This visit for the Investigation of Complaint IN00320321.

Complaint IN00320321 - Substantiated Federal/State deficiencies related to the allegation are cited at F600 and F609.

Survey dates: February 24 & 25, 2020

Facility number: 000368
Provider number: 155845
AIM number: 100275220

Census bed type:
SNF/NF: 20
Total: 20

Census payor type:
Medicare: 1
Medicaid: 18
Other: 1
Total: 20

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.


Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

Based on observation, record review and interview, the facility failed to ensure residents remained free from physical abuse related to witnessed rough treatment and facility staff not immediately addressing an allegation of abuse when notified of the allegation to ensure the safety of all residents. This resulted in the involved staff not immediately removed and an Investigation not immediately initiated.

(Resident C, Social Service staff 1, ADON)

Finding includes:

On 2/24/20 at 7:23 a.m., Resident C as observed in bed with covers over his head. The resident responded when his name was called. An ambulance transport vehicle arrived at 9:30 a.m. to transport the resident to hemodialysis.

The record for Resident C was reviewed on 2/24/20 at 9:17 a.m. Diagnoses included, but were not limited to anemia, dementia, anxiety disorder, gastrostomy and end stage renal disease.

The 11/20/19 Minimum Data Set Quarterly Assessment indicated the resident's cognitive skills for decision making were severely impaired. Behavioral symptoms directed towards others occurred 1-3 days during the seven day reference period. Extensive assistance of two
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 155845

<table>
<thead>
<tr>
<th>X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>staff members was needed for bed mobility, transfers, toilet use and personal hygiene. Range of motion was impaired on one upper and one lower extremity. Antipsychotic medications were administered 7 of 7 days during the reference period. When interviewed via telephone on 2/24/20 at 9:51 a.m., Ambulance Transporter 1 indicated he had transferred Resident C to and from hemodialysis treatment often. During one of his transports last week, he observed an employee (name) being rough with Resident C and reported this to his Supervisor. The transporter indicated he also informed the resident's father of the allegation of abuse as the father met the resident at every dialysis treatment. He indicated neither the facility Administrator nor the Director of Nursing had been made aware of the allegation. When interviewed via telephone on 2/24/20 at 11:30 a.m., Ambulance Transporter 2 indicated he was present with his partner (Transporter 1) on the day they observed staff hurrying while getting Resident C dressed for transport. The staff member was rough with the resident. They did not tell any staff in the building. Transporter 1 reported the occurrence to their Supervisor When interviewed on 2/24/20 at 3:18 p.m., Social Service staff member 1 indicated a friend of Resident C came to the facility and told her the Paramedic ambulance transport had concerns with how staff dressed and put on the Resident's coat. Social service staff indicated the friend had reported one of our staff members was observed being rough while trying to put Resident C's coat on. The friend told me &quot;staff was rough with putting his coat on.&quot; &quot;I think I told [Administrator's name] that the paramedics had</td>
<td></td>
<td>D.O.N. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a. No residents were affected. b. All residents were interviewed by Administrator and D.O.N. and no complaints of abuse were stated by cognitive residents. c. Charge nurse performed skin assessments to look for signs/symptoms of abuse assessed on residents with cognitive impairments. d. There have been no further incidents. e. Please see below for measures implemented and system for monitoring 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · ADON and Social Service Designee were immediately removed from resident care area and individual interviews were conducted immediately with A.D.O.N, Social Service Designee and Ambulance Service about</td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

SIMMONS LOVING CARE HEALTH FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 E 21ST AVE
GARY, IN 46407

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155845</td>
<td>A. BUILDING 00</td>
<td>COMPLETED 02/25/2020</td>
</tr>
<tr>
<td>B. WING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EVENT ID:** 7D7N11  **FACILITY ID:** 000368  **If continuation sheet**

Page 3 of 10
Concerns.

Resident C's father arrived to the facility on 2/24/20 at 2:50 p.m. The father indicated he had been at his son's hemodialysis appointment last week. One of the Ambulance transporters stated he needed to talk with him. The ambulance transporter was upset. The transporter then told him one staff member was rough with his son (Resident C) while dressing him to go out. He indicated he had also called to the facility and talked to SS 1 to inform her of this knowledge of what occurred when facility staff were getting him ready to go out.

When interviewed on 2/24/20 at 3:34 p.m., the ADON (Assistant Director of Nursing) indicated she was helping with breakfast in the Dining Room and heard the ambulance staff were here for Resident C about a week ago. She came out and put Resident C's coat on after making sure he was clean and dry. "I was mad because the transporters would not help get him on the cart. They just stood there and did not help at all. They were not the usual staff that pick him up. I even called the Transportation Company and told them the transporters were not doing their jobs." She indicated the resident's girlfriend came in and talked to Social Service that day and said there was allegation that staff was "rough handling him." The ADON indicated she did not inform the DON or the Administrator and she did not consider someone reporting staff being "rough" to be an allegation of abuse.

The Director of Nursing was interviewed on 2/24/20 at 3:26 p.m. and indicated neither she nor the Administrator had any reports or knowledge of any abuse allegations until Resident C's father told her today about the alleged incident.

- Both Social Service Designee and A.D.O.N were put on suspension immediately pending investigation.
- All staff in-service has been conducted for all staff related to prevention of abuse. The in-service included abuse policy review including abuse prevention, abuse identification, and abuse reporting.
- All Staff members completed abuse policy and reporting allegations of abuse in-service on 2-28-20.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and

a. Quality Improvement Tool initiated to randomly interview 5 residents to determine if they have witnessed abuse either for themselves or others.

b. Five staff members will also be interviewed to determine understanding of abuse prevention, abuse identification and abuse reporting.

c. The Administrator and Director of Nursing/designee will complete this tool weekly x3, then monthly x3 then quarterly x3. Any issues identified will be

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Event ID: 7D7N11 Facility ID: 000368 If continuation sheet Page 4 of 10
roughness concerns. Social Service did not tell the Administrator or DON of the allegation of roughness until questioned today. No other staff reported any abuse. "This should have been reported to the Administrator and myself immediately and an Investigation would have been initiated at that time as per our policy. The employees involved would have been interviewed and sent home immediately. An investigation would have been initiated. The above staff have been removed at this time and will be interviewed."

The current Abuse Policy was reviewed on 2/24/20 at 9:05 a.m. The policy indicated all residents were to be protected from abuse, neglect, and harm. All employees must report any abuse or suspicion of abuse to the Administration immediately. Employees accused of alleged abuse will be immediately removed from the facility.

This Federal tag relates to Complaint IN00320321.

3.1-27(a)

483.12(c)(1)(4)
Reporting of Alleged Violations
§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0609</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>immediately corrected.</td>
<td></td>
</tr>
</tbody>
</table>

- **d.** The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.
- **e.** D.O.N. will be responsible for investigations of allegations of abuse and reporting findings to administrator who will implement any disciplinary actions from written actions up to termination of employment.
- **f.** D.O.N. will report to the Quality Assurance Committee at scheduled meetings all allegations of abuse reports for review and the committee will give recommendations as needed.

5. **By what date the systemic changes for each deficiency will be completed.**
- 2-25-20 Completion of investigation
- 2-28-20 Compliance date.
- ISBOH revisited on 3/9/20 and found no findings.
- Attorney General visited on 3/10/20 and found no findings.
§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Based on observation, record review and interview the facility failed to ensure an allegation of Staff to Resident physical abuse was immediately reported to the Director of Nursing and Administrator which resulted in the delay of the initiating an abuse investigation for 1 of 1 Abuse allegations reviewed. (Resident C, Assistant Director of Nursing and Social Service 1).

Finding includes:

On 2/24/20 at 7:23 a.m., Resident C was
observed in bed with covers over him. The resident responded when his name was called.

An Ambulance Transport vehicle arrived at 9:30 a.m. to take the resident out for hemodialysis. Two ambulance attendees lifted the resident on the stretcher. Resident C was awake and dressed and had no complaints during the transfer.

When interviewed on 2/24/20 at 9:20 a.m., the Director of Nursing indicated there had not been any allegations of any abuse in the 90 days.

When interviewed via telephone on 2/24/20 at 9:51 a.m., an Ambulance transporter indicated he had transferred Resident C to and from hemodialysis treatment often. During one of his transports last week he observed an employee being rough with Resident C and reported this to his Supervisor. The transporter indicated he informed the resident's father of the allegation of abuse. He indicated the father meets the resident at every dialysis treatment. Neither the facility Administrator nor the Director of Nursing had been made aware of the allegation.

When interviewed on 2/24/20 at 3:18 p.m., Social Service (SS) 1 indicated a friend of Resident C came to the facility and told her the paramedic ambulance transport had concerns with the way staff dressed and put on the resident's coat. The friend told her "staff was rough with putting his coat on." "I think I told [Administrator's name] that the paramedics had concerns."

Resident C's father arrived to the facility on 2/24/20 at 2:50 p.m. The father indicated he had been at his son's hemodialysis appointment last week. One of the Ambulance transporters stated and Ambulance Service about alleged incident.

b. Both Social Service Designee and A.D.O.N were put on suspension pending investigation immediately.

c. Allegations of Abuse Policy was reviewed with all staff present in the facility.

d. Investigation of allegation was immediately initiated by D.O.N.

2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;

a. No residents were affected.

b. All residents were interviewed by Administrator and D.O.N. no complaints of abuse were stated by cognitive residents.

c. Charge nurse performed skin assessments to look for signs/symptoms of abuse assessed on residents with cognitive impairments.

d. There have been no further incidents.

e. Please see below for measures implemented and system for monitoring
he needed to talk with him. The ambulance transporter was upset. The transporter then told him one staff member was rough with his son (Resident C) while dressing him to go out. The father indicated he also had called to the facility and talked to SS 1 to inform her of this knowledge of what occurred when facility staff were getting him ready to go out.

The facility Director of Nursing was interviewed on 2/24/20 at 3:26 p.m. and indicated she had no reports or knowledge of any abuse allegations until Resident C's Father told her today about the roughness concerns. Social Service did not tell the Administrator or DON of the allegation of roughness until today. No other staff reported any abuse. This should have been reported to the Administrator and myself immediately and an Investigation would have been initiated at that time as per our policy.

When interviewed on 2/24/20 at 3:34 p.m., the ADON (Assistant Director of Nursing) indicated she was helping with breakfast in the Dining Room and heard the ambulance staff were here for Resident C about a week ago. She came out and put Resident C's coat on after making sure he was clean and dry. "I was mad because the transporters would not help get him on the cart. They just stood there and did not help at all. They were not the usual staff that pick him up. I even called the Transportation Company and told them the transporters were not doing their jobs." The Resident's girl friend came in and talked to Social Service that day. The girlfriend said there was allegation that staff was "rough handling him." The ADON indicated she did not inform the DON or the Administrator. The ADON indicated she did not consider someone reporting staff being "rough" to be an allegation.

3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;

a. ADON and Social Service Designee were immediately removed from resident care area and individual interviews were conducted immediately with A.D.O.N, Social Service Designee and Ambulance Service about alleged incident.

b. Both Social Service Designee and A.D.O.N were put on suspension immediately pending investigation.

c. All staff in-service has been conducted for all staff related to prevention of abuse. The in-service included abuse policy review including abuse prevention, abuse identification, and abuse reporting.

d. All Staff members completed abuse policy and reporting allegations of abuse in-service on 2-28-20.

4. How the corrective action(s) will be monitored to ensure the deficient practice
of abuse.

The record for Resident C was reviewed on 2/24/20 at 9:17 a.m. Diagnoses included, but were not limited to anemia, dementia, anxiety disorder, gastronomy and end stage renal disease.

The 11/20/19 Minimum Data Set Quarterly Assessment indicated the resident's cognitive skills for decision making were severely impaired. Behavioral symptoms directed towards others occurred 1-3 days the seven day reference period. Extensive assistance of two staff members was needed for bed mobility, transfers, toilet use and personal hygiene. Range of motion was impaired on one upper and one lower extremity. Antipsychotic medications were administered (7) of (7) days during the reference period.

When interviewed on 2/25/20 at 8:30 a.m., the Director of Nursing indicated the above allegation made by the ambulance employee should have been reported to the Administrator and herself immediately.

The current Abuse Policy was reviewed on 2/24/20 at 9:05 a.m. The policy indicated all residents were to be protected from abuse, neglect, and harm. All employees must report any abuse or suspicion of abuse to the Administration immediately.

This Federal tag relates to Complaint IN00320321.

3.1-28(c)

will not recur, i.e., what quality assurance program will be put into place; and

a. Quality Improvement Tool initiated to randomly interview 5 residents to determine if they have witnessed abuse either for themselves or others.

b. Five staff members will also be interviewed to determine understanding of abuse prevention, abuse identification and abuse reporting.

c. The Administrator and Director of Nursing or designee will complete this tool weekly x3, then monthly x3 then quarterly x3. Any issues identified will be immediately corrected.

d. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.

e. D.O.N. will be responsible for investigations of allegations of abuse and reporting findings to administrator who will implement any disciplinary actions from written actions up to termination of employment.

f. D.O.N. will report to the Quality Assurance Committee at
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>155845</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** MULTIPLE CONSTRUCTION

**DATE SURVEY COMPLETED:** 02/25/2020

**NAME OF PROVIDER OR SUPPLIER:** SIMMONS LOVING CARE HEALTH FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 700 E 21ST AVE, GARY, IN 46407

**PREFIX**

**TAG**

**REGULATORY OR LSC IDENTIFYING INFORMATION**

scheduled meetings all allegations of abuse reports for review and the committee will give recommendations as needed.

5. **By what date the systemic changes for each deficiency will be completed.**

2-25-20 Completion of investigation

2-28-20 Compliance date.

ISBOH revisited on 3/9/20 and found no findings.

Attorney General visited on 3/10/20 and found no findings.