STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	03/01/2023

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00390821, IN00393028, IN00394756, IN00397480, and IN00401554. Survey date: March 1, 2023 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 6 Medicaid: 78 Other: 1 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/6/23.	F 0000		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure ADL (activities of daily living) care was provided to a dependent resident related to assistance with toileting and showering twice weekly for 2 of 3 residents reviewed for ADL care.	F 0677	**677-ADL Care for Dependent Residents** **What corrective action(s) will be accomplished for those**	04/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Philip Birn	Administrator	03/20/2023

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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	(Residents C and D) Findings include: 1. Resident C's record was reviewed on 3/1/23 at 9:41 a.m. The resident was admitted to the facility on 10/19/22 and discharged to the hospital on 10/22/22. Diagnoses included, but were not limited to, acute respiratory failure and diabetes mellitus. The Discharge Minimum Data Set (MDS) assessment, dated 10/22/22, indicated the resident had moderate independence for daily decision making and his short-term memory was ok. He required limited assistance for bed mobility, transfers, dressing, and toilet use. He required supervision for personal hygiene. He was occasionally incontinent of bladder and frequently incontinent of bowel. A Care Plan, dated 10/19/22, indicated the resident had an ADL self-care performance deficit. Interventions included, but were not limited to, the resident required extensive assistance by one staff for toileting. The Activities of Daily Living CNA task sheet, indicated the resident was assisted with toileting on the following dates and times: - 10/19/22 at 7:52 p.m. - 10/20/22 at 2:41 a.m. - 10/21/22 at 1:01 a.m. - 10/21/22 at 11:51 a.m. - 10/21/22 at 9:20 p.m. - 10/22/22 at 2:14 a.m. - 10/22/22 at 8:34 p.m. There were no bowel movements or urinary incontinence noted in the Bowel and Bladder		**residents found to be affected by the deficient practice?** **· Resident C expired prior to the survey.** **· Resident D was provided with ADL care related to showers and did not have a negative outcome related to the alleged deficient practice.** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** **All dependent residents in the facility have the potential to be affected by the alleged deficient practice.** **· Audit completed showers to ensure that each resident has scheduled and agreed upon shower days.** **· Audit of all residents to determine need for toileting assistance completed.** **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** **· Staff in-servicing conducted related ADL care for dependent residents, utilizing the ADL policy with emphasis on assisting with toileting, documenting when resident is toileted showers and the use of shower sheets.** **How will the corrective**	

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	Eliminations. Interview with the Director of Nursing on 3/1/23 at 3:50 p.m., indicated she was unable to find any more documentation related to assisting the resident with toileting. 2. Resident D's record was reviewed on 3/1/23 at 11:38 a.m. Diagnoses included, but were not limited to, fracture of left femur, history of stroke, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/23, indicated the resident was cognitively intact for daily decision making. He required one person physical assist for bathing. A Care Plan, dated 12/1/22, indicated the resident had an ADL self-care performance deficit related to impaired mobility to the left hip. Interventions included, but were not limited to, provide assistance with bathing/showering. A Head to Toe Weekly Skin Assessment, dated 1/18/23, indicated the resident received a shower. A Head to Toe Weekly Skin Assessment, dated 2/1/23, indicated the resident received a bed bath. A Head to Toe Weekly Skin Assessment, dated 2/4/23, indicated the resident received a bed bath. A Head to Toe Weekly Skin Assessment, dated 2/8/23, indicated the resident received a bed bath. Interview with the Director of Nursing on 3/1/23 at 4:24 p.m., indicated she had no further documentation of the resident receiving bed baths or showers for January 2023 or February 2023.		**action(s) be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **· ADON/Unit Managers or designee will complete ADL care audits to monitor the resident's ADL status including showers.** **· ADON / Unit Manager or designee will complete ADL care audits to monitor the residents that require assistance with toileting and documentation.** **· Audits will be completed daily x 5 days, weekly x 4 weeks, bi-monthly x 2 months, monthly x 6 months and then quarterly to encompass all shifts until compliance is maintained for 2 consecutive quarters of 10 random residents.** **· The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance**	

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	This Federal tag relates to Complaints IN00394756 and IN00397480. 3.1-38(a)(2)(C) 3.1-38(b)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review and interview, the facility failed to ensure signs and symptoms of upper respiratory infections were monitored for 1 of 3 residents reviewed for death. (Resident K) Finding includes: Resident K's record was reviewed on 3/1/23 at 1:32 p.m. Diagnoses included, but were not limited to, COVID-19, chronic obstructive pulmonary disease (COPD), and heart disease. The Death Minimum Data Set (MDS) assessment, dated 12/24/22, indicated the resident died in the facility. A Physician's Order, dated 12/16/22, indicated the resident was in transmission based precautions (contact and droplet), receiving all care in the room with no roommate, to prevent the spread of	F 0695	**F695 Resp Care** **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?** · **Resident K expired before the survey.** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** **Any resident admitted with or being diagnosed with COVID has the potential to be affected by the alleged deficient practice.**	04/20/2023

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	infection to others due to COVID-19 infection, every shift. A set of vital signs, dated 12/17/22 at 8:21 p.m., indicated the resident's blood pressure was 128/68, temperature of 97.7 degrees Fahrenheit, heart rate of 70 beats per minute, respirations of 18 breaths per minute, and oxygen saturation of 98%. A set of vital signs, dated 12/21/22 at 7:49 p.m., indicated blood pressure of 140/69, temperature of 97.8 degrees Fahrenheit, heart rate of 70 beats per minute, respirations of 18 breaths per minute, and oxygen saturation of 97%. There was no documentation of a full respiratory assessment, including lung sounds, completed after the resident was diagnosed with COVID-19. Interview with the 200 Unit Manager on 3/1/23 at 3:21 p.m., indicated the resident tested positive for COVID-19 on 12/15/22. At that time, an order for vital signs and respiratory assessment every shift should have been put in for the nurses to know what assessments were to be completed. She was unable to locate any further assessments that had been completed. Interview with the Director of Nursing on 3/1/23 at 3:50 p.m., indicated an order for an assessment should have populated after she tested positive. The assessments would have been completed under the Medication/Treatment Administration Record. This Federal tag relates to Complaint IN00390821. 3.1-47(a)(6)		**· There are no COVID positive residents currently in the facility.** **· All residents will be monitored daily for s/sx of COVID.** **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** **· Upon admission/diagnosis of COVID an order will be placed in the resident's chart for a full respiratory assessment, including but not limited to vitals and lung sounds, every shift, for the duration of COVID.** **· Licensed nursing staff will be re-educated on the appropriate and necessary orders, following MD orders related to COVID respiratory monitoring.** **How will the corrective action(s) be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **· DON / IP or designee will audit admission chart to ensure that the order(s) are in place to monitor for S/Sx of Covid** **· DON / IP or designee will audit COVID positive residents to ensure that orders for Covid**	

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			positive batch orders, including but not limited to respiratory assessment, are in place. **· Audits will be completed daily x 5 days, weekly x 4 weeks, bi-monthly x 2 months, monthly x 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.** **· The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain medication was administered as ordered to a resident with a diagnosis of chronic pain syndrome for 1 of 3 residents reviewed for pain. (Resident G) Finding includes: The record for Resident G was reviewed on 3/1/23 at 1:15 p.m. Diagnoses included, but were not limited to, stroke, rheumatoid arthritis, and chronic	F 0697	**F697 Pain Management** **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?** **· Audit of resident G's pain medication doctor order(s) completed to ensure all orders present and correct.** **· Audit of resident G's**	04/20/2023

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	pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 1/31/23, indicated the resident was cognitively intact. The resident received scheduled pain medication and had occasional, mild pain in the last 5 days during the assessment period. A Care Plan, revised on 2/1/23, indicated the resident was on pain medication therapy related to a history of complaints of pain. The approaches were to administer pain medications as ordered by the Physician. A Care Plan, revised on 2/1/23, indicated the resident had pain related to a history of complaints of leg and knee pain and had the diagnosis of rheumatoid arthritis. The approaches were to administer pain medications as ordered. Physician's Orders, dated 3/31/22, indicated the resident was to receive a Norco tablet (a narcotic pain medication) 7.5-325 milligrams (mg). Give 1 tablet by mouth two times a day for pain. The Medication Administration Record (MAR), for the month of 2/2023, indicated the Norco was scheduled at 9:00 a.m. and 6:00 p.m. The 9:00 a.m. dose of the Norco was coded with a "9" (see progress notes) on 2/12, 2/17, 2/18, 2/21, and 2/22/23. The Norco was coded with a "4" (vitals outside of parameters) on 2/20/23. The 6:00 p.m. dose of the Norco was coded with a "9" on 2/11, 2/13-2/18, 2/20-2/22/23 and blank on 2/27/23. Nursing Progress Notes, dated 2/11/23 at 7:47		**ordered pain medication supply completed to ensure that all medication was / is available and in house.** · **Audit of resident G's pain medication orders to ensure that needed scripts / refill orders are signed and medication is reordered prior to exhaustion of resident G's current supply.** · Resident G continues to receive pain medication per MD orders and has not had any negative outcome related to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** **All residents receiving narcotic pain medications have the potential to be affected by the alleged deficient practice.** · **An audit will be completed of all current residents receiving pain medication to ensure that they have orders in place.** · **Audit of all residents receiving pain medication to ensure that supply of medication is available and in house.** · **Audit of all residents receiving pain medication to ensure that all needed scripts /**	

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	p.m., 2/12/23 at 10:24 a.m., 2/13/23 at 10:46 p.m., 2/14/23 at 5:21 p.m., 2/15/23 at 6:08 p.m., 2/16/23 at 5:30 p.m., 2/17/23 at 10:22 a.m., and 5:19 p.m., 2/18/23 at 3:58 p.m., 2/20/23 at 5:57 p.m., 2/21/23 at 10:14 a.m., and 2/22/23 at 9:53 a.m. and 7:41 p.m., indicated the Norco medication was unavailable. The narcotic sheet, dated 1/27/23, indicated 28 pills were delivered to the facility. The Norco was signed out as being administered 1/27-2/9/23 at 9:00 a.m. and 6:00 p.m. Another narcotic sheet, dated 2/23/23, indicated the Norco was delivered on 2/23/23 and the resident got her first pill from that batch on 2/23/23 at 6:00 p.m. Interview with LPN 1 on 3/1/23 at 1:50 p.m., indicated Agency staff did not have access to the Pyxis machine (a medication storage compartment). She further indicated, last month they had an issue with not getting the narcotic prescriptions signed by the Physician and the Nurse Practitioner (NP). The Physician would not come in and sign the prescriptions, so the Social Service Director (SSD) went to his office for something else and took the scripts for him to sign. Interview with the Director of Nursing on 3/1/23 at 4:30 p.m., indicated the Physician would not allow the NP to sign the narcotic prescriptions for some reason, however, he would not come in and sign the prescriptions in a timely manner so the residents had their medications available. The SSD took the prescriptions to his office to be signed. The Norco medication was available in the Pyxis machine, however, the nurses had to call the pharmacy each time to get a code to open the machine. This Federal tag relates to Complaint IN00394756.		**refill orders are signed, and medication is reordered prior to exhaustion of current supply.** **· Audit of all new admissions to ensure that pain medication is ordered correctly, needed documentation received, and medication in house upon admission and / or MD is notified up on admission and an alternative pain medication order is given for medication that is available in house until original medication order is received and has arrived at the facility.** **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** **· Nursing Leadership / IDT will be educated on the morning meeting process with focus on missed medication doses** **· Licensed nursing personnel will be re-educated on the importance of calling the pharmacy and notifying the MD when new scripts for narcotic pain meds are received and or are due for a refill.** **· Licensed nursing staff will be educated on the importance of notifying the MD/NP for an alternative pain**	

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	3.1-37(a)		**medication when the current ordered pain medication is not available.** **· Staff will document conversations with the NP, MD and/or pharmacy regarding the status of narcotic pain medications.** **· DON and ED will meet with the MD regarding the process and timeframe for renewal of narcotic pain medications prescriptions.** **How will the corrective action(s) be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **· Audits will be completed daily x 5 days, weekly x 4 weeks, bi-monthly x 2 months, monthly x 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters to ensure that pain medication is being received as ordered.** **· The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance**	