PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER B WING NAME OF PROVIDING OR SUPPLITE SIMMONS LOVING CARE HEALTH FACILITY IVA 11D SUMMARY STATEMENT OF DEPICIENCES PREFIX (LACI IDEPCINEY MISS III IN PRECEIDED BY TULL TAG PREFIX A EMERGENCY OR ISC IDENTIFYING INFORMATION) BIGG An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 The facility Number: 1002752200 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found in compliance with finergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05.03/2021 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05.03/2021 Facility Number: 155845 AIM Number: 1002752200 At this Life Safety Code survey, Simmons | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | | |
|---|--|----------------------|---|----------|-------------|-----------------------------------|--------|------------|--|
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (X6) ID SUMMARY STATEMENT OF DETICIENCIES PREFIX (BACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Bidg. — An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 10078725200 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 46 certified beds. At the time of the survey, the census was 20. Quality Review completed on 05/07/21 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILI | | | | COMPLETED | |
| SIMMONS LOVING CARE HEALTH FACILITY SIMMONS LOVING CARE HEALTH FACILITY (A4) ID PREFIX REGULATORY OR LSC IDENTIFYING DEFICIENCIES PREFIX An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/03/2021 Facility Number: 1002752200 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. 42 CFR 483.73 The facility has 46 certified beds. At the time of the survey, the census was 20. Quality Review completed on 05/07/21 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.903. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 ALM Number: 1002752200 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.903. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 ALM Number: 1002752200 | | | 155845 | B. WING | | | 05/03/ | 2021 | |
| SIMMONS LOVING CARE HEALTH FACILITY SIMMONS LOVING CARE HEALTH FACILITY (A4) ID PREFIX REGULATORY OR LSC IDENTIFYING DEFICIENCIES PREFIX An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/03/2021 Facility Number: 1002752200 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. 42 CFR 483.73 The facility has 46 certified beds. At the time of the survey, the census was 20. Quality Review completed on 05/07/21 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.903. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 ALM Number: 1002752200 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.903. Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 ALM Number: 1002752200 | | | | | TREET A | DDRESS CITY STATE ZIP CODE | | | |
| SIMMONS LOVING CARE HEALTH FACILITY GARY, IN 46407 | NAME OF I | PROVIDER OR SUPPLIE | R | | | | | | |
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| Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 | | A Life Safety Code | Recertification and State | K 000 | 0 | | | | |
| Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 | | | | 11000 | | | | | |
| CFR 483.90(a). Survey Date: 05/03/2021 Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 | | | | | | | | | |
| Facility Number: 000368 Provider Number: 155845 AIM Number: 1002752200 | | - | | | | | | | |
| Provider Number: 155845 AIM Number: 1002752200 | | Survey Date: 05/0 | 3/2021 | | | | | | |
| AIM Number: 1002752200 | | Facility Number: (| 000368 | | | | | | |
| | | Provider Number: | 155845 | | | | | | |
| At this Life Safety Code survey, Simmons | | AIM Number: 100 | 2752200 | | | | | | |
| | | At this Life Safety | Code survey, Simmons | | | | | | |

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | ľ í | | NSTRUCTION | (X3) DATE | | |
|--|-------------------------|------------------------------|---------------------------------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILI | | <u>01</u> | COMPL | |
| | | 155845 | B. WING | | | 05/03/ | 2021 |
| NAME OF B | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | 700 E 21ST AVE | | | | |
| SIMMON | S LOVING CARE H | EALTH FACILITY | (| GARY, I | N 46407 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PR | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | 1 | AG | DEFICIENCY) | | DATE |
| | Loving Care Health | Facility was found not in | | | | | |
| | - | quirements for Participation | | | | | |
| | | edicaid, 42 CFR Subpart | | | | | |
| | | ty from Fire and the 2012 | | | | | |
| | edition of the Nation | nal Fire Protection | | | | | |
| | |) 101, Life Safety Code | | | | | |
| | | Existing Health Care | | | | | |
| | Occupancies and 41 | 0 IAC 16.2. | | | | | |
| | This one story facili | ty with a partial basement, | | | | | |
| | built in 1967, was d | etermined to be of Type II | | | | | |
| | (111) construction a | nd was fully sprinklered. | | | | | |
| | The facility has a fin | e alarm system with smoke | | | | | |
| | detection in the corr | idors and spaces open to the | | | | | |
| | corridor. The facility | y has no emergency power | | | | | |
| | | resident rooms were provided | | | | | |
| | | d smoke detectors. The | | | | | |
| | | city for 46 and had a census | | | | | |
| | of 20 at the time of | this survey. | | | | | |
| | | to residents and areas | | | | | |
| | providing facility se | rvices were sprinklered. | | | | | |
| | Quality Review con | npleted on 05/07/21 | | | | | |
| K 0211 | NFPA 101 | | 1 | İ | | | |
| SS=F | Means of Egress - | General | | | | | |
| Bldg. 01 | Means of Egress - | General | | | | | |
| | Aisles, passagewa | ays, corridors, exit | | | | | |
| | discharges, exit lo | cations, and accesses are | | | | | |
| | in accordance with | n Chapter 7, and the | | | | | |
| | means of egress is | s continuously maintained | | | | | |
| | free of all obstruct | ions to full use in case of | | | | | |
| | | s modified by 18/19.2.2 | | | | | |
| | through 18/19.2.1 | | | | | | |
| | 18.2.1, 19.2.1, 7.1 | | | | | | |
| | | iew, observation and | K 021 | 1 | 1. What corrective action will b | | 06/02/2021 |
| | | ty failed to ensure 1 of 5 | | | accomplished for those reside | | |
| | _ | s continuously maintained | | | found to have been affected by | y | |
| | free of all obstruction | ons or impediments to full | | | the deficient practice? | | |

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

Event ID:

VVP121

Facility ID: 000368

If continuation sheet

Page 2 of 14

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C A. BUILDING | | | E SURVEY |
|-----------|-----------------------|--------------------------------|--------------------------------|---|------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING B. WING | 01 | | LETED |
| | | 155845 | _ | | | 3/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP | CODE | |
| | | | | 21ST AVE | | |
| SIMMON | S LOVING CARE H | HEALTH FACILITY | GARY | , IN 46407 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI | I SHOULD BE E APPROPRIATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| | instant use in the ca | | | | | |
| | | eficient practice could affect | | Chair was immediate | ely removed | |
| | | nd visitors if needing to exit | | from path of egress. | | |
| | the facility from the | e dining room. | | All staff made aware | | |
| | Eindines includes | | | pathways of egress a them clear at all time | • | |
| | Findings include: | | | Nursing staff notified | | |
| | Based on observation | on during a facility survey | | resident moves the fu | | |
| | | ger on 05/03/2021 at 12:52 | | redirect him but place | • | |
| | | structing the dining room east | | where it does not blo | | |
| | exit. Based on inter | | | pathways of egress. | , | |
| | | it Manager agreed the chair | | | | |
| | was obstructing the | exit and moved it out of the | | 2. How other residen | ts having the | |
| | path of egress. | | | potential to be affecte | ed by the | |
| | | | | same deficient practi | ce will be | |
| | | ng was reviewed with the | | identified and what co | orrective | |
| | Administrator at the | e time of exit. | | action will be taken. | | |
| | | | | No resident affected. | | |
| | | | | 3. What measures wi | ill be put into | |
| | | | | place or what system | nic changes | |
| | | | | will be made to ensur | re that the | |
| | | | | deficient practice doe | es not recur. | |
| | | | | All staff in-serviced n | ot to block | |
| | | | | any pathways of egre | | |
| | | | | time. | , | |
| | | | | Unit Manager will mo | nitor all | |
| | | | | pathways of egress of | | |
| | | | | week times 3 weeks | | |
| | | | | Charge Nurse will mo | | |
| | | | | pathways of egress t | - | |
| | | | | each shift daily through | ghout shift, | |
| | | | | ongoing. | | |
| | | | | Administrator/Design | ee will review | |
| | | | | monitoring weekly for | | |
| | | | | then monthly x 3 mor | | |
| | | | | quarterly ongoing. | | |
| | | | | | | |
| | | | 1 | I | | 1 |

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

Event ID:

VVP121

Facility ID: 000368

If continuation sheet

Page 3 of 14

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | COMPLETED | |
|---|---------------------|------------------------------|------------------------|--|-----------------------|
| AND PLAN | OF CORRECTION | 155845 | A. BUILDING B. WING | 01 | COMPLETED 05/03/2021 |
| | | 1000+0 | _ | ADDRESS SITU STATE TIP SOFT | 03/03/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE 21ST AVE | |
| SIMMON | S LOVING CARE H | HEALTH FACILITY | | IN 46407 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | DBE COMPLETION PRIATE |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | | | | Q.A. Committee will review | |
| | | | | monitoring monthly times 3 months then semi-annually | |
| | | | | ensure compliance. | |
| | | | | | |
| | | | | 4. Describe who will be the |) |
| | | | | person(s) responsible for | an at the a |
| | | | | implementing and monitori plan for future compliance | - |
| | | | | regulations. | with the |
| | | | | | |
| | | | | Staff in-serviced not to bloo | |
| | | | | pathways of egress at any will be performed upon hire | |
| | | | | quarterly, thereafter ongoir | |
| | | | | Unit Manager will monitor a | <u> </u> |
| | | | | pathways of egress daily 5 | - |
| | | | | week times 3 weeks during | g day. |
| | | | | Charge Nurse will monitor pathways of egress throug | hout |
| | | | | each shift daily throughout | |
| | | | | ongoing. | , |
| | | | | Administrator/Designee wil | I review |
| | | | | monitoring weekly for 3 we | |
| | | | | then monthly x 3 months th | nen |
| | | | | quarterly ongoing. | |
| | | | | Q.A. Committee will review | |
| | | | | monitoring monthly times 3 | |
| | | | | months then semi-annually | ' to |
| | | | | ensure compliance. | |
| | | | | | |
| | | | | 5. Completion Date: 6/2/2 | 1 |
| | | | | | |
| K 0291 | NFPA 101 | | | | |
| SS=E | Emergency Lightir | | | | |
| Bldg. 01 | Emergency Lightir | ng | | | |

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

Event ID:

VVP121

Facility ID: 000368

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | | SURVEY | | |
|--|------------------------|--|-------|--------------------------------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | A. BUILDING <u>01</u> COMPLETE | | | ETED |
| | | 155845 | B. WI | NG | - | 05/03/2021 | |
| | | | | CENTER | ADDRESS STEV STATE STRESSES | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | 21ST AVE | | |
| SIMMON | S LOVING CARE H | HEALTH FACILITY | | GARY, | IN 46407 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | 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 OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | Emergency lightin | g of at least 1-1/2-hour | | | | | |
| | duration is provide | ed automatically in | | | | | |
| | accordance with 7 | 7 .9. | | | | | |
| | 18.2.9.1, 19.2.9.1 | | | | | | |
| | Based on observation | on and interview, the facility | K 0 | 291 | - what corrective action(s) | will | 06/02/2021 |
| | failed to ensure 2 of | f 22 battery powered | | | be accomplished for those | | |
| | emergency lights w | ere maintained in accordance | | | residents found to have been | | |
| | with LSC 7.9. LSC | 7.9.2.6 states battery | | | affected by the deficient practi | ce; | |
| | operated emergency | lights shall use only reliable | | | | | |
| | types of rechargeab | le batteries provided with | | | New emergency lights installe | d. | |
| | suitable facilities fo | r maintaining them in | | | Staff will continue to test | | |
| | properly charged co | ondition. Batteries used in | | | emergency lights monthly and | | |
| | such lights or units | shall be approved for their | | | record results. | | |
| | intended use and sh | all comply with NFPA 70 | | | | | |
| | National Electric Co | ode. LSC 7.9.2.7 states the | | | - how other residents havii | ng | |
| | emergency lighting | system shall be either | | the potential to be affected | | the | |
| | continuously in ope | ration or shall be capable of | | | same deficient practice will be | | |
| | repeated automatic | operation without manual | | | identified and what corrective | | |
| | intervention. This d | eficient practice could affect | | | action(s) will be taken; | | |
| | 7 residents in the Ea | ast Wing, staff and visitors in | | | No one affected at this time. | | |
| | the facility. | | | | - what measures will be pu | ıt | |
| | | | | | into place and what systemic | | |
| | Findings include: | | | | changes will be made to ensu | | |
| | | | | | that the deficient practice does | 3 | |
| | | facility with the Unit | | | not recur; | | |
| | - | 2021 at 12:17 p.m. the | | | Backup emergency light will be | е | |
| | | ergency light in the East | | | kept on hand. | | |
| | _ | 05 failed to function when its | | | Emergency light monthly testing | - | |
| | _ | on was pushed five times. | | | will be ongoing by maintenance | e | |
| | | the battery powered | | | staff. | | |
| | | the bottom of the stairwell | | | Unit manager will monitor logs | and | |
| | | hen its respective test button | | | emergency lights monthly. | | |
| | | nes. Based on interview at the | | | New maintenance staff will be | | |
| | | tions, the Unit Manager | | | in-serviced on emergency ligh | t | |
| | agreed that the light | ts did not operate when tested. | | | testing ongoing. | | |
| | | | | | Administrator will monitor mon | - | |
| | | ng was reviewed with the | | | testing logs quarterly, ongoing | | |
| | Administrator at the | e time of the exit. | | | - how the corrective action | . , | |
| | | | | | will be monitored to ensure the | | |
| | 3.1-19(b) | | | | deficient practice will not recur | , | |

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Event ID:

VVP121

Facility ID: 000368

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PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155845 | A. BUILDING 01 B. WING | COMPLETED 05/03/2021 | |
|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F TAG REGULATORY OR LSC IDENTIFYING INFORMAT | CROSS-REFERENCED TO THE APPROP | (X5) COMPLETION DATE | |
| K 0311 SS=E Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertica openings between floors are enclosed with construction having a fire resistance rating at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclose with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 2 stairwells in accordance of 19.3.1. LSC 19.3.1 | i.e., what quality assurance program will be put into place Emergency light monthly tewill be ongoing by maintenastaff. Unit manager will monitor locemergency lights monthly. New maintenance staff will in-serviced on emergency litesting ongoing. Administrator will monitor metesting logs quarterly, ongoing. Administrator will review in-service and procedure log quarterly for 3 months then semi-annually. - by what date the systechanges will be completed. 6/2/21 | ce; and sting ince ogs and be ght onthly ng. gs mic (s) will 06/02/2021 | |

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Event ID:

VVP121 Facility ID: 000368

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PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| | of correction identification number: 155845 | i i | <u>01</u> | COMPLETED 05/03/2021 |
|--------------------------|---|------------------------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | 700 E 2 | ADDRESS, CITY, STATE, ZIP CODE 21ST AVE IN 46407 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA | FULL PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | states where enclosure is provided, the construction shall have not less than a 1-hour resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing a door assemblies having a minimum ½-hour fire protection rating shall be permitted to continut to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. The deficient practice could affect 7 residents on the East Hall. Findings include: During a facility tour with the Unit Manager of 5/03/2021 at 1:15 p.m. two unsealed penetrations were found above the suspended ceiling tile in the corridor side of the stairwell Based on interview at the time of observation the Unit Manager agreed that the penetrations were not sealed. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) | l be le al ire ire ire ie his che | affected by the deficient practic. Two areas were immediately sealed with 3M approved smobarrier caulk product. Unit Manager will monitor repain building as repairs are done ensure not wall penetration or without being caulked, ongoing - how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; No one affected at this time. - what measures will be pure into place and what systemic changes will be made to ensure that the deficient practice does not recur; Unit Manager will monitor repain building as repairs are done ensure not wall penetration or without being caulked, ongoing Maintenance Staff will be responsible for filling areas with fire barrier caulking and record it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are performed how the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Unit Manager will monitor repairs are performed and the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; | ke airs to curs g |

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Event ID:

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PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | 01 | COMPLETED | |
|---|---|---|---------------------|--|----------------------|
| | | 155845 | | ADDRESS, CITY, STATE, ZIP CODE | 05/03/2021 |
| | PROVIDER OR SUPPLIEF IS LOVING CARE H | | 700 E 2 | 11ST AVE IN 46407 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| K 0321 SS=F Bldg. 01 | barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automa option is used, the from other spaces partitions and doc Doors shall be se automatic-closing nonrated or field-at do not exceed of the door. Describe the floor | are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting ors in accordance with 8.4. If-closing or and permitted to have applied protective plates d 48 inches from the bottom and zone locations of that are deficient in | | in building as repairs are done ensure not wall penetration of without being caulked, ongoin Maintenance Staff will be responsible for filling areas wi fire barrier caulking and record it on repair logs. Administrator will monitor fire barrier caulking quarterly, ongoing s repairs are perform Q.A. Committee will review re logs and fire barrier caulking lessemi-annually. - by what date the systemic changes will be completed. 6/2/21 | ed. pair |

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Event ID:

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Facility ID: 000368

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|--|--------------------------------------|--------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING <u>01</u> COMPLETED | | | | ETED |
| | | 155845 | B. W | ING | | 05/03/2021 | |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIEF | R | | | | | |
| CIMMACNI | 010//N0 04DE1 | IEALTH EACH ITY | | | 21ST AVE | | |
| SIMMON | S LOVING CARE I | HEALTH FACILITY | | GARY, | IN 46407 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | DDEELY (FACH CORRECTIVE ACTION SHOUL | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | 16 | DATE |
| | Area | Automatic Sprinkler | | | | | |
| | Separation | N/A | | | | | |
| | • | l-Fired Heater Rooms | | | | | |
| | | er than 100 square feet) | | | | | |
| | , - | nance, and Paint Shops | | | | | |
| | - | ooms (exceeding 64 | | | | | |
| | gallons) | oeme (execuming o : | | | | | |
| | e. Trash Collectio | n Rooms | | | | | |
| | (exceeding 64 gal | | | | | | |
| | | orage Rooms/Spaces | | | | | |
| | (over 50 square fe | | | | | | |
| | , , | classified as Severe | | | | | |
| | Hazard - see K32 | | | | | | |
| | | on and interview, the facility | K 0 | 321 | - what corrective action(s) | will | 06/02/2021 |
| | | east 4 hazardous areas such as | 12 0 | U-1 | be accomplished for those | | 00,02,2021 |
| | | rooms containing fuel fired | | | residents found to have been | | |
| | _ | parated from other spaces by | | | affected by the deficient practi | ce; | |
| | | titions and doors. Doors | | | | • | |
| | _ | g or automatic closing in | | | a. Front office/conference | | |
| | | 2.1.8. This deficient practice | | | room self-closure device adde | d to | |
| | | dents, staff and visitors in the | | | door. | | |
| | | ed Utility room near the North | | | b. Janitors room in baseme | nt | |
| | Hall nurse's station | | | | self-closure device added to d | oor. | |
| | | | | | c. Mrs. Miller's storage | | |
| | Findings include: | | | | deadbolt was removed and | | |
| | - | | | | replaced with a locking doorkr | ob. | |
| | During a tour of the | e facility with the Unit | | | d. Wire was removed and d | oor | |
| | Manager on 05/03/2 | 2021 from 12:10 p.m. to | | | self closes. | | |
| | 1:15 p.m., the follo | wing was observed: | | | | | |
| | a) The front office/ | conference room contained a | | | - how other residents havi | ng | |
| | large amount of par | per in boxes. The corridor | | | the potential to be affected by | the | |
| | door did not self-cl | ose. Based on interview at | | | same deficient practice will be | | |
| | the time of observa | tion, the Unit Manager agreed | | | identified and what corrective | | |
| | | hazardous area due to the | | | action(s) will be taken; | | |
| | amount of paper. | | | | No one affected at this time. | | |
| | | in the basement contained a | | | - what measures will be pւ | ıt | |
| | | orage in boxes. The room was | | | into place and what systemic | | |
| | equipped with a sel | f-closing device, however | | | changes will be made to ensu | re | |
| | | or did not close at latch into | | | that the deficient practice does | 8 | |
| | the frame. Based o | n interview, the Unit Manager | | | not recur; | | |
| | large amount of sto equipped with a sel when tested, the do | orage in boxes. The room was if-closing device, however or did not close at latch into | | | into place and what systemic changes will be made to ensu that the deficient practice does | re | |

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PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | ULTIPLE CO JILDING | ONSTRUCTION | (X3) DATE S | | |
|---|-----------------------|---|-----------------------|-------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | B. W | | 01 | COMPL | |
| | | 155845 | D. W | | | 05/03/ | 2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | 21ST AVE | | |
| SIMMON | S LOVING CARE F | IEALTH FACILITY | | GARY, | IN 46407 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | 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 DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | 16 | DATE |
| | agreed that the door | did not fully close and latch | | | Backup emergency light will b | е | |
| | into the frame when | tested. | | | kept on hand. | | |
| | c) "Ms. Miller's" Ro | oom in the basement | | | In-service held with custodial | and | |
| | contained storage. | The corridor door was | | | laundry staff about deficient | | |
| | equipped with a self | f-closing device, however the | | | practices. | | |
| | _ | red with a manual deadbolt | | | Unit manager will monitor prop | er | |
| | _ | ly latch into the door frame. | | | door closure logs monthly. | | |
| | | at the time of observation, | | | Maintenance will be responsib | | |
| | | greed that the door did not | | | for completing door closure log | gs | |
| | positively latch into | | | | monthly. | | |
| | | n, which contained fuel-fired | | | Administrator will monitor logs | | |
| | equipment, had a co | | | | monthly times 3 months then | | |
| | | r, the door was held open by | | | quarterly, ongoing. | | |
| | | terview at the time of it Manager agreed that the | | | - how the corrective action | (0) | |
| | · · | by a wire and would not | | | how the corrective action will be monitored to ensure the | ` ' | |
| | self-close. | by a wife and would not | | | deficient practice will not recui | | |
| | sen-close. | | | | i.e., what quality assurance | , | |
| | This deficient findi | ng was reviewed with the | | | program will be put into place; | and | |
| | Administrator at the | _ | | | program will be put line place, | unu | |
| | | | | | Unit manager will monitor prop | er | |
| | 3.1-19(b) | | | | door closure logs monthly. | | |
| | | | | | Maintenance will be responsib | le | |
| | | | | | for completing door closure log | gs | |
| | | | | | monthly. | | |
| | | | | | Administrator will monitor logs | | |
| | | | | | monthly times 3 months then | | |
| | | | | | quarterly, ongoing. | | |
| | | | | | | | |
| | | | | | Q.A. Committee will review log | js | |
| | | | | | quarterly for 3 months then | | |
| | | | | | semi-annually. | | |
| | | | | | by what date the systemi | _ | |
| | | | | | changes will be completed. | · | |
| | | | | | 6/2/21 | | |
| | | | | | | | |
| | | | | | | | |
| K 0511 | NFPA 101 | | | | | | |
| SS=D | Utilities - Gas and | Electric | | | | | |
| | | | | | | | |

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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. BUILDING <u>01</u> | | | COMPLETED | |
| | | 155845 | B. WI | NG | | 05/03/2021 | |
| | | | | CTDEET / | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | L. | | | | | |
| 01141401 | 0.1.0\//\\0.000 | IEAL THEACH ITY | 700 E 21ST AVE GARY, IN 46407 | | | | |
| SIMIMON | S LOVING CARE H | 1EALTH FACILITY | | GARY, | IN 40407 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | 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 APPROPRIATE | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | · L | DATE |
| Bldg. 01 | Utilities - Gas and | Electric | | | | | |
| | Equipment using of | gas or related gas piping | | | | | |
| | | PA 54, National Fuel Gas | | | | | |
| | • | iring and equipment | | | | | |
| | | PA 70, National Electric | | | | | |
| | • | tallations can continue in | | | | | |
| | service provided n | | | | | | |
| | 18.5.1.1, 19.5.1.1, | | | | | | |
| | | on, the facility failed to | K 0: | 511 | What corrective action will b | e | 06/02/2021 |
| | | ical junction boxes observed | 15 0. | J 1 1 | accomplished for those resider | | 00/02/2021 |
| | | a safe operating condition. | | | found to have been affected by | | |
| | | es utilities comply with | | | the deficient practice? | , | |
| | _ | .1.2 requires electrical wiring | | | and demoistric produces: | | |
| | | omply with NFPA 70, | | | Electrical plate covers were | | |
| | | Code. NFPA 70, 2011 | | | immediately purchased and | | |
| | | 2.28(3) (c) states junction | | | placed over junction boxes on | the | |
| | | ided with covers compatible | | | east exit light and dining room | uic | |
| | _ | itable for the conditions of | | | emergency light. | | |
| | | netal covers shall comply with | | | 2. How other residents having | the | |
| | | rements of 250.110. This | | | potential to be affected by the | 410 | |
| | | ould affect staff only. | | | same deficient practice will be | | |
| | deficient practice ec | said affect staff only. | | | identified and what corrective | | |
| | Findings include: | | | | action will be taken. | | |
| | i manigs metade. | | | | dollori wiii be takeri. | | |
| | During a tour of the | facility with the Unit | | | No resident affected. | | |
| | | 21 from 12:10 p.m. to 1:15 | | | 3. What measures will be put i | nto | |
| | _ | conditions were found: | | | place or what systemic change | | |
| | | ergency light was missing a | | | will be made to ensure that the | | |
| | cover plate. | rigency right was missing a | | | deficient practice does not reci | | |
| | _ | oom exit emergency light was | | | delicient practice does not reci | ui. | |
| | missing a junction b | | | | Unit Manager will assign mont | hlv | |
| | Based on interview | | | | surveillance of all junction box | - | |
| | | it Manager agreed that the | | | covers on emergency lights thi | | |
| | | re missing cover plates. | | | will be added to the monthly | J | |
| | electrical boxes wer | e missing cover plates. | | | emergency light testing audit to | ool | |
| | This deficient for 1:- | an was ravioused with the | | | emergency light testing addit to | JUI. | |
| | Administrator at the | ng was reviewed with the | | | Unit Manager will in convice | | |
| | Administrator at the | time of exit. | | | Unit Manager will in-service maintenance staff to additional | ı | |
| | 2 1 10(b) | | | | | I | |
| | 3.1-19(b) | | | | monitoring on new audit tool. | | |
| | | | | | | | |

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| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155845 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 05/03/2021 |
|----------------------------|--|--|--|---------------------------------------|
| | ROVIDER OR SUPPLIER S LOVING CARE HEALTH FACILITY | STREET A 700 E 2 GARY, | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| | | | Administrator/Designee will re log sheets monthly x 3 months then semi-annually, ongoing tensure compliance. | S |
| | | | 4. Describe who will be the person(s) responsible for implementing and monitoring plan for future compliance with regulations. | |
| | | | Unit Manager will in-service maintenance staff to additiona monitoring on new audit tool. | ıl |
| | | | Administrator/Designee will re log sheets monthly x 3 months then semi-annually, ongoing tensure compliance. | S |
| | | | Unit Manager will submit log sheets to Administrator and Q Committee for review monthly ensure compliance x 3 month months then semi-annually ongoing. | to |
| K 0712 SS=F Bldg. 01 | NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established | | 5. Completion Date: 6/2/21 | |

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Event ID:

VVP121

Facility ID: 000368

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | (X3) DATE SURVEY | | | | |
|--|---|------------------------------|-----------------------------------|--|--|--|--|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | <u>01</u> | COMPLETED | | | |
| | | 155845 | B. WING | | 05/03/2021 | | | |
| NAME OF P | DOVIDED OF GUIDNI TER | | STREET | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| NAME OF P | ROVIDER OR SUPPLIEF | X. | 700 E | 21ST AVE | | | | |
| SIMMONS LOVING CARE HEALTH FACILITY | | | GARY, IN 46407 | | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | PROVIDER'S PLAN OF CORRECTION (X5) | | | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE | CTIVE ACTION SHOULD BE COMPLETION ENCED TO THE APPROPRIATE | | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) DATE | | | | |
| | | rills are conducted between | | | | | | |
| | 9:00 PM and 6:00 AM, a coded | | | | | | | |
| | announcement may be used instead of | | | | | | | |
| | audible alarms. | | | | | | | |
| | 19.7.1.4 through 1 | | | | | | | |
| | | view and interview, the | K 0712 | , | what corrective action(s) will $06/02/2021$ | | | |
| | facility failed to conduct 2 of 12 quarterly shift | | | be accomplished for those | | | | |
| | fire drills during the most recent 12 month time | | | residents found to have been | | | | |
| | period. LSC 19.7.1.6 requires drills to be | | | affected by the deficient prac | ctice; | | | |
| | conducted quarterly on each shift under varied | | | | | | | |
| | conditions. Due to the COVID-19 Public Health | | | Fire Drill held on the fourth shift. Fire Drill schedule reviewed with | | | | |
| | Emergency, documented training may be used in | | | | | | | |
| | | allowed. This deficient | | unit manager. | | | | |
| | practice affects all staff and residents. | | | | | | | |
| | | | | - how other residents have | • | | | |
| | Findings include: | | | the potential to be affected b | - I | | | |
| | | | | same deficient practice will be | | | | |
| | During record review with the Director of | | | identified and what corrective | | | | |
| | Nursing on 05/03/2021 at 11:00 a.m., the | | | action(s) will be taken; | | | | |
| | facility was unable to provide documentation of | | | No one affected at this time. | | | | |
| | fire drills or approved training for the third shift | | | la at management will be a | | | | |
| | for the fourth quarter of 2020, or second shift of | | | - what measures will be put | | | | |
| | first quarter of 2021. Based on interview at the time of record review, the Director of Nursing | | | into place and what systemic changes will be made to ens | l l | | | |
| | agreed that the documentation could not be | | | that the deficient practice do | l l | | | |
| | provided. | | | not recur; | | | | |
| | provided. | | | Hot recui, | | | | |
| | This deficient finding was reviewed with the | | | In-service held with Unit Manager | | | | |
| | Administrator at the time of exit. | | | who will be responsible for h | · | | | |
| | | | fire drills according to fire dri | • | | | | |
| 3.1-19(b) | | | schedule. | | | | | |
| 3.1-51(c) | | | Fire Drill logs will be revied b | y | | | | |
| | | | | Administrator as they month | - | | | |
| | | | | occur. | | | | |
| | | | | - how the corrective action | on(s) | | | |
| | | | | will be monitored to ensure t | | | | |
| | | | | deficient practice will not rec | | | | |
| | | | | i.e., what quality assurance | · | | | |
| | | | | program will be put into place | e; and | | | |
| | | | | ' 'J' ''' ''' ''' ''' ''' ''' | , - | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 05/03/2021 | | |
|--|-------------------------------------|---|---|--|---------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM | | | |
| | | | | In-service held with Unit Mar who will be responsible for h fire drills according to fire dri schedule. Fire Drill logs will be revied be Administrator as they monthl occur. Q.A. Committee will review findrills q 3 months and semi-annually thereafter. - by what date the system changes will be completed. 6/2/21 | olding II Dy ly ire | | |

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