this deficient practice. All MDS assessments have be	t. et. e r e d	11/11/2022
		sion Minimum Data Set (MDS) ed it had been completed but r transmitted.			audited for current residents a have been exported in complia with required time frames.		

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3. The record for Resident 23 was reviewed on

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Measures to Ensure the

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIER S LOVING CARE H			700 E 2	ADDRESS, CITY, STATE, ZIP COD 11ST AVE IN 46407		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF 10/5/22 at 11:52 a.r The 5/18/22 Quarte assessment, indicate was not exported or 4. The record for Re 10/5/22 at 12:37 p.r. The 5/20/22 Admis	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION n. rly Minimum Data Set (MDS) ed it had been completed but transmitted. esident 5 was reviewed on n. sion Minimum Data Set (MDS) ed it had been completed but		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Deficient Practice Does Not Recur DON will monitor MDS calend weekly and address complian morning meetings on Wednesday. MDS have been outsourced but they will be do in-house until new MDS Coordinator is hired. MDS will be reviewed by DON Nurse Consultant weekly to ensure compliance and tracking log will be reviewed with Administrator and Q.A. Committee. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Director of Nursing or designee will audit MDS	lar ce at nne I and	(X5) COMPLETION DATE
F 0641 SS=A Bldg. 00	S=A Accuracy of Assessments		F 06	541	assessments for timely completion twice a week for for weeks, then once every week on-going. Audit results will be reviewed per the QAA Commi with further revisions or action implemented as deemed necessary. DATE: 11/11/22	ittee	11/11/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155845 B. WING 10/06/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure the Minimum Data Set (MDS) Corrective Action(s) for comprehensive assessment was accurately Residents Affected by the completed related to antipsychotic medication use **Deficient Practice** and falls with major injury for 2 of 17 MDS Resident B- correction to MDS assessments reviewed. (Residents B and 20) was completed and assessment is now in compliance. Findings include: Corrective Action(s) for Other 1. The record for Resident B was reviewed on **Residents Potentially Affected** 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia All residents have the potential to with behaviors, glaucoma, anxiety, major be affected by this deficient depressive disorder, psychotic disorder with practice. hallucinations, and insomnia. All MDS assessments have been audited for current residents and The Modified Significant Change Minimum Data have been exported in compliance Set (MDS) assessment, dated 7/7/22, indicated the with required time frames. resident was not cognitively intact. The resident needed supervision with 1 person physical assist Measures to Ensure the for bed mobility and 1 person physical assist for **Deficient Practice Does Not** transfers. The resident had 1 fall with injury Recur (except major) since the last assessment. A fracture had not been checked. DON will monitor MDS calendar weekly and address psychotropic Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated drug use compliance at morning at 4:30 a.m., the resident's roommate alerted staff meetings on Wednesday. MDS the resident was on the floor. The resident had a have been outsourced but they will bruise on the upper lip and slight bleeding from be done in-house until new MDS the nostril. The lower eyelid was swollen and Coordinator is hired. dark. 911 was notified and the resident was sent to the emergency room. MDS will be reviewed by DON and Nurse Consultant weekly to Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated ensure compliance and tracking the resident was being transferred to another log will be reviewed with hospital due to a fracture of the facial bone. Administrator and Q.A. Committee. Interview with the Director of Nursing (DON) on 10/5/22 at 1:30 p.m., indicated the fracture was not The Monitoring Process to coded on the Significant Change MDS **Ensure the Deficient Practice**

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assessment.

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Does Not Recur

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/06/2022			ETED		
		155845	B. W	ING		10/06/	2022
	PROVIDER OR SUPPLIED	R HEALTH FACILITY		700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIS DI AN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	2. The record for F 10/4/22 at 11:44 a. were not limited, to schizoaffective disc syndrome, and maj The Quarterly Min assessment, dated 8 progress and not co. The Annual MDS a completed on 6/3/2 cognitively intact. Tresident being cons PASARR (Preadm. Review) process to and/or intellectual was marked "No." had received an ant medication. Antips with a "0". Physician's Orders, Perphenazine (an a 4 milligrams (mg). a day for anxiety.	Resident 20 was reviewed on m. Diagnoses included, but o insomnia, anxiety, order, post traumatic stress or depressive disorder. imum Data Set (MDS) 8/20/22, indicated it was still in ompleted. assessment, dated as being 8/2, indicated the resident was The question regarding the sidered by the State Level II ission Screening and Resident of have serious mental illness disability or a related condition. In the last 7 days, the resident ti-anxiety and antidepressant sychotic medication was coded. Adated 9/18/21, indicated ntipsychotic medication) tablet. Give 1 tablet by mouth one time. Director of Nursing on 10/5/22 ated she was aware the MDS		TAG	The Director of Nursing or designee will audit MDS assessments for timely completion twice a week for foweeks, then once every week on-going. Audit results will be reviewed per the QAA Commiwith further revisions or action implemented as deemed necessary. DATE: 11/11/22	ttee	DATE
F 0645 SS=D Bldg. 00	individuals with a	ing for MD & ID mission Screening for mental disorder and itellectual disability.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	LETED
		155845	B. WING	3		10/06	/2022
				CED FEET 4	DDDEGG CUTY CTATE JID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
CINANACNI	IC LOVING GADE I	IEAL THEACH ITY			1ST AVE		
SIMMON	S LOVING CARE I	HEALTH FACILITY	Ι'	GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	7	TAG	DEFICIENCY)		DATE
	§483.20(k)(1) A n	ursing facility must not					
	admit, on or after	January 1, 1989, any new					
	residents with:						
	(i) Mental disorde	r as defined in paragraph (k)					
	(3)(i) of this section, unless the State mental						
	health authority has determined, based on an						
	independent physical and mental evaluation						
	performed by a person or entity other than						
	the State mental h	nealth authority, prior to					
	admission,						
	(A) That, because	of the physical and mental					
	condition of the individual, the individual						
	requires the level of services provided by a						
	nursing facility; and						
	(B) If the individua	al requires such level of					
		the individual requires					
	specialized servic						
	1 ' '	ability, as defined in					
		i) of this section, unless the					
		disability or developmental					
	disability authority	has determined prior to					
	admission-						
	1 ' '	of the physical and mental					
		dividual, the individual					
	I	of services provided by a					
	nursing facility; an						
	, ,	al requires such level of					
		the individual requires					
	specialized servic	es for intellectual disability.					
	0.400.00/1.\/0\.E						
		ceptions. For purposes of					
	this section-	on corooning programs and s					
	1 ''	on screening program under					
		f this section need not					
	l ·	ninations in the case of the					
	readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a						
		as transferred for care in a					
	hospital.	, also a second to a second to the c					
	(II) The State may	choose not to apply the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section-(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. Based on record review and interview, the facility F 0645 F645 11/11/2022 failed to ensure a Level II PASARR (Preadmission Corrective Action(s) for Screening and Resident Review) was completed Residents Affected by the for a resident with a mental illness for 1 of 1 **Deficient Practice** residents reviewed for PASARR. (Resident 20) Resident 20 has had a Level II PASARR completed. Finding includes: Corrective Action(s) for Other The record for Resident 20 was reviewed on **Residents Potentially Affected** 10/4/22 at 11:44 a.m. Diagnoses included, but Any resident with a mental

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were not limited, to insomnia, anxiety,

schizoaffective disorder, post traumatic stress

syndrome, and major depressive disorder.

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disorder or intellectual disability as

defined at §483.20(k)(3) has the

potential to be affected by this deficient practice. An audit was

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/06/2022	
	ROVIDER OR SUPPLIER S LOVING CARE H		700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE , IN 46407	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	•	mum Data Set (MDS) /20/22, indicated it was still in		completed of Level I PASARF assessments for all current	₹
	progress and not co			residents, and there are curre	antly
	progress and not co	impieted.		no residents who require a Le	•
	The Annual MDS	assessment, dated as		PASARR assessment.	
	completed on 6/3/2	2, indicated the resident was		Measures to Ensure the	
	cognitively intact. The question regarding the			Deficient Practice Does Not	
	_	idered by the State Level II		Recur	
	PASARR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition				
				Social Worker will refer Resid	ent
	was marked "No." In the last 7 days the resident			20 to agency for Level II assessment	
	had received an anti-anxiety and antidepressant medication. Antipsychotic medication was coded with a "0".			assessment	
				The Monitoring Process to	
				Ensure the Deficient Practic	e
				Does Not Recur	
		R was completed on 8/2/22 and		The DON or designee will	
		nt needed a Level II		complete an audit of all new	
	assessment due to n	nental illness.		admissions within one week	
	T., 4	Ci-1 Ci Di (CCD)		admission to ensure that the	
		Social Service Director (SSD) o.m., indicated she was unaware		I PASARR assessment does require a Level II PASARR	not
		a Level II assessment and she		assessment. The audits will	
		o contact for the screening.		continue following each new	
		· ·		admission for three months. A	Audit
		Director of Nursing on 10/5/22		results will be reviewed per th	ie
	-	ted she was unaware the		QAA Committee with further	
	resident needed a P	ASARR Level II assessment.		revisions or actions implemen	nted
	3.1-16(d)(1)(B)			as deemed necessary.	
	3.1-10(d)(1)(b)			DATE: 11/11/22	
				ADDENDUM	
				F645	
				Audits of new admissions will	be
				discontinued when 100%	
				compliance has been achieve	
				3 consecutive admissions. wi	ll be
				discontinued when 100%	
				compliance has been achieved	
			1	one month. If not achieved, the	ie

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-0				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provide §483.24(a)(2) A recarry out activities necessary service nutrition, groomin hygiene; Based on observation interview, the facil residents received (activities of daily hair and eating asserviewed for ADL's Findings include: 1. On 10/3/22 at 97 was seated at a tare hair was greasy in On 10/4/22 at 10:3 the resident's hair record for Resident's hair record for Resident's a.m. Diagonal of the provided that the record for Resident's a.m. Diagonal for the record for Resident's	ed for Dependent Residents esident who is unable to sof daily living receives the esto maintain good g, and personal and oral on, record review and ity failed to ensure dependent assistance with ADL's living) related to shampooing of istance for 3 of 6 residents s. (Residents 7, 21, and 2) 100 a.m. and 1:30 p.m., Resident alble in the dining room. Her appearance. 10 a.m., 11:25 a.m., and 2:36 p.m., emained greasy in appearance. 11:25 a.m., and 11:08 a.m., emained greasy in appearance. 12:36 p.m., emained greasy in appearance.	F 0677	QAA Committee will determine need for further revisions or corrective actions as well as the frequency and length of continuation. F677 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 7. A new shampoon been trialed for the resident with an improvement in her hair presentation. Resident 21. We respectfully request IDR for this citation. Sexhibit 2. The resident is served liquids solid foods in accordance with diet order and care plan interventions. Meal assistance provided as needed. Resident 2 is in the hospital at this time. Corrective Action(s) for Other Residents Potentially Affected.	e the he he hued 11/11/2022 has ith See and her e is t		
	limited to, dementia with behavior disturbance, violent behaviors, and psychotic disorder with delusions.			All residents who require assistance with ADLs have the potential to be affected by this	e		

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The Quarterly Minimum Data Set (MDS)

assessment, dated 8/4/22, indicated the resident

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deficient practice. Residents

receive showers with shampoos in

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
11112 12111	or conditions	155845	B. WING	<u> </u>	10/06/2022
		1.000.10		_	10/00/2022
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD	
CIMMON	IS LOVING CARE H	JEALTH EACH ITV		21ST AVE IN 46407	
SIMIMON	IS LOVING CARE F	HEALTH FACILITY	GART,	IIN 40407	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		paired for daily decision making		accordance with the planned	
	and she required ex	tensive assistance for bathing.		shower schedule. Beverages a	
	l a Ri	1 0/4/22 : 1: 1.1		served prior to main entrees, a	
	A Care Plan, reviewed on 8/4/22, indicated the			additional liquids are provided	per
		L (activities of daily living) self		resident request. Staff are	
	_	eficit related to decreased		informed of individual resident	
		tions included, but were not		needs such as assistance with)
		ge the resident to participate to		meal set up including cutting	
	^	ossible with each interaction		meats, cueing and encourage	
	and monitor for any changes, any potential for improvement, reasons for self care deficit,			to eat solid foods, and special	
	expected course, and decline in function.			body or hair products.	
	expected course, and decline in function.			Measures to Ensure the	
	The October 2022 ADL flow sheet, indicated the			Deficient Practice Does Not	
	resident had received a shower on 10/1, 10/2, 10/3,			Recur	
		6/22. There was no		Licensed and certified staff ha	ove
		cating if the resident's hair had		been in-serviced on providing	·
	been washed.			individualized body or hair	
				products, serving liquids and	
	Interview with the	Director of Nursing on 10/6/22		assistance with meals includin	na
		ated the resident's hair would be		cutting meat.	ĭ
	washed. She also is	ndicated they were going to try			
	a different shampoo	o that wouldn't leave the		The Monitoring Process to	
	resident's hair greas	sy looking.		Ensure the Deficient Practice	,
				Does Not Recur	
	2. On 10/3/22 at 10	0:12 a.m., Resident 21 was		Charge nurses on each shift a	ıre
	observed seated at a	a table in the dining room. She		responsible for monitoring that	t
		akfast at that time. The		ADL assistance is provided to	
		y finished her coffee and juice.		dependent residents and that	meal
		any additional beverages		assistance is provided when	
	1	delivered. At 10:31 a.m., the		needed. The monitoring is	
		to eat her breakfast and she		documented on a daily Nurse	
	had not been offere	ed any beverages.		Rounds Sheet and will continu	
	0.10/5/22 : 0.54	4 4		on-going. The DON or designed	
		a.m., the resident was seated in		responsible for reviewing the N	
	her wheelchair at a table in the dining room. She was drinking coffee at that time. At 9:10 a.m., she received a bowl of cold cereal and she had			Rounds Sheets at least once	per
				week and for follow up to any	
				identified concerns. The DON	
		coffee and juice. At 9:51 a.m.,		prepare a summary of ADL an	ia
	sne received her bro	eakfast tray and was not	1	meal assistance monitoring	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE provided with any additional fluids. At 1:40 p.m., results for review per the QAA the resident received her lunch tray. She did not Committee with further revisions or receive anything to drink. At 1:49 p.m., the actions implemented as deemed resident received a glass of orange drink. She necessary. immediately picked up the glass and started DATE: 11/11/22 drinking the beverage. IDR Exhibit 2 The record for Resident 21 was reviewed on F677 2. 10/4/22 at 11:47 a.m. Diagnoses included, but We respectfully request this were not limited to, dementia with behavioral citation be struck from the record. disturbance. Resident 21 has extensive The Quarterly Minimum Data Set (MDS) cognitive impairments and assessment, dated 9/11/22, indicated the resident frequently prefers to drink only was cognitively impaired for daily decision making liquids rather than consume solid and she needed supervision with eating. foods. Staff are aware of this and attempt to provide her with A Care Plan, dated 9/25/22, indicated the resident adequate hydration while was at risk for altered nutrition related to the encouraging caloric intake of solid diagnoses of anorexia and decreased oral foods. The surveyor noted that the consumption. She required supervision with resident's care plan addressed the eating due to her short attention span and resident's risk for altered nutrition, advanced dementia. Interventions included, but and that this plan addresses the were not limited to, staff were to assist with meals short attention span and advanced as needed. dementia. The surveyor included in the citation that a planned Interview with the Director of Nursing on 10/5/22 intervention was that staff were to at 4:30 p.m., indicated the resident should have assist with meals as needed. The been provided with beverages in a more timely surveyor did not mention that meal manner. 3. During an observation of breakfast on assistance was not provided. 10/3/22 at 9:00 a.m., Resident 2 was in a wheelchair Instead, the citation clearly shows at the table. CNA 2 brought a breakfast plate to the resident was served liquids him at 9:58 a.m. CNA 2 cued the resident, telling before the breakfast meal was him where his food was located on the plate. The served on 10/3/22 at 10:12am as resident picked up his orange juice to drink. CNA stated "The resident had already 2 cued him once more and then left. The resident finished her coffee and juice". On then set his empty cup on top of his plate, turned 10/5/22 at 8:54am the surveyor his head, and did not eat. The resident was only observed the resident to be

given a large soup spoon for his eating utensil,

his sausage was not cut up and was left in whole

drinking coffee at that time. The

surveyor further observed that the

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	, ,	JILDING	onstruction 00	(X3) DATE COMPI 10/06	LETED	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF Patties. At 10:12 a.: medications and as assist him with his Resident 2's record 10:08 a.m. Diagnos limited to, schizoph depressive disorder The Quarterly Mini assessment, dated 6 was severely impair The resident needer mobility and toilet assessed for transfe hygiene, or bathing A Care Plan, dated had an Activities of performance deficit decreased mobility were not limited to participate, encoural light for assistance,	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION m., LPN 1 gave the resident his ked CNA 1 to come over and meal. was reviewed on 10/4/22 at see included, but were not be included, but were not included, but were		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOES (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION	ed or ids. affic ded at itored ly put nic y . The k 6/22). cale, ates a as anber of he vice ad a daily. rs well with ner	(X5) COMPLETION DATE	
					interventions.			

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CENTERS FOR	MEDICARE & MEDICAID SERVICE	ES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/06/2022		
	ROVIDER OR SUPPLIER			700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST 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)	TE	(X5) COMPLETION DATE
F 0679 SS=E Bldg. 00	§483.24(c) Activiti §483.24(c)(1) The on the comprehend plan and the preferongoing program and the preferongoing program and choice of activities group and individual independent activities and psychosocial encouraging both interaction in the comprehend and psychosocial encouraging both interaction in the comprehend and dependent activity program was impaired and dependents reviewed and the program was impaired and dependents reviewed and the program was impaired and dependents reviewed and the program was impaired and dependent activity program was impaired and dependents reviewed and the program was impaired and dependent activity program was impaired and dependent activi	facility must provide, based sive assessment and care rences of each resident, and to support residents in their s, both facility-sponsored and activities and sties, designed to meet the upport the physical, mental, well-being of each resident, independence and	F 00	679	F679 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 4. A care plan related individualized activity programmed has been developed and implemented. The Activities Quarterly Participation Review been reviewed and updated. Activity progress notes are current. Resident 21. A care plan related to individualized activity programming has been developed and implemented. The Activitic Quarterly Participation Review been reviewed and updated. Activity progress notes are current. Resident 1. A care plan related individualized activity programmed has been developed and implemented. The Activities Quarterly Participation Review been reviewed and updated. Activity Programmed has been developed and implemented. The Activities Quarterly Participation Review been reviewed and updated.	ming has ed ped es has d to ming	11/11/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155845	B. W			10/06	
	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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	On 10/5/22 at 8:56	a.m., the resident was seated at			Activity progress notes are		
	a table in the dining	g room. He was waiting on			current. The resident is now		
	breakfast and playing with a deck of cards. At				positioned in bed so that the 1	√V is	
	10:19 a.m., the resid	dent remained in the dining			in his line of vision.		
	room. He continue	d to play with the deck of cards			Resident B. A care plan relate	ed to	
	and a talk show was	s on the television.			individualized activity program	ıming	
					has been developed and		
	No activity calenda	r was observed to be posted in			implemented. The Activities		
	the dining room.				Quarterly Participation Reviev	v has	
					been reviewed and updated.		
	The record for Resi	dent 4 was reviewed on 10/5/22			Activity progress notes are		
	at 9:35 a.m. Diagnoses included, but were not				current. The resident is now		
limited to, intellectual disability, Down Syndrome,				positioned in bed so that the 1	√V is		
	and mood disorder.				in his line of vision.		
		mum Data Set (MDS)			Corrective Action(s) for Other	er	
		3/22/22, was in progress. The		Residents Potentially Affected			
	resident was moder	ately impaired for daily			All residents have the potentia	al to	
	decision making.				be affected by this deficient		
					practice. Residents have beer	า	
		Care Plan related to activity			interviewed and individualized	care	
	participation.				plans reflecting leisure interes		
					and activity preferences are ir		
	· ·	rterly Participation Review,			place. Activity progress notes		
	· ·	cated the resident participated			Activities Quarterly Participation	on	
		at least once a week and he			Reviews are current for all		
		atio outings, snacks and			residents. Monthly Activity		
	movies, and card ga	ames.			Calendars have been updated		
					reflect the preferred activities		
	The last documente dated 4/18/22.	ed activity progress note was			are posted in the dining room.		
					Measures to Ensure the		
	Interview with the I	Director of Nursing on 10/5/22			Deficient Practice Does Not		
		ted the Activity Assistant was			Recur		
		was having to be used on the			Activity staff have been in-ser	viced	
		ime so activities were lacking.			on job responsibilities related		
		·			the facility Activity Program.		
	2. On 10/3/22 at 11:30 a.m., Resident 21 was observed propelling herself up and down the				Supplies have been purchase	d for	
					the department to ensure that		
		ision was on in the dining room			diverse activities can be offere		
	I	8	1		1	• •	1

12/07/2022 PRINTED:

	OF HEALTH AND HU						RM APPROVED		
	MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(7/2) 1/	LIL TIDLE CO	ONICEDITICE TON	_	IB NO. 0938-039		
	T OF DEFICIENCIES	ľ ′			ONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL			
		155845	B. W	ING		10/06	/2022		
			-	STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF F	ROVIDER OR SUPPLIER	(700 E 21ST AVE						
SIMMON	S LOVING CARE H	HEALTH FACILITY		GARY, 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 APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	but no activities we	re taking place.							
					The Monitoring Process to				
	On 10/4/22 at 10:27	7 a.m., the resident was seated in			Ensure the Deficient Practice)			
	her wheelchair in th	ne dining room. The television			Does Not Recur				
		nized activities were taking			The Administrator or designee	will			
	_	was propelling herself in and			be responsible for ensuring the				
	_	om. At 11:08 a.m., the resident			planned activities occur on a d				
		n. At 11:25 a.m., the resident			basis Monday through Friday.				
	_	dining room by NA 1. At			Charge nurse will be responsible				
	11:27 a.m., the resident again left the dining room.				for ensuring that planned activ				
	At 11:45 a.m., she was seated in her wheelchair				occur on weekends. Activity				
	next to a table in the dining room. Her eyes were				audits will be conducted by the				
		At 11:46 a.m., she was woken			Administrator or designee onc				
		rator and given a ball to hold.			weekly for two months, then or				
		resident's eyes were closed and			every two weeks for a month.				
	_	n the table in front of her. At			Audit results will be reviewed	ner			
		ent remained seated in the			the QAA Committee with further				
		elevision remained on in the			revisions or actions implement				
		organized activities were			as deemed necessary.				
		esident received her lunch tray			as assimou necessary.				
		2:57 p.m., the resident remained			DATE: 11/11/22				
	_	s sleeping. No activities were			5,112. 1.,11,22				
	taking place.	s steeping. The wear traces were			ADDENDUM				
					F679				
	On 10/5/22 at 10:25	5 a.m., the resident continued to			Audits of the Activity Program	will			
		d out of the dining room. The			be discontinued when 100%	*****			
		ut no organized activities were			compliance has been achieved	d for			
		04 p.m., the resident was			one month. If not achieved, the				
		io with the other residents			QAA Committee will determine				
	and NA 1.	and called residents			need for further program revisi				
					or corrective actions as well as				
	The record for Resi	dent 21 was reviewed on			frequency and length of contin				
					audits.	ucu			
	10/4/22 at 11:47 a.m. Diagnoses included, but				audits.				
	were not limited to, dementia with behavioral disturbance.								
	distuivance.								

making.

The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident was cognitively impaired for daily decision

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/06/2022	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE	
	resident was dependent emotional, intellect related to cognitive included, but were activities the reside compatible with physical compatible with knyadapted as needed (resident lacked han segmentation), command abilities, and again and abilities and abil	erly Review, dated 9/11/22, ent participated in news/coffee, c/meditation, and had a hard time staying to one activities as she cted. Her favorite activity was						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL		
		155845	B. W	ING		10/06/2022		
NAME OF F	PROVIDER OR SUPPLIEF	- R			ADDRESS, CITY, STATE, ZIP COD			
SIMMON	S LOVING CARE H	JENI TU ENCII ITV			1ST AVE IN 46407			
	S LOVING CARE F	HEALTH FACILITY		GART,	IIN 4040 <i>1</i>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (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		ed. His eyes were open and he		ING			DATE	
		eiling. The television was						
	turned on, but behin	nd his head and to the right,						
	completely out of view for him to see.							
	The record for Resi	ident 1 was reviewed on 10/4/22						
	at 10:52 a.m. Diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, and aphasia (difficulty speaking).							
	The Quarterly Minimum Data Set (MDS)							
	assessment, dated 7/7/22, indicated he was not cognitively intact. The resident was totally							
	dependent on staff with 2 person physical assist							
	for transfers.							
	There was no Care	Plan for activities.						
	A 9/12/21 Admissio	on Activity Assessment,						
	indicated the reside	ent preferred 1 to 1 visits with						
	staff.							
	There were no 1 to	1 activity visits documented.						
	Interview with the l	Director of Nursing on 10/5/22						
		ted the resident's television was						
	on the wall and he	was not able to see it.						
	4. On 10/3/22 at 11	:20 a.m., Resident B was						
		n. At that time, the resident						
	was awake and was	s positioned by his bed. Staff						
	left him there and d	lid not turn on the television.						
	On 10/4/22 at 10:40	0 a.m. to 12:55 p.m., the resident						
		in bed. The television was						
	turned on, however	, it was located on the night						
		ad. The resident was not able						
	to see the television	1.						
	On 10/4/22 at 3:00	p.m., to 3:30 p.m., the resident						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	
		155845	B. W	ING		10/06	/2022
NAME OF T	DOMINED OD CUMBUTET		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
	PROVIDER OR SUPPLIEF				21ST AVE		
SIMMON	S LOVING CARE I	HEALTH FACILITY		GARY, IN 46407			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		awake in bed. The television					
	set was turned on, however, it was positioned on the night stand behind his head and completely						
	out of view for him						
		. 10 500.					
		ident B was reviewed on					
	10/5/22 at 8:46 a.m. Diagnoses included, but were						
		entia with behaviors, anxiety,					
	major depressive disorder, psychotic disorder						
	with hallucinations, and glaucoma.						
	The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was not cognitively intact. The resident						
	needed supervision	with 1 person physical assist					
	1	d 1 person physical assist for					
		dent liked to listen to music for					
	activities.						
	A Care Plan, revise	ed on 7/7/22, indicated the					
		limited tolerance for activity					
	programs due to his	s diagnosis of dementia with					
	behaviors.						
	A Come Plan marriage	ed on 7/7/22, indicated the					
		red visual function related to					
	glaucoma.	ed visual function related to					
	<i>G</i>						
		Director of Nursing on 10/5/22					
		ted the resident's television was					
	behind his head wh	ile he was in bed.					
	3.1-33(a)						
F 0684	483.25						
SS=D	Quality of Care	- f					
Bldg. 00	§ 483.25 Quality						
	1	a fundamental principle that tment and care provided to					
	facility residents						

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 15845 NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY OX1, ID SUMMARY STATEMENT OF DEFICIENCIE PRIEFIX TAG COMPRETEND SUPPLIER SUMMONS LOVING CARE HEALTH FACILITY OCTOBER SUPPLIER TAG COMPRETEND SUPPLIER SUMMONS LOVING CARE HEALTH FACILITY OCTOBER SUPPLIER TAG COMPRETEND SUPPLIER TAG COMPRETEND SUPPLIER SUMMONS LOVING CARE HEALTH FACILITY OCTOBER SUPPLIER TAG COMPRETEND PRIEFIX TAG COMPRETEND PRIEFIX TAG COMPRETEND PRIEFIX TAG COMPRETEND PRIEFIX TAG COMPRETEND TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TAG TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG ID PRIEFIX TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG ID PRIEFIX TAG COMPRETEND TO DE 21ST AVE GARY, IN 46407 TAG ID PRIEFIX TAG ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 TAG ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 TAG ID PRIEFIX TAG ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION CARY IN 46407 ID PRIEFIX TAG ID PROVIDENT STANCE CORRECTION TAG ID PROVIDENT STANCE CORRECTION T	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
SIMMON'S LOVING CARE HEALTH FACILITY ON JID SUMMARY STATEMENT OF DEFICIENCIE BREITX (INCALI DEFICURCY MUST HE PRECIDED BY TILL). TAG ENGLIZATIONY ROUS EDENTIFYING NOROMATION comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centred care plan, and the residents' choices. Based on record fereive and fill follow up assessment and documentation was completed for 1 of 2 residents reveived for falls. (Resident B) Finding includes: The record for Resident B was reviewed on 10/55/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Set (MIDS) assessment, dated 77/22, indicated the resident was not cagnitively intact. The resident needed supervision with 1 person physical assist for toransfers. The resident has last of mobility and 1 person physical assist for transfers. The resident has a fact to fall follow-up assessments and documentation. A Care Plan, revised on 77/72, indicated the resident was not cagnitively intact. The resident enedication. The approaches were to ensure the resident was a risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was a risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was proprehate Footward (non-skid shoes/socks) when ambulating or mobilizing in his wheelchair. Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the residents roommatic alerted staff	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
SIMMONS LOVING CARE HEALTH FACILITY IN SUMMARY STATEMENT OF DEFICIENCIE RECULATORY OR LSC IDENTIFYING INFORMATION Comprehensive assessment of a resident, the facility professional standards of practice, the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a fall follow up assessment and documentation was completed for 1 of 2 residents reviewed for falls. (Resident B) Finding includes: The record for Resident B was reviewed on 10/5/22 at 8-46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia. The Modified Significant Change Minimum Data Sct (MIDS) assessment, dated 7/7/22, indicated the resident was not congitively intact. The resident acceded supervision with 1 person physical assist for bed mobility and 1 person physical assist for transfers. The resident had 1 fall with injury (except major) since the last assessment. A fracture had not been checked. A Care Plan, revised on 7/7/22, indicated the resident was at risk for falls related to a history of falls, unsteady gait and balance, impaired cognition, and the use of psychotropic medication. The approaches were to ensure the resident was wasting appropriate footwear (non-skid shoes/socks) when ambulating or mobilizing in his wheelchair. Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's noormate alerted staff			155845	B. W	ING		10/06/	/2022
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mobilizing in his wheelchair. follow-up assessment documentation once weekly for two months, then once every two weeks for a month. follow-up assessment documentation once weekly for two months, then once every two weeks for a month.			0 11 1			_	ınd	
Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff documentation once weekly for two months, then once every two weeks for a month.						_	IIU	
Nurses' Notes, dated 6/26/22 at 6:20 a.m., indicated at 4:30 a.m., the resident's roommate alerted staff two months, then once every two weeks for a month.		moonizing in iiis w	necician.			1	or.	
at 4:30 a.m., the resident's roommate alerted staff weeks for a month.		Nurses' Notes date	ed 6/26/22 at 6:20 a m_indicated			-		
						•	1440	
The resident was on the hoor. The resident had a property of Ahon reshirs will be reviewed her			the floor. The resident had a			Audit results will be reviewed	ner	

12/07/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE bruise on the upper lip and slight bleeding from the QAA Committee with further the nostril. The lower eyelid was swollen and revisions or actions implemented dark. 911 was notified and the resident was sent to as deemed necessary. the emergency room. DATE: 11/11/22 Nurses' Notes, dated 6/26/22 at 8:42 a.m., indicated **ADDENDUM** the resident was being transferred to another F684 hospital due to a fracture of the facial bones. The Audits of falls and follow-up resident returned on 6/28/22. assessments will be discontinued when 100% compliance has been Nurses' Notes, dated 7/7/22 at 1:37 a.m., indicated achieved for one month. If not the resident was observed on the floor mat next to achieved, the QAA Committee will his bed at 7:00 p.m. The resident was assisted determine the need for further back to the bed and the Director of Nursing revisions or corrective actions as (DON) was notified, who instructed the writer to well as the frequency and length of send the resident to the emergency room for an continued audits. evaluation. 911 was called and the paramedic indicated the hospital was full and there was no bed available. The DON was notified again regarding the hospital status and the resident was left at the facility for close observation. Nurses' Notes, dated 7/7/22 at 7:34 a.m., indicated the resident had a large bowel movement that morning and incontinence care was rendered. The resident refused to be bathed. A full set of vital signs were obtained. A Physician's Progress Note, dated 7/7/22, indicated acute visit for right hip pain and the inability to bear weight. He had a right hip xray done yesterday which was reviewed and was negative. The resident recently returned from the hospital after an evaluation for facial fractures.

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The resident had pain with range of motion to the right hip. An xray of the knee and CT/MRI of the right hip with and without contrast was ordered. "He is a very complex resident and with the current and multiple comorbidities make him at risk for hospitalization." The resident needed close

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CENTERS FOR		OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	(X2) MUI A. BUII B. WIN	DING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/06/2022	
	PROVIDER OR SUPPLIE	R HEALTH FACILITY		700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	7/8/22 at 12:47 a.m was having difficul in bed most of the president tolerated his no distress. Staff with the next document 2:59 p.m., which in appointment at the the right hip. Nurses' Notes, date indicated the reside and tolerated his not resident was still us bed most of the time and cooperative with symptoms of distrest the resident in Nurses' Notes, date the resident in Nurses' Notes, date the resident had a for chair at that time with resident's safety was noted. The next document 7/11/22 at 4:48 p.m was alert and verbal continued pain to the unable to bear weight which was negative was negative.	ted Nurses' Note, was dated an, which indicated the resident lety standing. The resident was time except for dinner. The is medication and meals with ill continue to monitor. The ded Nurses' Note was 7/8/22 at adicated the resident had an hospital for a Cat Scan (CT) of let ded 7/8/22 at 11:57 p.m., and was alert with confusion, medications and meals. The mable to stand and remained in let. The resident was pleasant the care, with no signs or less. Will continue to monitor. The mentation or an assessment of less' Notes on 7/9/22. The ded 7/10/22 at 7:06 a.m., indicated lear night. He was up in the less maintained and no distress led Nurses' Note was on an, which indicated the resident less maintained and hip and was left. An x-ray was performed less. The resident had less. The resident had					

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complaints of pain when attempting to bear weight. A CT scan was ordered and performed at

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/06/2022				
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E 2	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	continue to monitor							
	indicated the Physic the resident had an hip. Naproxen (an	d 7/11/22 at 7:38 p.m., cian had called and indicated impacted fracture to the right anti-inflammatory medication) g) twice a day was ordered for						
	vital signs after the	monitoring with a full set of fall on 7/6/22. There was no nt of the resident's hip or						
	at 1:30 p.m., indica	Director of Nursing on 10/5/22 ted there was no fall follow up a monitoring of the resident /22.						
	3.1-37(a)							
F 0689 SS=D Bldg. 00		ents.						
	adequate supervision prevent accident Based on observation interview, the facilitative triangle interventions were history of falls with	h resident receives sion and assistance devices nts. on, record review, and ty failed to ensure post fall in place for a resident with a a fracture related to a floor mat wearing non-skid socks for 1	F 0689	F689 Corrective Action(s) for Residents Affected by the Deficient Practice Resident B. The resident was	11/01/2022			

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of 2 residents reviewed for falls. (Resident B)

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moved to a low bed on 10/6/22.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The resident's wheelchair is now Finding includes: equipped with anti-tipper bars. Staff ensure the resident has On 10/3/22 at 9:22 a.m., Resident B was observed non-skid footwear in place when sitting in a wheelchair at table by himself in the he is in the wheelchair. A motion main dining room. The resident's wheelchair sensor is at the bedside to alert brakes were locked and he started moving the staff if the resident attempts to table to the left, right, and forward. The resident exit the low bed. The care plan was agitated and was speaking nonsensical. He has been reviewed and updated. pushed the table forward and the front of his wheelchair popped up leaving him sitting in the Corrective Action(s) for Other chair only on back wheels. He continued to do **Residents Potentially Affected** this until the nurse was summoned immediately All residents at risk of falling have into the dining room as there was no other staff the potential to be affected. around. There were no anti-tippers on the back of Residents are assessed upon his wheelchair to prevent him from tipping admission, quarterly and with backwards. significant change for the risk of falling. Individualized fall prevention On 10/4/22 at 10:40 a.m. until 12:55 p.m., the interventions are implemented as resident was observed in bed. He was dressed in deemed appropriate. Care plans street clothes, with no shoes on, and wearing just are reviewed and updated as plain socks to both of his feet. The 1/4 side rail needed after each fall and each was observed in the upright position. There was assessment. Incident reports will no floor mat beside the bed and the bed was not continue to be completed in PCC in the lowest position. after any fall has occurred. On 10/4/22 at 3:00 p.m., to 3:30 p.m., the resident Measures to Ensure the

was observed in bed, a floor mat was placed beside the bed, however, the bed was not in the Recur lowest position. The resident was wearing plain

black socks to both feet.

The record for Resident B was reviewed on 10/5/22 at 8:46 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, anxiety, major depressive disorder, psychotic disorder with hallucinations, and insomnia.

The Modified Significant Change Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the **Deficient Practice Does Not**

Staff have been in-serviced on facility policy related to fall prevention. Disciplinary actions will be taken per facility policy if repeated infractions are identified.

The Monitoring Process to **Ensure the Deficient Practice Does Not Recur**

Charge nurses on each shift are responsible for monitoring that fall

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
155845		B. WING		10/06/2022			
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E 2	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DE COMPENSA DE COM	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	ì ·	R LSC IDENTIFYING INFORMATION	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	resident was not co	gnitively intact. The resident		prevention interventions are in	1		
	needed supervision	with 1 person physical assist		place as planned. The monitor			
	for bed mobility and	d 1 person physical assist for		is documented on a daily Nurs	_		
	1	lent had 1 fall with injury		Rounds Sheet and will continu			
		e the last assessment. A		on-going. The DON or design			
	fracture had not bee			will continue to review all			
				Incident/Accident Reports and	l will		
	A Care Plan revise	d on 7/7/22, indicated the		investigate any incidents relate			
		for falls related to a history of		falls to determine root causes			
		and balance, impaired		potential need for new	and		
		-		interventions. The investigation	n		
	cognition, and the use of psychotropic medication. The approaches were to ensure the			results will be documented and			
resident was wearing appropriate footwear			will be reviewed per the QAA				
(non-skid shoes/socks) when ambulating or			Committee with further revision	no or			
	mobilizing in the w	,					
	inodinzing in the w	neerchan.		actions implemented as deem	eu		
	NonIN-4 d-4-	1 (/2(/22 -+ (-20 :- +: -+- +		necessary.			
		d 6/26/22 at 6:20 a.m., indicated		DATE 44/4/00			
		sident's roommate alerted staff		DATE:11/1/22			
		the floor. The resident had a		ADDENDUM			
		lip and slight bleeding from		F689			
		ver eyelid was swollen and		The DON or designee will revi			
		ied and the resident was sent to		incident/accident reports once			
	the emergency room	n.		weekly for two months, then o			
				every two weeks for two month			
		the face, neck and head, dated		then at least monthly on-going			
		he resident had an acute left		The DON or designee will con			
		ry complex fracture of the left		to investigate any incidents rel			
	1	t inferior and lateral orbital wall		to falls to determine root cause	es		
		ry sinus (this type of fracture		and potential need for new			
	was a result from bl	lunt trauma to the periorbital		interventions. Daily Rounds			
	area).			Sheets will be reviewed at least			
				once per week for two months			
		d 6/26/22 at 8:42 a.m., indicated		then once every two weeks for	r two		
		ing transferred to another		months, then at least monthly			
	_	acture of the facial bones. The		on-going. Fall investigation results			
	resident returned or	n 6/28/22.		will be documented and review	ved		
				per the QAA Committee with			
		d 7/7/22 at 1:37 a.m., indicated		further revisions or actions			
	the resident was ob	served on the floor mat next to		implemented as deemed			
	his bed at 7:00 p.m.	. The resident was assisted		necessary. The frequency and	1		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845					COMPL 10/06		
100040						10/06/	
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
SIMMONS LOVING CARE HEALTH FACILITY					1ST AVE IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DI ANI CE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the Director of Nursing			length of continued reviews w	ill be	
		d who instructed the writer to the emergency room for an			determined as well.		
		as called and the paramedic					
		al was full and there was no					
	_	DON was notified again					
		tal status and the resident was					
		or close observation.					
	A Nurses' Note, dat	ted 7/11/22 at 4:48 p.m.,					
		nt was alert and verbally					
		continued to have pain to the					
	right leg and hip an	d was unable to bear weight.					
		rmed which was negative for a					
		ted degenerative changes. The					
	_	aints of pain when attempting					
	_	T scan was ordered and					
	performed at the hospital and results were still						
	pending. Will continue to monitor for any changes.						
	changes.						
		d 7/11/22 at 7:38 p.m.,					
	1	cian had called and indicated					
		impacted fracture to the right					
		anti-inflammatory medication)					
		g) twice a day was ordered for					
	pain.						
	A CT scan of the ri	ght hip, dated 7/11/22,					
		ted fracture of the femoral neck.					
	Physician's Orders.	dated 6/28/22, indicated fall					
	and safety precautions. Place floor mat at bedside						
	when resident was in bed. Alarm sensor in room						
	to alert staff of tran	sfers.					
	Interview with the l	Director of Nursing (DON) on					
		., indicated the floor mat should					
		poor next to the bed at all times					
	and the bed should	be in the lowest position.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 10/06/2022				
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E 2	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0695 SS=D Bldg. 00	to change out his bedone. 3.1-45(a)(2) 483.25(i) Respiratory/Trach Suctioning § 483.25(i) Respiratory tracheostomy care in provided such comprehensive per the residents' goal 483.65 of this sub Based on record residents in fection. (Resident Finding includes: The record for Residents in the residents of the residents in fection. (Resident Finding includes: The record for Residents in the residents of the residents in fection. (Resident Finding includes: The record for Residents in the record for Residents in fection. (Resident Finding includes: The record for Residents in the record for Residents in fection. (Resident finding includes: The record for Residents in the record for Resident for the record for Residents in the record for Resident	e and tracheal suctioning, care, consistent with dards of practice, the erson-centered care plan, and preferences, and part. View and interview, the facility grounds for a resident with as also receiving an antibiotic reviewed for respiratory at 22) dent 22 was reviewed on a Diagnoses included, but were	F 0695	F695 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 22. Unable to correct The pneumonia has resolved. Daily respiratory status is completed for on-going COVII monitoring. Corrective Action(s) for Othe Residents Potentially Affected. All residents with a respiratory infection have the potential to affected by this deficient pract There are currently no resider with a respiratory infection or require respiratory care.	er ed y be tice.			
				Measures to Ensure the				

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

A Care Plan, dated 9/30/22, indicated the resident

Event ID:

CWMF11 Facility ID: 000368

If continuation sheet

Deficient Practice Does Not

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/06/2022		
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 PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	piotic therapy due to the			Recur			
		nonia. Interventions included,			Licensed nurses have been			
		d to, administer antibiotics as			re-educated on standard			
		tate lungs and document			assessment practices when a			
	findings at least on	ce every 24 hours.			resident is being treated for a			
					respiratory infection. A new to			
	-	er, dated 9/28/22, indicated the			has been developed to assist			
		eive Levofloxacin (an			licensed staff with follow-up			
	· · ·	ligrams (mg) daily, every other			assessments and documenta			
		. The antibiotic was			post hospitalization or condition	on		
	discontinued on 9/30/22.				change.			
	A Physician's Order, dated 9/28/22, indicated the				The Monitoring Process to			
	•	eive Doxycycline Hyclate (an			Ensure the Deficient Practice	^		
		twice a day for pneumonia until			Does Not Recur	C		
	10/5/22.	twice a day for pheamonia and			Quality of Care audits for resid	dents		
	10/0/22				with condition changes are be			
	The resident was re	eadmitted to the facility on			conducted by the Nurse	,g		
	9/26/22 at 8:31 p.m. There was no assessment of				Consultant on a concurrent ba	asis		
	his lung sounds.				and will continue for three mo			
	C				Audit results will be reviewed	per		
	There was no assessment of the resident's lung				the QAA Committee with furth	-		
	sounds in the nurse	es' notes dated 9/28, 10/1, 10/2,			revisions or actions implemen	ited		
	10/4, and 10/5/22.				as deemed necessary.			
	Interview with the Director of Nursing on 10/6/22				DATE: 11/11/22			
	-	ted the resident's lung sounds			ADDENDUM			
	should have been a	ssessed while he was being			F695			
	treated for pneumo	nia.			The frequency of Quality of C			
					audits is directly dependent u	•		
	3.1-47(a)(6)				the frequency with which a ch			
					of condition occurs. This inclu			
					a change in physical or menta			
					health status requiring physici	ian		
					intervention or an incident or			
					accident resulting in injury			
					requiring physician intervention			
					The Nurse Consultant monito			
					24-hour reports in Point Click			
			1		and completes a Quality of Ca	are	1	

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155845	B. WING		10/06/2022
NAME OF I	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP COD	
CINANACN		IEAL THEACH ITY		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	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				audit within five business days	
				when these occurrences are	
				evident. The Nurse Consultant	
				notifies the DON of any concer when found. The audits will be	
				discontinued when 100%	
				compliance has been achieved	d for
				one month. If not achieved, the	
				QAA Committee will determine	
				need for further revisions or	
				corrective actions as well as th	ie
				frequency and length of contin	ued
				audits.	
F 0697	483.25(k)				
SS=D	Pain Managemen				
Bldg. 00	§483.25(k) Pain N	_			
	The facility must e	•			
		rovided to residents who ices, consistent with			
	l '	dards of practice, the			
		erson-centered care plan,			
		goals and preferences.			
		view and interview, the facility	F 0697	F697	11/11/2022
		esident who had sustained a	1 0057	Corrective Action(s) for	11/11/2022
	fall and had compla	aints of right hip pain when		Residents Affected by the	
	standing received p	ain medication for 1 of 1		Deficient Practice	
	residents reviewed	for pain. (Resident B)		Resident B. Unable to correct.	The
				resident continues to receive	
	Finding includes:			Naproxen 500mg twice daily. A	
				current Pain Interview assessn	nent
		ident B was reviewed on		has been completed without	
		. Diagnoses included, but were		evidence of pain per verbal or	
		entia with behaviors, glaucoma,		non-verbal expression.	
		ressive disorder, psychotic		Commontino Anti	_
	alsorder with hallu	cinations, and insomnia.		Corrective Action(s) for Othe	l l
	The Medified Si	ifiaant Changa Minimum Data		Residents Potentially Affecte	l l
	I The Modified Sign	ificant Change Minimum Data	- 1	All residents have the potentia	I IU

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

Set (MDS) assessment, dated 7/7/22, indicated the

Event ID:

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be affected by this deficient

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	ONSTRUCTION 00	(X3) DATE COMPL	LETED
		155845	B. W	ING		10/06	/2022
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	•	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	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		gnitively intact. The resident			practice. Charge nurses are		
	_	with 1 person physical assist			responsible for responding to		
		d 1 person physical assist for			verbal or non-verbal expression	ons of	
		dent had 1 fall with injury			pain. Certified staff are respor	nsible	
		e the last assessment. A			for reporting to charge nurses		
	fracture had not be	en checked.			when aware of verbal or non-	verbal	
					expression of pain. The Pain		
		ed on 7/7/22, indicated the			Interview assessment tool is		
		for falls related to a history of			utilized when any new physica		
		and balance, impaired			condition or injury is apparent		
	cognition, and the				Pain management intervention		
		oproaches were to ensure the			are planned and implemented		
	resident was wearing appropriate footwear				care plans updated as necess	sary.	
	(non-skid shoes/socks) when ambulating or						
	mobilizing in whee	elchair.					
					Measures to Ensure the		
		ed 6/26/22 at 6:20 a.m., indicated			Deficient Practice Does Not		
		sident's roommate alerted staff			Recur		
		the floor. The resident had a			Licensed and certified staff ha		
		lip and slight bleeding from			been re-educated on the need	d to	
		wer eyelid was swollen and			report, monitor and provide		
		fied and the resident was sent to			interventions for any verbal or		
	the emergency room	m.			non-verbal expressions of pai	n.	
	A Cat Scan (CT) as	f the face, neck and head, dated			The Monitoring Process to		
		the resident had an acute left			Ensure the Deficient Practice	•	
	· ·	ry complex fracture of the left			Does Not Recur	•	
		it inferior and lateral orbital wall,			Quality of Care audits for resid	dents	
		ary sinus (this type of fracture			with condition changes are be		
		lunt trauma to the periorbital			conducted by the Nurse	iiig	
	area).	runt truuma to the periorotan			Consultant on a concurrent ba	neie	
					and will continue for three mo		
	Nurses' Notes, date	ed 6/26/22 at 8:42 a.m., indicated			The audits include monitoring		
		ing transferred to another			appropriate interventions are		
		acture of the facial bones. The			planned and executed for any	,	
	resident returned or				resident with a new injury or		
		 -			physical condition that could		
	Nurses' Notes, date	ed 7/7/22 at 1:37 a.m., indicated			result in pain. Audit results wil	l be	
		served on the floor mat next to			reviewed per the QAA Commi		
		. The resident was assisted			with further revisions or action		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		155845	B. W	ING		10/06	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	R			SIST AVE		
SIMMON	S LOVING CARE I	HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the Director of Nursing			implemented as deemed		
		d who instructed the writer to			necessary.		
		the emergency room for an					
		as called and the paramedic			DATE: 11/11/22		
	-	tal was full and there was no			ADDENDUM		
		DON was notified again			F697		
		tal status and the resident was			The frequency of Quality of C		
	left at the facility for	or close observation.			audits is directly dependent u		
		A Physician's Progress Note, dated 7/7/22,			the frequency with which a ch	-	
	, ,				of condition occurs. This inclu		
		t for right hip pain and the			a change in physical or menta		
	-	eight. The resident recently			health status requiring physici	an	
	returned from the hospital after an evaluation for				intervention or an incident or		
	facial fractures. The resident had pain with range				accident resulting in injury		
	of motion to the rig	ght hip.			requiring physician intervention		
					The Nurse Consultant monito		
		ed Nurses' Note, was dated			24-hour reports in Point Click		
		., which indicated the resident			and completes a Quality of Ca		
	_	ty standing. The resident was			audit within five business day	5	
		time except for dinner. The			when these occurrences are		
		nedication and meals with no			evident. The Nurse Consultan		
	distress. Will contin	nue to monitor.			notifies the DON of any conce		
					when found. The audits will be	Э	
		d 7/8/22 at 11:57 p.m.,			discontinued when 100%		
		ent was alert with confusion,			compliance has been achieve		
		s medications and meals. The			one month. If not achieved, th	е	
		nable to stand and remained in			QAA Committee will determin	e the	
	bed most of the tim	e. The resident was pleasant			need for further revisions or		
	and cooperative with	th care, with no signs or			corrective actions as well as t	he	
	symptoms of distre	ss. Will continue to monitor.			frequency and length of contir	nued	
					audits.		
	There was no docur	mentation or an assessment of					
	the resident in Nurs	ses' Notes on 7/9/22.					
		d 7/11/22 at 4:48 p.m.,					
	indicated the resident was alert and verbally responsive. He continued to have pain to the right						
	leg and hip and was	s unable to bear weight. An					
	x-ray was performe	ed which was negative for a					
	-	ted degenerative changes. The					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845 A. BUILDING B. WING		(X2) MULTIPLE CO A. BUILDING B. WING	OO (X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIEF		700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE IN 46407	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	resident had completo bear weight. A C performed at the hopending. Will contichanges.	aints of pain when attempting T scan was ordered and espital and results were still nue to monitor for any			
	indicated the Physic the resident had an hip. Naproxen (an 500 milligrams (mg pain.	d 7/11/22 at 7:38 p.m., cian had called and indicated impacted fracture to the right anti-inflammatory medication) g) twice a day was ordered for			
	A CT scan of the right hip, dated 7/11/22, indicated an impacted fracture of the femoral neck. Physician's Orders, dated 7/11/22, indicated				
	Naproxen Tablet 50 two times a day for	00 mg, give 1 tablet by mouth pain.			
	indicated the reside the first time on 7/1 other pain relief me	Iministration Record for 7/2022, nt received the Naproxen for 2/22 at 9:00 a.m. There was no edication ordered or resident after the fall with the			
	indicated Tylenol w	sment, completed on 6/28/22, was administered at the hospital re and the resident was unable d pain.			
	There was no Pain resident after the fa	Assessment completed for the ll on 7/6/22.			
	at 1:30 p.m., indica not been completed There was no moni	Director of Nursing on 10/5/22 ted a new pain assessment had after the most recent fall. toring of the resident's pain dication given until 7/12/22.			

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Event ID:

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If continuation sheet

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CENTEROTOR	THE CONTENTS OF THE PARTY	THE SERVICES			312 1.31 0700 007
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155845	B. WING		10/06/2022
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIER	2		21ST AVE	
SIMMON	S LOVING CARE H	HEALTH FACILITY		IN 46407	
	Г			<u> </u>	(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DET CIENCIT	DATE
	2 1 27(-)				
	3.1-37(a)				
F 0698	402 25/1)				
SS=D	483.25(I) Dialysis				
Bldg. 00	§483.25(I) Dialysis	2			
Diag. 00	. , , .	s. ensure that residents who			
	I -	ceive such services,			
		ofessional standards of			
		orehensive person-centered			
	l .	e residents' goals and			
	preferences.	residents goals and			
	l :	view and interview, the facility	F 0698	F698	11/11/2022
		-	F 0098	Corrective Action(s) for	11/11/2022
	failed to ensure a dialysis access site was assessed for 1 of 1 residents reviewed for dialysis.			Residents Affected by the	
	(Resident 8)	residents reviewed for diarysis.		Deficient Practice	
	(Resident 6)			Resident 8. Physician orders t	
	Finding includes:			listen for the bruit/thrill and che	
	I maing metades.			the AV fistula site for signs an	
	The record for Resi	dent 8 was reviewed on 10/4/22		symptoms of infection every s	
		noses included, but were not		are being completed as ordered	
	limited to, end stage			are being completed as ordere	Ju.
	dependence on rena			Corrective Action(s) for Other	r
				Residents Potentially Affects	
	The Annual Minim	um Data Set (MDS)		All residents with a dialysis	,•
		7/17/22, indicated the resident		access site have the potential	to
	l '	paired for daily decision making		be affected by this deficient	
	and she received dia	•		practice.	
		•		Physician orders to listen for t	he
	A Care Plan, dated	1/29/22, indicated the resident		bruit/thrill and check the AV fis	
	was at risk for com	plications related to requiring		site for signs and symptoms o	
	dialysis. Intervention	ons included, but were not		infection every shift are being	
	1 -	r bruit and thrill every shift on		completed as ordered.	
	the arteriovenous fi	stula (AVF) to the right upper			
	arm and check for o	complications to the right AVF		Measures to Ensure the	
	every shift.			Deficient Practice Does Not	
				Recur	
	Physician's Orders,	dated 11/23/21, indicated to		Licensed nurses have been	
	listen for the bruit/t	hrill, check AV fistula site		re-educated on the need to	
	for signs and sympt	toms of infection or		complete physician orders and	d l

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

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	ΓED
		155845	B. WI	NG		10/06/20	022
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CIMANAON					21ST AVE		
SIMIMON	IS LOVING CARE I	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE ,	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	complications ever	y shift for renal dialysis.			document the same in PCC.		
				Disciplinary actions will be		.en	
	The August 2022 T	Treatment Administration			per facility policy if repeated		
	Record (TAR), ind	icated the resident's AV fistula			infractions are identified.		
	had not been check	ted for a bruit and thrill or signs					
	and symptoms of infection on the following shifts:				The Monitoring Process to		
					Ensure the Deficient Practice	•	
	7-3: 8/10 and 8/27	/22			Does Not Recur		
					Monitoring of residents with		
	3-11: 8/21 and 8/2	2/22			dialysis access sites will be		
	11-7: 8/21/22				completed through Medication	1	
					Administration Record Audits		
					weekly be the DON or designe	e =	
	Interview with the Director of Nursing on 10/5/22				for two months, then every two	o	
	-	ated documentation should have			weeks for one month. Audit		
	been completed rel	ated to the resident's fistula.			results will be reviewed per the	е	
					QAA Committee with further		
	3.1-37(a)				revisions or actions implemen	ted	
					as deemed necessary.		
					DATE: 11/11/22		
					ADDENDUM		
					F698		
					Audits of Medication		
					Administration Records will be	,	
					discontinued when 100%		
					compliance has been achieve	d for	
					one month. If not achieved, th		
					QAA Committee will determine	e the	
					need for further revisions or		
					corrective actions as well as the	ne	
					frequency and length of contir	nued	
					audits.		
F 0732	483.35(g)(1)-(4)						
SS=C	Posted Nurse Sta	_					
Bldg. 00	- ''	Staffing Information.					
		ta requirements. The facility					
	The state of the s	owing information on a daily					
1	basis:						

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

Event ID:

CWMF11 Facility ID: 000368

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155845	B. WING		10/06/2022
	PROVIDER OR SUPPLIEF		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	ID	T	(Y5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	(i) Facility name. (ii) The current da (iii) The total number of the control of the current da (iii) The total number of the current da (iii) The total number of the current day or the current day of the	te. ber and the actual hours owing categories of censed nursing staff directly sident care per shift: rses. tical nurses or licensed (as defined under State e aides. sus. sting requirements. st post the nurse staffing baragraph (g)(1) of this basis at the beginning of costed as follows: dable format. t place readily accessible to tors. blic access to posted nurse e facility must, upon oral or make nurse staffing data ublic for review at a cost not munity standard. cility data retention e facility must maintain the e staffing data for a boths, or as required by	F 0732	F732	10/17/2022
	failed to post in a ti sheet which indicat working in the facil	mely manner the daily staffing ed how many staff were lity and the facility census.	1 0/32	Corrective Action(s) for Residents Affected by the Deficient Practice	10/17/2022

who resided in the facility.

affected by this deficient practice.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OM	B NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	155845	B. W.			10/06/	
	PROVIDER OR SUPPLIER NS LOVING CARE F			STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407			(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Finding includes:				The posted staff schedule she are being updated daily.	eis	
	located in the foyer 9/30/22. The Octob posted. Interview with the lateral control of the contr	a.m., the daily staffing sheet was dated 9/16 through per staffing sheet was not Director of Nursing on 10/6/22 ated the staffing sheet had not the weekend.			Corrective Action(s) for Othe Residents Potentially Affecte All residents have the potential be affected by this deficient practice. The posted staff schedule sheets are being updated daily. Residents and families/responsible parties wil reminded that this information posted in the front lobby. Measures to Ensure the Deficient Practice Does Not Recur Licensed staff have been re-educated on the need to up the posted staff schedule daily The Monitoring Process to Ensure the Deficient Practice Does Not Recur The DON or designee will be responsible for monitoring that posted staff schedules are updated daily. The monitoring be documented on an audit for once weekly for two months, the every two weeks for one month Audit results will be reviewed put the QAA Committee with further revisions or actions implement as deemed necessary. DATE: 10/17/22 ADDENDUM	d I to II be is date /. the will rm nen h. per er	

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If continuation sheet

Audits of posted staff schedules

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AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETE		COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIER		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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				will be discontinued when 1000 compliance has been achieved one month. If not achieved, the QAA Committee will determine need for further revisions or corrective actions as well as the frequency and length of continuaudits.	d for e e the ne
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnect Each resident's drug from unnecessary drug is any drug w §483.45(d)(1) In each duplicate drug ther §483.45(d)(2) For §483.45(d)(3) With or	xcessive dose (including			
	for its use; or §483.45(d)(5) In the consequences while should be reduced	ne presence of adverse ich indicate the dose d or discontinued; or			
	reasons stated in p (5) of this section. Based on record rev failed to ensure an a pressures were mon were held per blood	paragraphs (d)(1) through	F 0757	F757 Corrective Action(s) for Residents Affected by the Deficient Practice Resident 7. Orders to monitor	10/10/2022

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (Residents 7, 1, and 20) apical pulse and blood pressure and hold parameters for Findings include: antihypertensive medication are now in place. 1. The record for Resident 7 was reviewed on Resident 1. Orders to monitor 10/5/22 at 10:52 a.m. Diagnoses included, but apical pulse and blood pressure were not limited to, hypertension and dementia and hold parameters for with behavior disturbance. antihypertensive medication are now in place. The Quarterly Minimum Data Set (MDS) Resident 20. Orders to monitor assessment, dated 8/4/22, indicated the resident apical pulse and blood pressure was cognitively impaired for daily decision and hold parameters for making. antihypertensive medication are now in place. A Physician's Order, dated 1/26/22, indicated the resident was to receive Metoprolol Tartrate (a Corrective Action(s) for Other cardiac medication) 25 milligrams (mg) give 12.5 **Residents Potentially Affected** mg twice a day for hypertension. Hold the All residents receiving medication if the systolic blood pressure (top antihypertensive medications have number) was less than 110 or the heart rate was the potential to be affected by this less than 70. deficient practice. Antihypertensive medication The September 2022 Medication Administration orders have been reviewed, and Record (MAR), indicated the resident received the orders to monitor apical pulse and Metoprolol on the following dates and times when blood pressure and to hold the her systolic blood pressure was less than 110: medication based upon specific - 9/3/22 at 9:00 a.m. and 6:00 p.m., blood pressure parameters are in place. 101/85 - 9/8/22 at 9:00 a.m., blood pressure 103/64 Measures to Ensure the - 9/9/22 at 9:00 a.m. and 6:00 p.m., blood pressure **Deficient Practice Does Not** 109/75 Recur - 9/10/22 at 6:00 p.m., 108/78 Licensed staff have been re-educated on the need to ensure The August 2022 MAR, indicated the resident

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less than 110:

received the Metoprolol on the following dates

and times when her systolic blood pressure was

- 8/2/22 at 6:00 p.m., blood pressure 100/69 - 8/7/22 at 6:00 p.m., blood pressure 96/66

- 8/10/22 at 6:00 p.m., no blood pressure

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residents who receive

antihypertensive medications have

apical pulse, blood pressure, and

hold parameter orders in place.

Ensure the Deficient Practice

The Monitoring Process to

If continuation sheet

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Metoprolol was blank and not signed out as being administered on 8/2 at 8:00 a.m., and 8/10 and

The 9/2022 MAR, indicated there was no heart rate documented prior to the administration of the 8:00 a.m., or 6:00 p.m. dose of Metoprolol.

8/16/22 for the 6:00 p.m. dose.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155845	B. W	ING		10/06	/2022
NAME OF D	PROVIDER OR SUPPLIER	•	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					1ST AVE		
SIMMON	S LOVING CARE F	HEALTH FACILITY		GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The 10/2022 MAR	indicated there was no heart					
	·	ior to the administration of the					
	-	.m. dose of Metoprolol.					
	•	•					
		d heart rate in the Vital Sign					
	section was on 3/22	/21.					
	Interview with the Director of Nursing on 10/5/22,						
		rate was not documented prior					
		n of the Metoprolol.					
	3. The record for Resident 20 was reviewed on						
		n. Diagnoses included, but					
	angina.	high blood pressure and					
	angma.						
	The Quarterly Mini	mum Data Set (MDS)					
	assessment, dated 8	/20/22, indicated it was still in					
	progress and not co	mpleted.					
	The Assess IMDC						
		assessment, dated as 2, indicated the resident was					
	cognitively intact.	2, indicated the resident was					
	-	dated 4/16/22, indicated					
	-	(a medication used to lower					
	-	heart rate) tablet 25 milligrams					
	· •/	by mouth two times a day, number) blood pressure was					
		olic (bottom number) blood					
		an 60 and heart rate was less					
	than 60.						
		ministration Records (MAR)					
		9/2022, and 10/2022, indicated rate documented prior to the					
		e 8:00 a.m., or 6:00 p.m. dose of					
	Metoprolol.	o o o o o o o o o o o o o o o o o o o					
	•						
	i		1				1

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	` ′	JILDING	INSTRUCTION 00	(X3) DATE COMPL 10/06	LETED
	PROVIDER OR SUPPLIER			700 E 2	ADDRESS, CITY, STATE, ZIP COD 1ST AVE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	at 1:30 p.m., indica	Director of Nursing on 10/5/22 ted the pulse was not to the administration of the					
F 0758 SS=D Bldg. 00	Use §483.45(e) Psych §483.45(c)(3) A particular that affects be with mental proce	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any rain activities associated sses and behavior. These are not limited to, drugs in gories:					
	resident, the facilities §483.45(e)(1) Respondential psychotropic drugunless the medical specific condition documented in the §483.45(e)(2) Respondential psychotropic drugunless clinically conto discontinue the	e clinical record; sidents who use s receive gradual dose chavioral interventions, ontraindicated, in an effort se drugs;					
	psychotropic drug	sidents do not receive s pursuant to a PRN order ation is necessary to treat					

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a diagnosed specific condition that is

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attempted.

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All residents receiving

antipsychotic medications have

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note, dated 9/15/22, indicated the resident had a

history of intermittent behaviors of yelling,

inappropriate language to staff. The staff

screaming, throwing herself on the floor, and

reported the intermittent behaviors were less

frequent. Nonpharmacological interventions were

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have developed a calendar which

identifies dates that GDR reviews

consultant pharmacist and/or the

Psychiatric Nurse Practitioner.

They will monitor compliance at

must be completed by the

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	i í	JILDING	00	COMPL	
		155845	B. W			10/06/	
				CENTER	ADDRESS SITU STATE TIP SOD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
CIVAVAOVI	S LOVING CARE H	JENI TH ENCH ITY			21ST AVE IN 46407		
SIIVIIVION	3 LOVING CARE F	TEALTH FACILITY		GART,	IN 40407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		No GDR at this time due to			least once per month for three		
	instability.				months and document the res		
					Results will be reviewed per the	ne	
		mentation of prior GDR			QAA Committee with further		
	attempts.				revisions or actions implemen	ted	
	ara ta ta at a	D: 10/5/22			as deemed necessary.		
		Director of Nursing on 10/5/22			DATE: 44/44/00		
	-	ted behavior charting on the what was in the nurses' notes			DATE: 11/11/22		
		2. The record for Resident 20			ADDENDUM		
	* *	2. The record for Resident 20 0/4/22 at 11:44 a.m. Diagnoses			F758		
		not limited, insomnia, anxiety,			Compliance monitors of GDR documentation will be		
	schizoaffective disorder, post traumatic stress				discontinued when 100%		
	syndrome (PTSD), and major depressive disorder.				compliance has been achieve	d for	
	syndrome (1 13D), and major depressive disorder.				one month. If not achieved, th		
	The Ouarterly Mini	mum Data Set (MDS)			QAA Committee will determine		
		3/20/22, indicated it was still in			need for further revisions or	0 1110	
	progress and not co				corrective actions as well as t	he	
	1 0	1			frequency and length of contir		
	The Annual MDS	assessment, dated as			audits.		
	completed on 6/3/2	2, indicated the resident was					
	cognitively intact.	In the last 7 days the resident					
	had received an ant	i-anxiety and antidepressant					
	medication. Antips	sychotic medication was coded					
	with a "0".						
		sed on 8/2022, indicated the					
		otropic medications related to					
	-	nizoaffective disorder and					
	PTSD.						
	Diaminia L O 1	1-4-10/10/21 :1' 4 1					
	_	dated 9/18/21, indicated					
	-	ntipsychotic medication) tablet					
	a day for anxiety.	Give 1 tablet by mouth one time					
	a day for anxiety.						
	Physician's Orders	dated 3/29/21 indicated					
	Physician's Orders, dated 3/29/21,indicated monitor behaviors for the following (specify)						
		skin, restlessness, agitation,					
		complaints, biting, kicking,					

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155845	 JILDING	00	COMPL 10/06	ETED
	PROVIDER OR SUPPLIER		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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		cial slurs, elopement, stealing, ations, psychosis, aggression,				
	Note, dated 8/25/22 seen today for follo adjustment with mu including major ded disorder, anxiety, a changes in behavior continued intermitty behaviors while rectreatment. Her behaviors while rectreatment. Her behavior of refusal of care in non-pharmacologic ineffective. She had mood with periods at times. No GDR (time. This provider medical record and facility. Continue of plan of care including documentation of documentation of documentation. There was no documentation of documentation. Interview with the literature of the seen of the month of the support the documentation.	mented behaviors in Nurses' ns of 6/2022, 7/2022, and 8/2022 mented progress note for no R of the antipsychotic Director of Nursing on 10/5/22				
	at 1:30 p.m., indica documentation of b	ted there was no continued ehaviors for the GDR.				
F 0773 SS=D	3.1-48(b)(2) 483.50(a)(2)(i)(ii) Lab Srvcs Physici	an Order/Notify of Results				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155845	B. WING		10/06/2022	
			0777577	ADDRESS CITY STATE TO COD		
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD		
CIVAVAOVI		JENI TH ENGILITY		21ST AVE		
SIMIMON	S LOVING CARE F	TEAL I IT FAUILITY	GARY,	IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
Bldg. 00	§483.50(a)(2) The	e facility must-				
	(i) Provide or obta	in laboratory services only				
	when ordered by a	a physician; physician				
	assistant; nurse p	ractitioner or clinical nurse				
	specialist in accor	dance with State law,				
	including scope of	f practice laws.				
	(ii) Promptly notify	the ordering physician,				
	physician assistar	nt, nurse practitioner, or				
	clinical nurse spec	cialist of laboratory results				
	that fall outside of	clinical reference ranges in				
	accordance with fa	acility policies and				
	procedures for no	tification of a practitioner or				
	per the ordering p	hysician's orders.				
	Based on record rev	view and interview, the facility	F 0773	F773	11/11/2022	
	failed to ensure lab	results were obtained in a				
	timely manner and	the Physician was notified for 1		Corrective Action(s) for		
	of 4 residents review	wed for hospitalization.		Residents Affected by the		
	(Resident 19)			Deficient Practice		
				Resident 19. The resident rece	eived	
	Finding includes:			treatment for hypernatremia in	the	
				hospital and returned to the fac	cility	
	The record for Resi	dent 19 was reviewed on		on 10/12/22. He remains in sta	ıble	
	10/6/22 at 10:25 a.r.	n. Diagnoses included, but		condition.		
	were not limited to,	end stage renal disease,				
	diabetes mellitus, st	troke, non-Alzheimer's		Corrective Action(s) for Othe	r	
	dementia, and schiz	cophrenia.		Residents Potentially Affecte	d	
				All residents with orders for		
	Physician's Orders,	dated 9/2/22, indicated the		laboratory monitoring have the		
	following laborator	y tests were to be collected:		potential to be affected by this		
	- Complete blood co	ount (CBC) with differential		deficient practice. The lab has		
	every 3 months star	ting on the 12th.		provided results of all laborator	ry	
		(a test for monitoring blood		tests completed in September.	· .	
	sugar averages) eve	ery month starting on the 23rd.		new laboratory orders have be		
	- Valproic acid (a te	est to measure anticonvulsant		received.		
	medication) every 3					
	- Thyroid stimulatir	ng hormone (TSH) every month		Measures to Ensure the		
		related to hypothyroidism		Deficient Practice Does Not		
	(low thyroid).			Recur		
	- Metabolic 14 pane	el (a test to evaluate liver,		The DON has obtained a direc	t	
		ney function) every 3 months		contract with the laboratory wh		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155845	B. WING 10/06/2022			2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			1ST AVE		
SIMMON	S LOVING CARE H	HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID		J	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	starting on the 12th				includes the requirement that	lab	
	_	vithout microscopic test every 3			results be transmitted to the		
	months starting on t				facility as soon as the results	are	
					available. Licensed nurses ha		
	The labs were draw	n on 9/19/22. The laboratory			been in-serviced on the labora		
		o the Physician by the lab on			arrangement.	, l	
		ity received the lab results from					
		/5/22. There was no			The Monitoring Process to		
		ollow up with the lab for			Ensure the Deficient Practice	e	
		ry. The lab results indicated			Does Not Recur		
	1	emia (low blood count),			The DON or designee will		
	decreased kidney fu	nction, elevated TSH levels,			complete laboratory testing au	ıdits	
	decreased valproic acid levels, and a possible				monthly.		
	urinary tract infection	on (UTI).			Audit results will be reviewed	per	
					the QAA Committee with furth	er	
	During an interview	with LPN 1 on 10/5/22 at 2:00			revisions or actions implemen	ted	
	p.m., she indicated	the resident was admitted to			as deemed necessary.		
	the hospital for hyp	ernatremia (an elevated					
	sodium level).				DATE: 11/11/22		
	Interview with the I	Director of Nursing (DON) on					
		n., indicated the lab they were					
		ne facility and the lab never					
	_	acility, but rather directly to					
		DON also indicated the facility					
		to online lab results. She					
		copy of the contract with the					
	_	ed the contract may be held by					
	the Physician.	<i>yy</i>					
	3.1-49(f)(2)						
F 0867	483.75(g)(2)(ii)						
SS=F	QAPI/QAA Improv						
Bldg. 00	§483.75(g) Quality	y assessment and					
	assurance.						
	\$400 7E/~\/0\ Tb =	auglity appears and and					
	(0,1,	e quality assessment and					
	assurance commit						
	(ii) Develop and in	nplement appropriate plans					

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/06/2022 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of action to correct identified quality deficiencies: F 0867 Based on observation, record review, and F867 11/11/2022 interview, the facility failed to identify unresolved Corrective Action(s) for quality deficiencies, some of which had been cited Residents Affected by the on previous surveys, and ensure actions were **Deficient Practice** developed and implemented to attempt to correct No specific residents were the deficiencies through the quality assessment identified as affected by the and assurance (QAA) process as evidenced by deficient practice. the number of deficiencies cited involving quality of care for transmitting Minimum Data Set (MDS) Corrective Action(s) for Other assessments, pressure ulcers, pain, unnecessary Residents Potentially Affected medications, and infection control. This deficient All residents have the potential to practice affected 22 of 22 residents residing in the be affected by this deficient facility. practice. Corrective actions will be taken for deficient practices Findings include: involving transmitting Minimum Data Set assessments, pressure Interview with the Director of Nursing on 10/6/22 ulcers, pain, unnecessary at 1:34 p.m., indicated the Quality Assessment and medications, and infection control Assurance (QAA) Committee met at least as submitted in this report. quarterly and the committee consisted of the Medical Director, the Administrator, the DON, Measures to Ensure the Infection Control Nurse, the Minimum Data Set **Deficient Practice Does Not** (MDS) Nurse, the Dietitian, the Food Sanitation Recur Supervisor, the Pharmacist, and Maintenance. The Quality Assurance and Performance Improvement The Quality Assurance and Performance committee will continue to meet at Improvement (QAPI) plan requested at the least quarterly to review quality Entrance Conference, was provided during the performance measured through a survey by the DON. The plan was a general variety of audits. Performance outline of how to set up a QAPI committee and improvement projects will be what the committee should do. Chapters Four and developed and implemented when Five of the plan indicated how to implement deemed necessary or appropriate. performance improvement projects (PIP) as part of the QAPI program and implementing the QAPI The Monitoring Process to

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program planning and processes.

1. The following deficiencies were cited on this

survey at an isolated scope with potential for

Event ID:

CWMF11

Facility ID: 000368

Does Not Recur

Ensure the Deficient Practice

Monitoring will occur through all

audits identified in this report.

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155845		(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/06/2022				
	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	ILD BE COMPLETION DATE			
	more than minimal previously as follow - F684 Quality of C Recertification survand 4/27/21 F686 Pressure Uld Recertification survand 4/27/21 F698 Dialysis was Recertification survand 4/27/21 F757 Unnecessary cited on Recertification survand 4/27/21 F758 Unnecessary was previously citedated 4/21/22, 10/2 - F880 Infection Co Recertification survand 4/27/21. 2. The following d survey at a pattern potential for no mo - F640 Transmitting assessments was pr	harm and had been cited ws: Care was previously cited on veys dated 4/21/22, 10/29/21, cers was previously cited on veys dated 4/21/22, 10/29/21, sers was previously cited on veys dated 4/21/22, 10/29/21, Medications was previously cited surveys dated 4/21/22, 10/29/21, Medications was previously citen surveys dated 4/21/22, 10/29/21, Psychotropic Medications don Recertification surveys 9/21, and 4/27/21. Control was previously cited on veys dated 4/21/22, 10/29/21, Meficiency was cited on this scope with no actual harm with re than minimal harm. By of Minimum Data Set (MDS)		Audit results will be reviet the QAA Committee with revisions or actions imple as deemed necessary. DATE: 11/11/22 ADDENDUM F867 QAA Committee to meet quarterly, and available u request and be actively in making systemic changes prevent deficiency reoccur	wed per further emented			
	developed, or imple continued to monite	ence the facility had identified, emented action plans and/or or any corrective actions taken acies were cited previously.						
	indicated she and the addressing the issue	DON on 10/6/22 at 1:45 p.m., ne Nurse Consultant were e of transmitting the MDS dating the Care Plans. She						

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CWMF11 Facility ID: 000368

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLI				
		155845	B. W	ING		10/06	/2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
F 0880 SS=D Bldg. 00	also indicated this h The DON was also were repeat deficier of the areas had bee systems needed to b recurrence. 3.1-52(b)(2) 483.80(a)(1)(2)(4) Infection Preventic §483.80 Infection The facility must e infection preventic designed to provic comfortable enviro the development a communicable dis §483.80(a) Infectio program. The facility must e prevention and co must include, at a elements: §483.80(a)(1) A sy identifying, reporti controlling infectio diseases for all re- visitors, and other services under a c based upon the fa conducted accord following accepted §483.80(a)(2) Writ	and been an ongoing issue. aware the above concerns noies and she indicated some on identified and ongoing be put into place to prevent (e)(f) on & Control Control establish and maintain an on and control program de a safe, sanitary and onment and to help prevent and transmission of eases and infections. on prevention and control establish an infection ntrol program (IPCP) that minimum, the following yestem for preventing, ng, investigating, and ons and communicable esidents, staff, volunteers, individuals providing contractual arrangement cility assessment ing to §483.70(e) and d national standards; tten standards, policies, or the program, which must					
	· ·	veillance designed to					

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Event ID:

CWMF11 Facility ID: 000368

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155845	B. W	ING	_	10/06/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			1ST AVE		
SIMMONS LOVING CARE HEALTH FACILITY					IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	BROWDENG N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	identify possible o	communicable diseases or					
		they can spread to other					
	persons in the fac						
	(ii) When and to w	whom possible incidents of					
	communicable dis	sease or infections should					
	be reported;						
	(iii) Standard and	transmission-based					
	1 '	followed to prevent spread					
	of infections;						
		v isolation should be used					
		luding but not limited to:					
		duration of the isolation,					
		he infectious agent or 					
	organism involved						
		that the isolation should be					
	under the circums	e possible for the resident					
		nces under which the facility					
	must prohibit emp	-					
		sease or infected skin					
		t contact with residents or					
		t contact will transmit the					
	disease; and						
	l '	ene procedures to be					
		nvolved in direct resident					
	contact.						
		ystem for recording					
		d under the facility's IPCP					
		e actions taken by the					
	facility.						
	§483.80(e) Linens						
		andle, store, process, and					
	1	o as to prevent the spread					
	of infection.						
	8/83 80/f) Applica	Lraviaw					
	§483.80(f) Annual	review. nduct an annual review of					
		ate their program, as					
	is ii oi aliu upua	ate their program, as					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
15584		155845	B. WI	B. WING 10/0		10/06/	10/06/2022	
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			21ST AVE			
SIMMONS LOVING CARE HEALTH FACILITY					IN 46407			
SIMIMON	13 LOVING CARE I	IEALTTFACILITY		GART,	111 40407			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	necessary.							
		on, record review, and	F 08	380	F880		11/11/2022	
	interview, the facili	ty failed to ensure infection			Corrective Action(s) for			
	_	vere in place and implemented,			Residents Affected by the			
		prevent and/or contain			Deficient Practice			
		to mask use and hand hygiene						
	_	ervations of infection control			Resident 5. Physician 1 wears	a		
	and 1 of 1 treatmen	ts observed. (Residents 5 and			mask when visiting the resider			
	2)				Resident 2. The resident remains			
					in the hospital.			
	Findings include:							
					Corrective Action(s) for Other			
	1. During a random observation on 10/4/22 at 2:05				Residents Potentially Affects			
	p.m., Dietary Cook 1 entered the dining room with			All residents have the potential to		ıl to		
	_	wn below her nose and mouth.			be affected by this deficient			
	_	ke to the residents at that time.			practice.			
		ip her mask, however, it was			All staff are required to wear			
	_	her nose. At 2:07 p.m., she			masks in proper positions while	e in		
	_	the kitchen and came back to			direct resident contact and to	use		
	_	th another cake. Again, the			proper hand hygiene while			
	Cook's mask was p	ositioned beneath her nose.			providing care to residents.			
		Director of Nursing on 10/6/22			Measures to Ensure the			
	at 10:20 a.m., indic	ated the Cook should have had			Deficient Practice Does Not			
	her mask pulled up	when she was serving cake to			Recur			
	the residents.				All staff have been re-educate	d on		
					the proper position and metho	d of		
	2. During a randon	n observation on 10/5/22 at 9:53			donning a mask and the prope	er		
	a.m., Physician 1 er	ntered the dining room with his			hand hygiene techniques.			
	mask pulled down	below his nose and mouth. He			Disciplinary actions will be tak	en		
	proceeded to the tal	ble where Resident 5 was			per facility policy if repeated			
	_	p his mask and it was			infractions are identified.			
	_	is nose. Physician 1 started						
	_	ent. When the resident			The Monitoring Process to			
		't hear him, he pulled down his			Ensure the Deficient Practice	•		
	mask and it rested b	pelow his chin.			Does Not Recur			
					Surveillance of mask and			
		the resident, Physician 1			handwashing compliance will	be		
	_	to the resident's heart with his			documented on Mask and			
	mask pulled down. After he was done speaking				Handwashing Compliance aud	dit l		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155845	B. WING		10/06/2022
NAME OF F	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD 21ST AVE	
SIMMONS LOVING CARE HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC DLANLOS CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	with the resident, h	e pulled up his mask but it was		forms at least once per week	for
	positioned below hi	is nose. He shook hands with		two months, then once every	two
	the resident and wa	lked out of the dining room.		weeks for four months by D.O	ı.N./
	He did not use hand	d sanitizer prior to leaving the		Designee Audit results will be	
	dining room.			reviewed per the QAA Commi	ittee
				with further revisions or action	ıs
	Interview with the	Director of Nursing on 10/6/22		implemented as deemed	
	at 10:20 a.m., indic	ated Physician 1 should have		necessary.	
	had his mask pulled	d up and he should have used			
	hand sanitizer prior	to leaving the dining room. 3.		DATE: 11/1/22	
	During an observat	ion of Resident 2's wound			
	treatment with LPN	I 1 on 10/4/22 at 2:46 p.m., the			
	LPN washed her ha	ands with soap and water, then			
		essings. She removed her			
	_	er hands, and cleaned the			
		id not perform hand hygiene			
	-	g the wound, prior to the			
		iHoney gel and a clean			
	_	with LPN 1 at that time,			
		ware she should have			
		giene prior to applying a clean			
	dressing.				
	Interview with the	Director of Nursing on 10/5/22			
		ted she would be in-servicing			
	_	d hygiene during treatments.			
		sease Control and Prevention,			
		Healthcare Settings," last			
		0, indicated "Hand Hygiene			
		care personnel should use an			
		rub or wash with soap and			
		ving clinical indicationsafter			
		body fluids, or contaminated			
	surfaces"				
	3.1-18(b)				
F 0921	483.90(i)				

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Safe/Functional/Sanitary/Comfortable Environ

SS=E

Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155845		B. WING 10/06/2022		
				CTREET	ADDRECC CITY CTATE ZIR COD	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 21ST AVE	
SIMMON	S LOVING CARE I	HEALTH FACILITY			IN 46407	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	DATE
Bldg. 00	• (,	Environmental Conditions provide a safe, functional,				
		nfortable environment for				
	residents, staff ar					
		on and interview, the facility	F 09	921	F921	11/11/2022
		esident's environment clean			Corrective Action(s) for	11/11/2022
	and in good repair	related to loose faucets and			Residents Affected by the	
	toilet seats, dirty ba	aseboards and toilet bases, and			Deficient Practice	
	-	the bathroom call light for 2 of 2			No residents were identified a	s
	_	e facility. (The East and West			affected by the deficient practi	
	Halls)				Room 105 – the toilet seat has	
	T 1 1 1 1 1				been secured and a cord for the	he
	Finding includes:				bathroom room call light is in	
	Duning the Envisor	amontal tour on 10/6/22 at 10:00			place.	
	a.m., the following	nmental tour on 10/6/22 at 10:00			Room 113 – the sink faucet has been secured to the wall.	as
	a.m., the following	was observed.			Room 108 – The toilet seat ha	26
	East Hall				been cleaned. The baseboard	
					this bathroom and the base of	
	a. Room 105 - The	toilet seat was observed to be			toilet have been cleaned.	
	loose and there was	s no cord for the bathroom call				
		s resided in the room and two			Corrective Action(s) for Othe	
	residents shared the	e bathroom.			Residents Potentially Affects	
					All residents have the potentia	al to
		sink faucet was observed to be			be affected by this deficient	
	residents shared the	ts resided in the room and four			practice.	
	residents shared the	vaunoom.			A facility-wide environmental	nd to
	West Hall				evaluation has been complete identify any loose toilet seats,	
	,, ost 11011				loose sinks, and that any area	
	a. Room 108 - The	toilet seat was observed to be			adhered dirt have been cleane	
		adhered dirt along the			Call lights cords are in place,	
	-	athroom and around the base			any identified areas in need of	
	of the toilet. Two r	esidents resided in the room			repair have been repaired.	
	and four residents	shared the bathroom.				
					Measures to Ensure the	
		on 10/6/22 at 10:13 a.m., the			Deficient Practice Does Not	
	`	g indicated the above areas			Recur	
	should have been c	leaned and/or repaired.			Maintenance staff have been	
1			1		re educated on the need to	1

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

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AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155845	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 10/06/2022		
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 700 E 21ST AVE GARY, IN 46407				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(f)			monitor the safety of resident equipment and the cleanlines the environment on a regular basis. They are aware of their responsibility to submit reques for any needed supplies or reparts in a timely manner. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Administrator or designed complete an environmental assessment of equipment, ha resident rooms, and common areas once per week for two months, then once every two weeks for one month. Assessment results will be documented and submitted to QAA Committee for review wifurther revisions or actions implemented as deemed necessary. DATE: 11/11/22 ADDENDUM F921 Environmental assessments who be discontinued when 100% compliance has been achieved one month. If not achieved, the QAA Committee will determin need for further revisions or corrective actions as well as the frequency and length of continued its.	s of sts pair e e will Ils, othe th will will ed for lie lie the he		

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