STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIMMONS LOVING CARE HEALTH FACILITY	**700 E 21ST AVE GARY, IN 46407**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation and interview the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain COVID-19 related to staff members and contracted staff without proper medical masks in place. This had the potential to affect all 21 residents in the facility under LPN 1's care. (LPN 1 and contracted Maintenance Staff 1). Findings includes: 1. On 9/18/20 at 8:30 a.m., LPN 1 was observed at the Nurses Station. The LPN had a cloth mask over her mouth and nose and did not have a surgical mask under the cloth mask. LPN 1 was the nurse on duty for the shift and responsible for all resident medications and any direct resident care assistance or assessments needed. When interviewed at this time, LPN 1 indicated she was not aware staff were required to wear surgical masks. 2. On 9/18/20 at 8:45 a.m., Maintenance Staff 2 was observed walking in front of the Nurses Station and was wearing a cloth mask. Maintenance staff 2 was not wearing a surgical mask under the cloth mask. When interviewed on 9/18/20 at this time, he staff indicated he wears the cloth mask, as paint would go right thru his surgical mask. He also indicated he had completed several projects at the facility. When interviewed on 9/18/20 at 9:30 a.m., the Director of Nursing indicated she was unaware all staff were required to wear medical masks in the facility. 3.1-18(a)
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on interview and review of the the facility Infection Control policy and procedures, the facility failed to ensure weekly Covid 19 testing had been completed for 27 of 27 current employees and the Administrative staff as required by CMS (Centers for Medicare and Medicaid Services). This had the potential to affect all 21 residents residing in the facility. Finding includes: Review of the facility Infection Control logs and procedures indicated the facility had not initiated any weekly Covid 19 testing for all staff members from 8/25/2020 thru 9/18/2020 as required per current CMS Infection Control regulations based on county positivity rate. When interviewed on 9/ at 10:05 a.m., the Director of Nursing indicated she was not aware weekly Covid 19 testing was required for all staff. 3.1-18(a)(2)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE