

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey</p> <p>This visit was in conjunction with the Investigation of Complaint IN00130175.</p> <p>Survey dates: June 10, 11, 12, 13, 14 and 17, 2013</p> <p>Facility number: 000369 Provider number: 155530 Aim number: 100275190</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Cynthia Stramel, RN Heather Hite, RN (6/10, 6/11, 6/12, 6/13 and 6/17/13)</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 5 Medicaid: 57 Other: 0 Total: 62</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000		
---------	---	---------	--	--

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	IAC 16.2.  Quality review completed on June 23, 2013, by Janelyn Kulik, RN.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician was promptly notified of low blood glucose levels for 1 of 3 residents reviewed for</p>	F000157	The facility will ensure that notification occurs when there is a change in condition of the residents. Resident #82 has had a complete review of his/her chart. All notifications have been	07/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>hospitalization of the 6 residents who met the criteria for hospitalization. (Resident #82).</p> <p>Findings include:</p> <p>The record for Resident #82 was reviewed 6/13/13 at 8:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, morbid obesity, and cellulitis.</p> <p>A care plan for diabetes mellitus updated on 2/25/13, indicated a risk for hypo/hyperglycemia (low or high blood sugar). Interventions included, but were not limited to, monitor for signs and symptoms of hypo/hyperglycemia and notify the Physician, and to assess and record blood glucose levels as ordered.</p> <p>The Physician's Order Sheet for March 2013, indicated the resident's blood glucose was to be monitored twice daily at 6 a.m. and 4 p.m. and to hold the insulin if the blood glucose was less than 100 mg/dl (milligrams/deciliters). The insulin order was for Novolog (a short acting insulin) 10 units three times a day before meals and Levemir (a long acting insulin) 34 units at bedtime.</p>		<p>completed. Other charts were reviewed based on abnormalities in labs. All notifications were completed per facility protocol. Nurses will be in-serviced on the required notification upon change in condition as well as in other cases. The DON or designee will review all audit all notifications per critical labs at least 3 times per week. Results of audits will be reported to the QA for 6 months or until problem is considered to be resolved. The problem will be considered resolved if results of audits show no occurrences over a 3 month period of time. However, notification will continue to be monitored by nurses and managers.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/8/13 at 7:30 a.m., a nursing note indicated the resident's blood glucose was 47 mg/dl. A boxed diabetic shake was given. Thirty minutes later the blood glucose was rechecked and found to be 27 mg/dl. A glucagon (high glucose medication) injection was given. Thirty minutes later the blood glucose was rechecked and found to be 64 mg/dl. There was no evidence the Physician was notified of the low blood glucose levels.</p> <p>The House Supervisor was interviewed on 6/14/13 at 8:35 a.m. She indicated the Physician should have been notified of the resident's blood glucose level of 64 mg/dl at 8:00 a.m. on 3/8/13.</p> <p>3.1-5(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	The facility will ensure that all	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>interview, the facility failed to immediately notify the Administrator of an allegation of resident abuse. The facility also failed to remove an employee from the facility immediately after an allegation of abuse was made against the employee for 1 of 3 allegations of abuse reviewed. (Resident #B and CNA #1)</p> <p>Findings include:</p> <p>The facility's investigation of an abuse allegation voiced by Resident #B, was reviewed on 6/17/13 at 9:10 a.m.</p> <p>There was a "Statement" form written by LPN #4, that indicated the date of the incident was 3/13/13 and the time of the incident was 10:30 p.m. The statement indicated: "Mother called nurse asking did someone jump on (Resident #B's name), I asked her where did she get that from. She said (Resident #B's name) called her et (and) told her the aide jumped on him. I, writer, asked (Resident #B's name) what happened, he stated he was being too rough with me, he threw in the bed [sic]. Writer asked res (resident) where he was at other than the bed [sic]. Res ignored question et then said I want the lady to work with me.</p>		<p>allegations of abuse are reported to the Administrator or designee immediately upon the allegation of abuse. Resident #B has had a head to toe assessment, and Social Services interviewed and monitored the resident for change in socialization. No negative outcome noted. Other residents of the facility have been interviewed to ensure that they are free of abuse or care concerns. Staff will be in-serviced on the abuse policy with emphasis on immediate notification to the Administrator or designee, and emphasis on employees who are being investigated for abuse being removed from the premises immediately. Residents will be interviewed at least monthly to ensure that no concerns are noted. The results of the interviews will be report to QA for at least 6 months or until the issue is considered resolved. The facility will ensure that all allegations of abuse are reported to the Administrator or designee immediately upon the allegation of abuse. Resident #B has had a head to toe assessment, and Social Services interviewed and monitored the resident for change in socialization. No negative outcome noted. Other residents of the facility have been interviewed to ensure that they are free of abuse or care concerns. Staff will be in-serviced on the abuse policy</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Writer informed res the lady will work with him for the remaining 30 minutes if he needs anything. Res stated OK. Writer asked res was he in any pain, res stated no writer asked res to asses his body no redness/discoloration noted, skin remains intact no open areas..."</p> <p>There was a "Statement" form written by LPN #6 that was dated 3/14/13 and indicated: "Resident (Resident #B's name) room 507 A, reported that (CNA #1's name) threw him against wall [sic] in the evening about 9:30 p.m. states his glasses were broken. Observed glasses on resident's face - were not broken. Resident also reported that he broke his cell phone by throwing it against the wall - did not elaborate on when he destroyed his phone."</p> <p>A form titled, "Employee Warning Notice" was reviewed. It indicated the date of the warning was 3/14/13 at 3:00 p.m. It indicated CNA #1 was suspended due to the investigation of an allegation of abuse. CNA #1 was not suspended immediately on 3/13/13 at 10:30 p.m., when the allegation of abuse was first voiced.</p> <p>Review of the check off form for the abuse investigation indicated the</p>		<p>with emphasis on immediate notification to the Administrator or designee, and emphasis on employees who are being investigated for abuse being removed from the premises immediately. Residents will be interviewed at least monthly to ensure that no concerns are noted. The results of the interviews will be report to QA for at least 6 months or until the issue is considered resolved. Residents are assessed on an on-going basis by nurses, CNA's, Activities and other staff. Grievance forms are routinely completed and investigated when issues occur. All of these methods are in place to ensure that if a resident has any concerns to include abuse that the concerns are reported to the appropriate Managers. Resident interviews will be conducted by Social Services or designee on a weekly basis, selecting 5 residents per unit per week. Family is interviewed during care plan meetings or when contacted per complaint of a resident. Staff has been in-serviced about abuse and abuse reporting. Monitoring may be stopped if no complaints are noted over a 3 month period of time. However, residents will continue to be monitored for any signs of abuse or neglect.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator was notified of the allegation of abuse on 3/14/13 at 3:30 p.m. The Administrator was not notified immediately of the allegation on 3/13/13 at 10:30 p.m., when the allegation was voiced.</p> <p>Interview with the Restorative Nurse on 6/17/13 at 10:06 a.m., indicated CNA #1 remained in the facility until 11:00 p.m. on 3/13/13. She indicated the CNA was not sent home immediately. She also indicated the Administrator was not notified immediately of the allegation.</p> <p>3.1-28(c) 3.1-28(d)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their Abuse Policy related to the immediate notification of the Administrator of an allegation of resident abuse. The facility also failed to implement their Abuse Policy related to the immediate removal of an employee from the facility after an allegation of abuse was made against the employee for 1 of 3 allegations of abuse reviewed . (Resident #B and CNA #1)</p> <p>Findings include:</p> <p>The facility's investigation of an abuse allegation voiced by Resident #B, was reviewed on 6/17/13 at 9:10 a.m.</p> <p>There was a "Statement" form written by LPN #4, that indicated the date of the incident was 3/13/13 and the time of the incident was 10:30 p.m. The statement indicated: "Mother called nurse asking did someone jump on (Resident #B's name), I asked her where did she get</p>	F000226	<p>The facility will ensure that all allegations of abuse are reported to the Administrator or designee immediately upon the allegation of abuse. Resident #B has had a head to toe assessment, and Social Services interviewed and monitored the resident for change in socialization. No negative outcome noted. Other residents of the facility have been interviewed to ensure that they are free of abuse or care concerns. No concerns noted. Staff will be in-serviced on the abuse policy with emphasis on immediate notification to the Administrator or designee, and emphasis on employees who are being investigated for abuse being removed from the premises immediately. Residents will be interviewed at least monthly to ensure that no concerns are noted. The results of the interviews will be report to QA for at least 6 months or until the issue is considered resolved. The facility will ensure that all allegations of abuse are reported to the Administrator or designee immediately upon the allegation of abuse. Resident #B has had a head to toe assessment, and</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>that from. She said (Resident #B's name) called her et (and) told her the aide jumped on him. I, writer, asked (Resident #B's name) what happened, he stated he was being too rough with me, he threw in the bed [sic]. Writer asked res (resident) where he was at other than the bed [sic]. Res ignored question et then said I want the lady to work with me. Writer informed res the lady will work with him for the remaining 30 minutes if he needs anything. Res stated OK. Writer asked res was he in any pain, res stated no writer asked res to asses his body no redness/discoloration noted, skin remains intact no open areas..."</p> <p>There was a "Statement" form written by LPN #6 that was dated 3/14/13 and indicated: "Resident (Resident #B's name) room 507 A, reported that (CNA #1's name) threw him against wall [sic] in the evening about 9:30 p.m. states his glasses were broken. Observed glasses on resident's face - were not broken. Resident also reported that he broke his cell phone by throwing it against the wall - did not elaborate on when he destroyed his phone."</p> <p>A form titled, "Employee Warning Notice" was reviewed. It indicated the</p>		<p>Social Services interviewed and monitored the resident for change in socialization. No negative outcome noted. Other residents of the facility have been interviewed to ensure that they are free of abuse or care concerns. Staff will be in-serviced on the abuse policy with emphasis on immediate notification to the Administrator or designee, and emphasis on employees who are being investigated for abuse being removed from the premises immediately. Residents will be interviewed at least monthly to ensure that no concerns are noted. The results of the interviews will be report to QA for at least 6 months or until the issue is considered resolved. Residents are assessed on an on-going basis by nurses, CNA's, Activities and other staff. Grievance forms are routinely completed and investigated when issues occur. All of these methods are in place to ensure that if a resident has any concerns to include abuse that the concerns are reported to the appropriate Managers. Resident interviews will be conducted by Social Services or designee on a weekly basis, selecting 5 residents per unit per week. Family is interviewed during care plan meetings or when contacted per complaint of a resident. Staff has been in-serviced about abuse and abuse reporting. Monitoring</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>date of the warning was 3/14/13 at 3:00 p.m. It indicated CNA #1 was suspended due to the investigation of an allegation of abuse. CNA #1 was not suspended immediately on 3/13/13 at 10:30 p.m., when the allegation of abuse was first voiced.</p> <p>Review of the check off form for the abuse investigation indicated the Administrator was notified of the allegation of abuse on 3/14/13 at 3:30 p.m. The Administrator was not notified immediately of the allegation on 3/13/13 at 10:30 p.m., when the allegation of abuse was made.</p> <p>The policy titled "Abuse Prevention Program Facility Policy" revised on 6/1/12, was provided by the Business Office Manager on 6/17/13. She indicated the policy was current. The policy indicated: "Internal Reporting Requirements and Identification of Allegations Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor and the administrator. Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. Employees of this facility who have</p>		<p>may be stopped if no complaints are noted over a 3 month period of time. However, residents will continue to be monitored for any signs of abuse or neglect.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provided to residents."</p> <p>Interview with the Restorative Nurse on 6/17/13 at 10:06 a.m., indicated CNA #1 remained in the facility until 11:00 p.m. on 3/13/13. She indicated the CNA was not sent home immediately. She also indicated the Administrator was not notified immediately of the allegation. She indicated the facility's abuse policy was not followed.</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to provide reasonable accommodations of a resident's needs, related to a too-short bed mattress for 1 of 35 residents observed for positioning. (Resident #41)</p> <p>Findings include:</p> <p>On 6/10/13 at 2:09 p.m., Resident #41 was observed in his bed. His feet were hanging over the edge of his mattress and there was an eight inch gap between the end of the mattress and the footboard of the bed.</p> <p>Interview on 6/12/13 at 2:50 p.m., with the House Supervisor indicated the mattress did not fit the bed. She indicated it was an extra long bed frame with a standard size mattress and she would look into ordering a properly fitting mattress.</p> <p>Interview on 6/12/13 at 4:00 p.m.,</p>	F000246	<p>The facility will ensure that residents receive reasonable accommodations for needs and preferences. Resident #41 has received a new bed and mattress. An audit of the residents' beds and accommodations was completed and assured that all residents needs are being met. No other issues related to mattresses or bed frames were noted. The facility will continue to audit accommodations of residents by interview and by inspection. Inspections will be conducted by Maintenance Director or designee at least monthly. Results of the inspections will be reported to QA monthly for 6 months or until considered resolved. Bed frames and mattresses will be inspected by the Maintenance Director or designee. Residents will be interviewed on a monthly basis selecting 5 residents per unit per month. Monitoring may be stopped if no new issues are identified in a 3 month period.</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>with the Maintenance Supervisor indicated he had an extra long mattress available in storage.</p> <p>On 6/13/13 at 8:00 a.m., the resident's mattress had been replaced with one that properly fit the bed frame.</p> <p>3.1-3(v)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to falls and restorative nursing services for 1 of 25 residents reviewed for accurate MDS assessments. (Resident #6)</p>	F000278	<p>The facility will ensure that all MDS's are updated per accurate assessment of residents. Resident #6 has had his/her MDS updated to reflect recent fall. Other residents have had a review of the MDS's to verify accuracy. No other issues noted. MDS Coordinator has been replaced with an employee who</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>The record for Resident #6 was reviewed on 6/13/13 at 9:50 a.m. Review of Section J. "Health Conditions" of the resident's Significant Change Minimum Data Set (MDS) assessment dated May 27, 2013, indicated the resident had no falls since her prior assessment.</p> <p>Review of the Nursing progress notes dated 5/13/13 at 7:22 p.m., indicated the resident was found on the floor in her room due to sliding out of her wheelchair.</p> <p>Review of Section O. "Special treatments and Programs", indicated the resident had not received Passive range of motion (PROM) nor Active range of motion (AROM) for at least 15 minutes a day in the last 7 calendar days.</p> <p>Review of the Restorative Nursing Program Flow sheet for the month of May 2013, indicated the resident had received PROM and AROM 5/19-5/24 and 5/26-5/31/13.</p> <p>Interview with the MDS Coordinator on 6/17/13 at 10:55 a.m., indicated the resident's MDS was coded</p>		<p>has more experience with MDS's. Audits will be conducted at least monthly by MDS Coordinator or designee to ensure that MDS's continue to reflect accurate assessment of the residents. The results of the audits will be reported to QA Team for 6 months or until problem is considered resolved. All other residents have a review of the MDS's to verify accuracy. No other issues noted. Audits will continue until no new issues are noted within a 3 month period of time.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inaccurately related to falls and Restorative Nursing Services.  3.1-31(g)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a plan of care was initiated related to hydration for 1 of 1 residents reviewed for hydration of the 1 who met the criteria for hydration. The facility also failed to initiate a plan of care related to peripherally inserted central catheters (PICC) for 1 of 3 residents reviewed for special needs, urinary catheters for 1 of 2 residents reviewed for urinary catheters and medication care plans related to anticoagulants and psychoactive medications for 7 of 10</p>	F000279	The facility will ensure each resident receives a comprehensive care plan. All residents identified during survey have had a complete review of their care plans and corrections have been made accordingly. Corrections are consistent with resident assessment. Other care plans have been reviewed and corrections have been made according to resident assessment. A Care Plan Coordinator has been hired to ensure continued compliance. Care Plans will be audited at least weekly by Care Plan	07/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>residents reviewed for unnecessary medications. (Residents #11, #20, #29, #39, #40, #41, #44, #61, #62, and #64)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 6/11/13 at 2:54 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, anxiety, and acute psychosis.</p> <p>Review of the June 2013 Physician's order summary (POS), indicated the resident was receiving Clozapine (an antipsychotic medication) 50 milligrams (mg) and 100 mg twice a day.</p> <p>Review of the plan of care dated 5/21/13, indicated there was no care plan related to the resident's behaviors as well as the antipsychotic medication.</p> <p>Interview with the MDS Coordinator on 6/12/13 at 11:15 a.m., indicated that she was told there was no need to care plan the behaviors and psychoactive medications if the resident was not having any current behaviors or side effects from the medications. She indicated if the resident was still receiving the</p>		<p>Coordinator or designee to ensure continued compliance. Results of audits will be submitted to QA monthly for 6 months or until issue is considered resolved. All care plans have been reviewed for completeness and accuracy. Care plans will be reviewed at least twice per week during care plan meetings. This will ensure that at least 10 care plans are reviewed per week. Monitoring may be stopped if no new issues are identified within a 3 month period of time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>antipsychotic medication or was a behavior risk, the potential should be care planned.</p> <p>2. The record for Resident #62 was reviewed on 6/13/13 at 12:39 p.m. The resident's diagnoses included, but were not limited to, insomnia, mood disorder, manipulative personality disorder, psychotic disorder and deep vein thrombosis.</p> <p>Review of the June 2013 Physician's order summary (POS), indicated the resident was receiving Seroquel (an antipsychotic medication) 300 milligrams (mg) twice a day, Coumadin (a blood thinner) 4 mg daily, and Ambien (a hypnotic) 5 mg at bedtime.</p> <p>Review of the plan of care dated 5/23/13, indicated there was no care plan related to the Seroquel, Coumadin, and Ambien.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident should have had a care plan initiated related to insomnia, the antipsychotic medication and a care plan for bleeding risk related to the Coumadin.</p> <p>3. The record for Resident #40 was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed on 6/12/13 at 1:22 p.m. The resident's diagnosis included, but was not limited to, vascular dementia with behavior disturbance.</p> <p>Review of the June 2013 Physician's order summary (POS), indicated the resident was receiving Risperdal (an antipsychotic) 0.5 milligrams (mg) daily and Ambien (a hypnotic) 5 mg at bedtime.</p> <p>Review of the plan of care dated 5/2/13, indicated there was no care plan related to insomnia and the use of the Ambien as well as a care plan related to the resident receiving the Risperdal.</p> <p>Interview with the MDS Coordinator on 6/12/13 at 11:15 a.m., indicated that she was told there was no need to care plan the behaviors and psychoactive medications if the resident was not having any current behaviors or side effects from the medications. She indicated if the resident was still receiving the antipsychotic medication or was a behavior risk, the potential should be care planned.</p> <p>4. Resident #29 was observed on 6/13/13 at 11:45 a.m. He was seated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>in a wheelchair in his room. There was a transparent dressing on his right arm. Interview with LPN #1, at that time, indicated the dressing was covering the resident's PICC (peripherally inserted central catheter) line.</p> <p>The record for Resident #29 was reviewed on 6/13/13 at 3:16 p.m. The resident had diagnoses that included, but were not limited to left below knee amputation, dementia, and osteomyelitis (infection of the bone).</p> <p>The resident was admitted to the facility on 1/30/13. The Admission Nursing Assessment dated 1/30/13, indicated the resident had a PICC line in his right arm for intravenous antibiotic therapy.</p> <p>Review of the current care plan indicated there was no care plan in place for the PICC line.</p> <p>Interview with the House Supervisor on 6/14/13 at 2:37 p.m., indicated there was no care plan in place for the PICC line. She indicated there should have been a care plan in place for the resident's PICC line.</p> <p>5. The record for Resident #61 was reviewed on 6/11/13 at 2:58 p.m. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>resident had diagnoses, that included but were not limited to, hyperkalemia (high potassium level), diabetes, and dementia with delusional disturbance.</p> <p>The Physician order summary (POS) dated June 2013, indicated there were current physician orders for Remeron (an antidepressant) 15 mg (milligrams) once nightly and for Seroquel (an antipsychotic medication) 12.5 mg 1 tab every 12 hours.</p> <p>Review of the current care plans indicated there were no care plans for delusional behaviors, the use of an antidepressant or for the use of an antipsychotic medication.</p> <p>Interview with the Social Service Director on 6/12/13 at 9:32 a.m. indicated, there should have been care plans for the resident's behaviors</p> <p>The MDS (Minimum Data Set) Coordinator was interviewed on 6/12/13 at 11:14 a.m. She indicated there were no care plans in place for the use of the antipsychotic medication and the use of the antidepressant medication. She indicated there should have been care plans for the medications.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>6. The record for Resident # 39 was reviewed on 6/12/13 at 10:06 a.m. The resident had diagnoses that included, but were not limited to, psychosis, delusional thinking and anxiety.</p> <p>The June 2013 Physician order summary (POS) indicated the resident had current physician's orders for Coumadin (an anticoagulant medication) 4 mg (milligrams) daily, Lexapro (an antidepressant medication) 20 mg daily, and risperidone (an antipsychotic medication) 1 mg two times per day.</p> <p>Review of the current care plans indicated there were no care plans in place for the Coumadin, the Lexapro and the Risperidone.</p> <p>Interview with the MDS (Minimum Data Set) Coordinator on 6/12/12 at 1:16 p.m., indicated there were no care plans for Coumadin, Lexapro and Risperidone usage. She indicated there should be care plans for the use of those medications.</p> <p>7. Resident #20 was observed on 6/11/13 at 2:37 p.m. in bed. The resident had a urinary catheter (a tube placed into the bladder to drain</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>urine) in place.</p> <p>The record for Resident #20 was reviewed on 6/13/13 at 7:53 a.m. The resident had diagnoses that included, but were not limited to multiple sclerosis, paraplegia and neurogenic bladder.</p> <p>The Physician order summary (POS) dated June 2013, indicated physician's orders for Foley catheter care every shift.</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 4/22/13, the resident had an indwelling catheter.</p> <p>Review of the current care plans indicated there was no care plan for the use of the indwelling Foley catheter.</p> <p>Interview with the MDS Coordinator on 6/13/13 at 9:22 a.m., indicated there was no current care plan for the use of the Foley catheter. She indicated there should be a care plan for the use of the Foley catheter.</p> <p>8. The record for Resident #64 was reviewed on 6/17/13 at 8:30 a.m. The resident's diagnoses included, but were not limited to, paralysis from the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>waist down, post-gun shot wound to abdomen, depression and anxiety.</p> <p>The Minimum Data Set (MDS) assessment dated 1/6/13, indicated the resident was dehydrated.</p> <p>A History and Physical dated 12/10/12, indicated the resident had been hospitalized for severe septicemia (blood infection), respiratory failure, malnutrition, dehydration and electrolyte imbalance.</p> <p>A nursing note dated 1/4/13, indicated the resident was not drinking fluids. On 1/4/13, a Physician order was received for 0.9% normal saline to be given at 100 cc/hr (cubic centimeter/hour) intravenously.</p> <p>Review of the current care plan indicated there was no care plan for hydration or fluid imbalance in the resident's record.</p> <p>Interview with the MDS Coordinator on 6/17/13 at 10:40 a.m., indicated there was no care plan related to hydration or fluid volume despite the recent changes in his status related to dehydration.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>9. The record for Resident #41 was reviewed on 6/12/13 at 1:55 p.m. The Resident's diagnoses included, but were not limited to, psychosis with hallucinations, seizure disorder, depression, and alcohol related dementia.</p> <p>The Medication Administration Record for June 2013, indicated the resident was receiving psychotropic medications that included Depakote (anti-convulsant), Ativan (anti-anxiety), Seroquel (anti-psychotic) and Elavil (anti-depressant).</p> <p>Review of the resident's current care plan indicated there were no care plans for the psychotropic medications in the resident's record.</p> <p>Interview with the MDS Coordinator on 6/12/13 at 3:00, indicated she was unaware there needed to be care plans for psychotropic drugs.</p> <p>10. The record for Resident #44 was reviewed on 6/12/13 at 2:45 p.m. The resident had diagnoses that included, but were not limited to, dementia with behaviors, CVA (stroke), and depression.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Medication Administration Record for June 2013, indicated the resident was receiving psychotropic medications that included Ativan (anti-anxiety), Risperidone (anti-psychotic) and Elavil (anti-depressant).</p> <p>Review of the resident's current care plan indicated there were no care plans for the psychotropic medication in the resident's record.</p> <p>Interview with the MDS Coordinator on 6/12/13 at 3:00 p.m., indicated she was unaware there needed to be care plans for psychotropic drugs.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders as well as the plan of care were followed as written related to a bed alarm not in place for 1 of 3 residents reviewed for accidents of the 5 who met the criteria for accidents, soiled clothing for 1 of 3 residents reviewed for activities of daily living of the 8 who met the criteria for activities of daily living, bed positioning for 1 of 2 residents reviewed for positioning of the 2 who met the criteria for positioning, dressings not in place as ordered for 2 of 3 residents reviewed for pressure ulcers of the 3 who met the criteria for pressure ulcers, and insulin and glucometer checks not administered as ordered for 2 of 10 residents reviewed for unnecessary medications. (Residents #6, #38, #55, #62, and #72)</p> <p>Findings include:</p> <p>1. On 6/11/2013 at 10:44 a.m., Resident #6 was observed seated in her wheelchair in the hallway. The</p>	F000282	<p>The facility will ensure that physician orders and care planned needs are followed. All residents identified during survey have had a review of physician orders and care plans.</p> <p>Corrections processed as noted. Staff have been in-serviced on meeting residents' needs per care plans and physician orders.</p> <p>Other residents have had a review of physician orders and care plans and have been found to be in compliance. Care Cards audit tool has been revised to include all areas noted per the survey results. Care Plan Coordinator or designee will audit Care Cards and Physician Orders at least monthly. Results of audits will be reported to the QA Team monthly for 6 months or until problem is considered resolved. All residents were reviewed for accuracy of physician orders and care plans.</p> <p>Following care plans will be monitored by Care Cards. Care Cards will be updated monthly and will be used during audits to ensure that residents are receiving services per care plan.</p> <p>When physician orders are initiated, duplicate copy will be given to the Director of Nursing or</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident was observed with dried food spillage on her pant legs, around her sock on her right foot and on her right shoe around the ankle. On 6/11/13 at 2:38 p.m., the resident was seated in her wheelchair outside of the main dining room. The resident was observed with dried food spillage on her pant legs, around her sock on her right foot and on her right shoe around the ankle.</p> <p>On 6/13/13 at 9:04 a.m., the resident was observed in her room in bed. The resident's personal alarm was on top of the over bed light and not attached to the resident. The House Supervisor was in the resident's room at this time to do the dressing change to the pressure ulcer on the resident's left inner heel. There was no dressing to the resident's heel at this time. Interview with the House Supervisor at the time, indicated the dressing change was usually on midnights, and she did not know why the dressing was not in place.</p> <p>On 6/13/13 at 2:21 p.m., the resident was in her room in bed. The resident's personal alarm was on top of the over bed light and not attached to the resident.</p> <p>On 6/14/13 at 7:34 a.m., the resident</p>		<p>designee for cross referencing. This will ensure that physician orders are followed. Audit tools will include Care Card compliance and physician order compliance. Monitoring my be stopped if no issues are identified in a 3 month period.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was in her room in bed sleeping. The resident's personal alarm was not in place.</p> <p>The record for Resident #6 was reviewed on 6/13/13 at 9:50 a.m. Review of the June 2013 Physician's order summary (POS), indicated the resident was to have a personal alarm on while in bed and in the wheelchair.</p> <p>Review of the plan of care dated 5/30/13, indicated the resident was at risk for falls related to a history of falls, cognitive impairments, impulsiveness with attempts to transfer without staff assist, requires ADL (activities of daily living) assist for transfers and mobility, impaired ROM (range of motion), incontinence, decreased strength and endurance, diagnosis arthritis, osteoporosis, CVA (cerebral vascular accident/stroke) with possible hemiplegia/hemiparesis (weakness), and behavioral problems. The interventions included, but were not limited to, wheelchair and bed alarm.</p> <p>The plan of care dated 5/30/13, indicated the resident required full assistance for bathing, grooming and dressing related to right hemiparesis (weakness). Resident was able to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>wash face with cueing from staff. Relied on staff for remainder of bathing and dressing. The interventions included, but were not limited to, full assist for hygiene and grooming daily.</p> <p>A Physician's order dated 3/8/13, indicated the resident's left heel was to be cleansed with wound cleanser, pat dry, and apply collagen and wrap with Kerlix daily until healed.</p> <p>The plan of care dated 1/21/13 and reviewed on 5/30/13, indicated the resident had an alteration in skin integrity as evidenced by having a pressure ulcer and decreased mobility. The interventions included, but were not limited to, treat per Physician order.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident's personal alarm should have been in place when the resident was in bed as well as the resident being assisted to change her clothes in a timely manner.</p> <p>2. On 6/11/13 at 9:53 a.m., Resident #38 was observed in her room in bed. The resident appeared to be sleeping, she was leaning to her left side with her head against the wall.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 6/12 at 8:42 a.m. and 10:25 a.m., 6/13 at 9:30 a.m., and on 6/17/13 at 8:45 a.m., the resident was in her room in bed sleeping. The resident was positioned on her left side and her head was not on her pillow. She was curled up into a ball at this time (fetal position).</p> <p>The record for Resident #38 was reviewed on 6/12/13 at 9:00 a.m.</p> <p>The plan of care dated 3/19/13, indicated the resident required full assistance with bathing, dressing, and transfers related to a diagnosis of dementia. The interventions included, but were not limited to, ensure proper body alignment when in bed or chair.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident should have had extra positioning pillows while in bed to ensure proper positioning.</p> <p>3. The record for Resident #62 was reviewed on 6/13/13 at 12:39 p.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>A Physician's order dated 5/28/13, indicated the resident was to receive Lantus (insulin) 30 units</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>subcutaneously (sq) every evening. Discontinue Lantus 20 units sq every evening.</p> <p>Review of the June 2013 Medication Administration Record (MAR), indicated the resident received Lantus 20 units every evening rather than 30 units on 6/1-6/8, 6/10, 6/11, and 6/13/13.</p> <p>The plan of care dated 2/28/13 and reviewed on 5/23/13, indicated the resident was at risk for hypo/hyperglycemic (low or high blood sugar) reactions related to diagnosis of diabetes. The interventions included, but were not limited to, give medication as ordered by the Physician.</p> <p>Interview with LPN #3 on 6/14/13 at 11:25 a.m., indicated the resident should have been receiving the 30 units of insulin rather than 20.</p> <p>4. Resident # 55 was observed in bed on 6/12/13 at 11:29 a.m. The House Supervisor was providing treatments to the resident's pressure ulcers.</p> <p>The treatment to the resident's left knee was completed. The House Supervisor then turned the resident to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>her left side. Observation of the resident's buttocks indicated there was no dressing in place on her buttocks. There was an open area on the resident's sacral (buttocks) area.</p> <p>Interview with the House Supervisor at that time, indicated there was no dressing on the resident's sacral area. She indicated there should have been a dressing on the resident's wound.</p> <p>The record for Resident #55 was reviewed on 6/12/13 at 2:00 p.m. The resident had diagnoses that included, but were not limited to, multiple sclerosis and stroke.</p> <p>The Physician order summary (POS) dated June 2013 was reviewed. There was a Physician order that indicated, "Cleanse buttocks with wound cleanser, pat dry, and apply collagen and foam dressing daily and prn (as needed)."</p> <p>There was a care plan in place dated 1/17/13 that indicated the resident had a pressure ulcer related to incontinence and immobility. One of the interventions in place indicated the treatment was to be completed as ordered.</p> <p>Review of the June 2013 TAR</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(Treatment Administration Record), indicated there was no evidence that the treatment to the resident's buttocks was provided on 6/11/13. There were no initials documented on the record to indicate the treatment was completed.</p> <p>Interview with the House Supervisor on 6/12/13 at 2:10 p.m., indicated the June 2013 TAR, indicated the treatment to the resident's buttock's was not completed as ordered. She indicated the treatment should have been completed as ordered by the Physician and as indicated in the care plan.</p> <p>5. The record for Resident #72 was reviewed on 6/13/13 at 11:19 a.m. The resident had diagnoses that included, but were not limited to, depression, diabetes and anemia</p> <p>There was a care plan initiated on 4/17/12 and revised on 10/18/12, that indicated: "Resident at risk for hypo/hyperglycemic(low/high blood glucose levels) reactions r/t (related to) Dx (diagnosis) of diabetes. Goal: Resident will remain without hypo/hyperglycemia episodes thru (through)next review -give medications as ordered by MD</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(physician)</p> <p>-monitor for s/s (signs and symptoms) of hypoglycemia i.e. thirst, excessive appetite or voiding, sweating, blurred vision and notify MD</p> <p>-assess and record blood glucose levels as ordered</p> <p>-diets supplements as ordered</p> <p>-educate resident on s/s of hypo/hyperglycemia"</p> <p>There was a Physician order dated 1/11/13, that indicated, "novolin R per sliding scale prn (as needed) inject sub-q (subcutaneously) per sliding scale 1-150 0 units 151-200 2 units 201-250 4 units 251-300 6 units 301- 350 8 units 351-400 10 units &gt;400 call MD</p> <p>There was a Physician order dated 3/31/13, that indicated, "Monitor accuchecks (blood glucose levels) bid (twice daily)."</p> <p>Review of the May 2013 Medication Administration Record (MAR) indicated the accuchecks were obtained twice daily at 6:00 a.m. and 4:00 p.m., and were covered with insulin as per the sliding scale order.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Review of the June 2013 MAR, indicated accuchecks were completed only once daily at 6:00 a.m. The sliding scale insulin coverage was administered only once daily at 6:00 a.m. The accuchecks were not completed twice daily. The insulin was not administered per the sliding scale twice daily.</p> <p>Interview with the House Supervisor on 6/13/13 at 1:25 p.m., indicated the resident was to have accuchecks twice daily. She indicated the accuchecks should have been done at 6:00 a.m. and 4:00 p.m. She also indicated insulin should have been administered twice daily according to the accucheck reading. She indicated the Physician's orders and the resident's care plan were not followed.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to monitoring a hypoglycemic (low blood sugar) reaction and insulin administration which resulted in the resident being sent to the hospital for 1 of 3 residents reviewed for hospitalization of the 6 residents who met the criteria for hospitalization . The facility also failed to ensure the necessary treatment and services were provided related to bed positioning for 1 of 2 residents reviewed for positioning of the 2 residents who met the criteria for positioning. (Residents #38 and #82)</p> <p>Findings include:</p> <p>1. The record for Resident #82 was reviewed on 6/13/13 at 8:00 a.m. The resident's diagnoses included, but was not limited to, diabetes mellitus.</p> <p>The Physician's order summary</p>	F000309	<p>The facility will ensure that necessary care and services to attain or maintain physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care are provided to residents per policy. Resident #38 has had his/her bed repositioned to ensure that resident is not inappropriately positioned. Resident #82 has had a complete review of his/her chart. All notifications have been completed. Blood sugars have been reviewed and monitored. No further issues noted. In-serviced nurses on policy and procedure for hypo/hyperglycemic residents and care administration Facility policy has been updated to address management of blood glucose related to insulin administration. Audit tool for monitoring blood glucose has been updated to ensure proper notification, administration and follow up on any critical blood sugar values. DON or designee will audit blood glucose administration at least weekly. The results of the audits will be</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(POS) for June 2013, indicated the resident's blood glucose was to be monitored twice daily at 6:00 a.m. and 4:00 p.m. The insulin order was for Novolog (a fast acting insulin) 10 units three times a day before meals and hold if blood glucose level was less than 100 mg/dl (milligrams/deciliter). Levemir (a long acting insulin) 34 units was to be given at bedtime.</p> <p>On 3/8/13 at 7:30 a.m., a nursing progress note indicated the resident's blood glucose was 47 mg/dl. A boxed diabetic shake was given. Thirty minutes later the blood glucose was rechecked and found to be 27 mg/dl. A glucagon (high glucose medication) injection was given. Thirty minutes later the blood glucose was rechecked and found to be 64 mg/dl. There was no evidence the Physician was notified of the low blood glucose levels.</p> <p>Review of the diabetic flowsheet dated 3/8/13, indicated the resident received the scheduled 10 units of Novolog at 12 p.m. Review of the nursing progress notes dated 3/8/13 and the diabetic flowsheet dated 3/8/13 indicated there was no evidence a blood glucose level was obtained prior to the administration of the routine Novolog insulin.</p>		<p>reported to QA at least monthly for 6 months or until problem is considered resolved. The DON reviewed all residents for positioning. No new issues noted. Residents who have positioning orders have had their care cards updated to reflect the order. Rounds/Monitoring produced no new issues. All insulin records were reviewed for accuracy. Issues noted.</p> <p>In'services held with nurses. Disciplinary action taken when warranted. Positioning monitoring will occur on a daily basis. through rounds by the DON, Restorative or designee. Monitoring may be discontinued if no new issues are identified within a 3 month period.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/8/13 at 1:00 p.m., nursing progress notes indicated the resident was asleep. On 3/8/13 at 2:30 p.m., the family was at the bedside and voiced concern about the resident sleeping. The nursing progress note indicated the Physician was phoned, "...regarding +4 edema, pain med dosage et [sic] blood glucose level. Awaiting return call from Dr. ". Review of the Nursing progress notes and the diabetic flowsheet dated 3/8/13 indicated there was no evidence that a blood glucose level was obtained at 2:30 p.m. on 3/8/13.</p> <p>On 3/8/13 at 2:45 p.m., a nursing progress note indicated the Physician was called again and awaiting return call.</p> <p>A nursing progress note dated 3/8/13 at 3:20 p.m., indicated family voiced a concern that the resident was suddenly "groggy". A blood glucose level was obtained and found to be 49 mg/dl. The resident was eating with assistance from family.</p> <p>On 3/8/13 at 3:45 p.m., a nursing progress note indicated the resident's blood glucose was rechecked and found to be 55 mg/dl.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>At 4:16 p.m. on 3/8/13, a nursing progress note indicated there was a new Physician's order to give Glucagon 50 ml (milliliters) IM (intramuscular injection). The resident's glucose level at 4:30 p.m. on 3/8/13 was 102 mg/dl.</p> <p>A nursing progress note dated 3/8/13 at 4:45 p.m., indicated the glucose level was 56 mg/dl.</p> <p>A nursing progress note dated 3/8/13 at 5:40 p.m., indicated a new Physician order to begin Dextrose 5% 50 ml (milliliters) IV (intravenously) was obtained.</p> <p>A nursing progress note dated 3/8/13 at 5:52 p.m., indicated the glucose level was 58 mg/dl.</p> <p>On 3/8/13 at 6:00 p.m., the Physician gave orders for the resident to be sent to the Emergency Room to be evaluated.</p> <p>A nursing progress note dated 3/8/13 at 6:10 p.m., indicated the ambulance had arrived and the resident's glucose was checked again. The glucose level was 56 mg/dl.</p> <p>The resident was admitted to the hospital 3/8/13 and remained there</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>until 3/23/13.</p> <p>The hospital Discharge Summary, dated 3/30/13, indicated: " Treatments &amp; Course in Hospital With Complications If Any: Patient was admitted to the hospital with altered mental status, she was noted to be hypoglycemic, she also noted to be in acute respiratory failure [sic]. . . ...Discharge DX (diagnosis) was: hypoglycemia improved, diabetes mellitus, acute renal failure..."</p> <p>A care plan for Diabetes Mellitus updated on 2/25/13 indicated the resident was at risk for hypo/hyperglycemia (low or high blood sugar). Interventions included, but were not limited to, monitor for signs and symptoms of hypo/hyperglycemia and notify the physician, and to assess and record blood glucose levels as ordered.</p> <p>Interview with the Restorative Nurse at 3:20 p.m. on 6/13/13, indicated if a blood glucose level was low in the morning and the POS indicated to hold insulin, the administration of the afternoon dose of insulin would be " a nursing judgment".</p> <p>Interview with the House Supervisor on 6/14/13 at 8:35 a.m., indicated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>resident's blood glucose of 64 at 8:00 a.m. on 3/8/13 should have been rechecked again and the Physician should have been notified. She further indicated a blood glucose level should have been obtained prior to administering the noon insulin. She indicated the facility's policy for hypoglycemia was not followed.</p> <p>The Policy and Procedure for Management of Hypoglycemia was received from the Restorative Nurse on 6/13/13 at 3:20 p.m. She indicated the policy was current. The policy indicated an asymptomatic and responsive resident with blood glucose less than 70 mg/dl should be given a rapidly absorbed glucose and the blood sugar rechecked in 15 minutes. If blood sugar still less than 70 mg/dl repeat oral glucose and recheck blood sugar in 15 minutes.</p> <p>2. On 6/11/13 at 9:53 a.m., Resident #38 was observed in her room in bed. The resident appeared to be sleeping, she was leaning to her left side with her head against the wall.</p> <p>On 6/12 at 8:42 a.m. and 10:25 a.m., 6/13 at 9:30 a.m., and on 6/17/13 at 8:45 a.m., the resident was in her room in bed sleeping. The resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was positioned on her left side and her head was not on her pillow. She was curled up into a ball at this time (fetal position).</p> <p>The record for Resident #38 was reviewed on 6/12/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, altered mental status and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 3/7/13, indicated the resident was totally dependent for bed mobility with one person assist (4/2).</p> <p>The plan of care dated 3/19/13, indicated the resident required full assistance with bathing, dressing, and transfers related to a diagnosis of dementia. The interventions included, but were not limited to, ensure proper body alignment when in bed or chair.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident should have had extra positioning pillows while in bed to ensure proper positioning.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observation, record review and interview, the facility failed to ensure the necessary services were provided to maintain good grooming related to soiled clothing as well as hair and nail care for 2 of 3 residents reviewed for activities of daily living of the 3 residents who met the criteria for activities of daily living. (Residents #6 and #47)</p> <p>Findings include:</p> <p>1. On 6/11/2013 at 10:44 a.m., Resident #6 was observed seated in her wheelchair in the hallway. The resident was observed with dried food spillage on her pant legs, around her sock on her right foot and on her right shoe around the ankle. On 6/11/13 at 2:38 p.m., the resident was seated in her wheelchair outside of the main dining room. The resident was observed with dried food spillage on her pant legs, around her sock on her right foot and on her right shoe around the ankle.</p>	F000312	<p>The facility will ensure that residents receive necessary services to maintain good nutrition, grooming and personal hygiene. Residents #6 has received a compartmental plate to minimize the potential for spillage during meal service. Compliance rounds will be completed after meals to ensure residents receive appropriate changes. Resident #47 has a care plan for refusal of ADL's. Resident will be monitored and documentiion will be updated according to participation or refusal by resident of services.. Facility rounds have conducted to identify problems with ADL assistance. Some issues noted and corrected. Staff have been in-serviced on ADL Care and documentation of refusal of services. ADL sheets will be updated to accurately reflect refusal of services. ADL audit will be conducted by DON or designee to ensure that ADL services are provided according to the Care Plan, physician orders or resident needs. Results of audits will be reported to the QA team on a monthly basis for 6 months or until issue is</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The record for Resident #6 was reviewed on 6/13/13 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and hemiplegia (weakness).</p> <p>Review of the Significant change Minimum Data Set (MDS) assessment dated 5/27/13, indicated the resident was totally dependent for dressing and personal hygiene.</p> <p>The plan of care dated 5/30/13, indicated the resident required full assistance for bathing, grooming and dressing related to right hemiparesis (weakness). Resident was able to wash face with cueing from staff. Relied on staff for remainder of bathing and dressing. The interventions included, but were not limited to, full assist for hygiene and grooming daily.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident should have been assisted to change her clothes in a timely manner.</p> <p>2. On 6/10/13 at 9:30 a.m. and on 6/11/13 at 11:00 a.m., Resident #47 was observed in activities. Her hair was combed back from her face, and her hair was oily and had white</p>		<p>considered resolved. Audits will be completed at least weekly. Audits will continue until to new issues have been noted in a 3 month period of time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>specks along the hairline. The resident's fingernails were observed to be chipped and dirty.</p> <p>The record for Resident #47 was reviewed 6/12/13 at 11:55 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, impulse control disorder, seizure disorder and psychosis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 3/3/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 4, which indicated severe cognitive impairment. It also indicated the resident required extensive assistance with personal hygiene and was totally dependent with bathing.</p> <p>The nursing assistant shower records indicated this resident was showered on 6/11/13 during the midnight shift.</p> <p>Interview with the Restorative Nurse on 6/12/13 at 11:55, indicated the resident's hair and nail care was to be done with showers. She further indicated the resident put oil in her hair. She indicted there should not have been white specks in her hair and her nails should not be chipped and dirty.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-38(a)(3) 3.1-38(a)(3)(B) 3.1-38(a)(3)(E)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure ulcer dressings were in place for 2 of 3 residents reviewed for pressure ulcers of the 3 residents who met the criteria for pressure ulcers. (Residents #6 and #55)</p> <p>Findings include:</p> <p>1. On 6/13/13 at 9:04 a.m., Resident #6 was observed in her room in bed. The House Supervisor was in the resident's room at that time to do the dressing change to the pressure ulcer on the resident's left inner heel. There was no dressing to the resident's heel at that time. A thick yellow scab was observed to the resident's heel. Interview with the House Supervisor at the time, indicated the dressing change was usually on midnights, and she did not know why the dressing</p>	F000314	<p>The facility will ensure that treatments are appropriately administered to promote healing and prevent infection of pressure sores. Resident #6 has had his/her care plan updated to reflect that he/she frequently removes applied dressings. Resident #55 has had a full body assessment to ensure that all open areas have been addressed. No new areas noted. Resident will continue to receive treatments per orders. TAR's will be updated to ensure that treatments are administered and maintained according to orders. Wound Nurse or designee will audit treatment administration at least weekly to ensure compliance. Staff will be in-serviced on compliance protocol for treatment administration. Audits will be reported to the QA team monthly for 6 months or until issues is considered resolved. All residents have received updated skin</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was not in place.</p> <p>The record for Resident #6 was reviewed on 6/13/13 at 9:50 a.m. The resident's diagnoses included, but were not limited to, uncontrolled diabetes and diabetic peripheral neuropathy.</p> <p>A Physician's order dated 3/8/13, indicated the resident's left heel was to be cleansed with wound cleanser, pat dry, apply collagen and wrap with Kerlix daily until healed.</p> <p>Review of the Significant change Minimum Data Set (MDS) assessment dated 5/27/13, indicated the resident had one or more unhealed pressure areas at a Stage 1 or higher. The MDS indicated the resident had one Stage 2 pressure area.</p> <p>The plan of care dated 1/21/13 and reviewed on 5/30/13, indicated the resident had an alteration in skin integrity as evidenced by having a pressure ulcer and decreased mobility. The interventions included, but were not limited to, treat per Physician order.</p> <p>Review of the Pressure Ulcer assessment, indicated upon initial</p>		<p>assessments. No new issues were noted. TAR's have been updated to ensure that all dressings in place as specified per orders. Audits may stop if no new issues are identified within a 3 month period of time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>identification of the wound on 1/24/13, it was identified as an unstageable (full thickness skin or tissue loss-depth unknown) area that measured 3 centimeters (cm) x 3.1 cm x 0.3 cm. On 6/12/13, the area to the left heel was identified as a scab covering Stage 2 (Partial thickness).</p> <p>2. Resident # 55 was observed in bed on 6/12/13 at 11:29 a.m. The House Supervisor was providing treatments to the resident's pressure ulcers.</p> <p>The treatment to the resident's left knee was completed. The House Supervisor then turned the resident to her left side. Observation of the resident's buttocks indicated there was no dressing in place on her buttocks. There was an open area on the resident's sacral (buttocks) area that was measured by the House Supervisor. The open area measured 0.3 x 0.7 x 0.2 centimeters in size. She indicated the wound was a healing Stage III (full thickness tissue loss) pressure ulcer. The area currently had partial thickness loss of the dermis.</p> <p>Interview with the House Supervisor at that time, indicated there was no dressing on the resident's sacral area.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>She indicated there should have been a dressing on the resident's wound.</p> <p>The record for Resident #55 was reviewed on 6/12/13 at 2:00 p.m. The resident had diagnoses that included, but were not limited to, multiple sclerosis and stroke.</p> <p>The Physician order summary (POS) dated June 2013, was reviewed. There was a physician order that indicated, "Cleanse buttocks with wound cleanser, pat dry, and apply collagen and foam dressing daily and prn (as needed)."</p> <p>The annual MDS (Minimum Data Set) assessment dated 4/1/13, indicated the resident was at risk for pressure ulcers and currently had pressure ulcers.</p> <p>There was a care plan in place dated 1/17/13, that indicated the resident had a pressure ulcer related to incontinence and immobility. One of the interventions in place indicated the treatment was to be completed as ordered.</p> <p>A Braden assessment was completed on 5/6/13 and indicated a risk score of 11 for developing pressure ulcers. A score of 12 or less was a high risk.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" was reviewed. There was an entry dated 6/5/13 that indicated the resident had a stage III pressure ulcer to her sacral (buttocks) area. The area was 0.1 x 0.1 x 0.1 cm (centimeters) in size and the area was 100% red.</p> <p>Review of the June 2013 TAR (Treatment Administration Record), indicated there was no evidence that the treatment to the resident's buttocks was provided on 6/11/13. There were no initials documented on the record to indicate the treatment was completed.</p> <p>Interview with the House Supervisor on 6/12/13 at 2:10 p.m., indicated the June 2013 TAR indicated the treatment to the resident's buttock's was not completed as ordered. She indicated the treatment should have been completed as ordered by the physician.</p> <p>3.1-40(a)(2)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to ensure a resident received appropriate treatment to prevent further decrease in range of motion related to not applying a splint to a contracted hand for 1 of 3 resident's reviewed for range of motion of the 8 who met the criteria for range of motion. (Resident #63).</p> <p>Findings include:</p> <p>On 6/10/13 at 9:05 a.m. and on 6/11/13 at 9:20 a.m., Resident #63 was observed in his room. The resident's right hand was contracted and he was not wearing a splint. He was unable to use this hand. Resident was alert, unable to speak but able to nods his head yes or no.</p> <p>The record for Resident #63 was reviewed on 6/11/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, depression, anxiety, unspecified mental disorder,</p>	F000318	The facility will ensure that residents who have orders for splints receive them per facility policy. Resident #63 has received his/her splint per physician order. The facility's Orthopedic Company has assessed resident's splint to ensure proper fit. No new issues noted. Other residents with physician orders for orthotics have been assessed. No new issues noted. Staff will be in-serviced on compliance with physicians' orders for splints and placement per physician orders. Restorative Nurse or designee will make rounds at least daily to ensure that all orthotics are in place per physician orders. Results of rounds will be reported to the QA Team for 6 months or until considered resolved to ensure continued compliance. Audits may stop if no new issues are identified within a 3 month period of time.	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>post CVA (stroke), and aphasia (unable to speak).</p> <p>An Occupational Therapy note dated 2/6/13, indicated, "recommend R (right) resting hand splint to prevent further contracture of fingers".</p> <p>A Physician's order dated 3/19/13, indicated Occupational Therapy was to evaluate the right hand for a splint.</p> <p>Interview with the Occupational Therapist (OT) on 6/12/13 at 9:22 a.m., indicated she had evaluated the resident for a hand splint on 3/19/13. She had a Resident Care Plan for the resident regarding the use of the splint. She indicated the resident's care was turned over to Restorative Nursing at that time.</p> <p>Interview with the Restorative Nurse on 6/12/13 at 11:45 a.m., indicated there had been a miscommunication between the OT and Restorative Nursing and the resident had not been using a splint since it was ordered on 3/19/13.</p> <p>3.1-42(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a personal alarm was in place for 1 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. The facility also failed to ensure there was not a gap of greater than 4 3/4 inches in between the side rails for 2 of 3 residents reviewed for potential accident hazards/bed side rails of the 3 residents who met the criteria for potential accident hazards. (Residents #6, #40, and #55)</p> <p>Findings include:</p> <p>1. On 6/13/13 at 9:04 a.m., Resident #6 was observed in her room in bed. The resident's personal alarm was on top of the over bed light and not attached to the resident. On 6/13/13 at 2:21 p.m., the resident was in her room in bed. The resident's personal alarm was on top of the over bed light and not attached to the resident.</p> <p>On 6/14/13 at 7:34 a.m., the resident</p>	F000323	The facility will ensure that residents' environment remains free of hazards. Resident #6 has been monitored to ensure that his/her bed alarm remains in place to minimize the potential for falls. During monitoring, no new issues noted. Residents #40 and #55 have had their beds padded pending receipt of new beds. No other issues noted. Auditing tool has been implemented for compliance rounds of alarms and bed padding. Staff will be in-serviced on maintaining an environment that is free of hazards. Rounds will be conducted by Restorative Nurse or designee related to alarms, and by Environmental Director related to side rails. Results of rounds will be reported to the QA team for 6 months or until considered resolved Compliance will be completed by the Restorative Nurse or designee. Audit tool will be completed at least 3 times per week. Audits may stop if no new issues are identified within a 3 month period of time.	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was in her room in bed sleeping. The resident's personal alarm was not in place.</p> <p>The record for Resident #6 was reviewed on 6/13/13 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetic peripheral neuropathy.</p> <p>Review of the June 2013 Physician's order summary (POS), indicated the resident was to have a personal alarm on while in bed and in the wheelchair.</p> <p>Review of the Nursing progress note dated 5/13/13 at 7:22 p.m., indicated staff heard the resident's alarm sounding. When staff entered the room, the resident was sitting on the floor with her back against the wheelchair. No injuries were noted.</p> <p>Review of the Significant change Minimum Data Set (MDS) assessment dated 5/27/13, indicated the resident was dependent on staff for transfers.</p> <p>Review of the plan of care dated 5/30/13, indicated the resident was at risk for falls related to a history of falls, cognitive impairments, impulsiveness with attempts to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>transfer without staff assist, requires ADL (activities of daily living) assist for transfers and mobility, impaired ROM (range of motion), incontinence, decreased strength and endurance, diagnosis arthritis, osteoporosis, CVA (cerebral vascular accident/stroke) with possible hemiplegia/hemiparesis (weakness), and behavioral problems. The interventions included, but were not limited to, wheelchair and bed alarm.</p> <p>Review of the Fall Risk assessment dated 2/20/13, indicated the resident scored a "14" a high risk for falls. The Fall Risk assessments dated 5/13 and 5/23/13, indicated the resident scored a "12" a high risk for falls.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident's personal alarm should have been in place when the resident was in bed.</p> <p>2. On 6/11/13 at 9:18 a.m., Resident #40 was observed in bed. The resident had full side rails, which were in the raised position, to each side of his bed. There was a five inch space in between the metal bar and the side rail.</p> <p>The record for Resident #40 was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reviewed on 6/12/13 at 1:22 p.m. The resident's diagnosis included, but was not limited to, bilateral above the knee amputation.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 4/29/13, indicated the resident used side rails daily.</p> <p>The plan of care dated 6/10/13, indicated side rails up times 2 as enabler to assist with turning and repositioning. The interventions included, but were not limited to, side rails up as ordered.</p> <p>Interview with the Administrator on 6/12/13 at 2:55 p.m., indicated there was a gap between the metal bar and side rail that was greater than 4 3/4 inches.</p> <p>3. Resident #55 was observed on 6/10/13 at 2:13 p.m. in bed. The resident had full side rails up on both sides of the bed. The bottom portion of the side rail had 3 openings between the metal bars. One opening was 5 inches by 17 and 1/2 inches, the center opening was 5 inches by 27 inches and the third opening was 5 inches by 17 and 1/2 inches in size.</p> <p>The record for Resident #55 was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed on 6/12/13 at 2:00 p.m. There was a care plan dated 2/21/13 that indicated: "side rails up x 2 d/t (due to ) resident's existing condition, resident has dx (diagnosis) multiple sclerosis utilizes sr (side rails) for turning and repositioning Goal -no injuries from falling out of bed daily Intervention: -side rail up x 2 to prevent injury from falling out of bed -reposition per turning schedule -visual check at least q (every) 2 hours for positioning and circulatory problems"</p> <p>The annual Minimum Data Set (MDS) assessment dated 4/1/13, indicated the resident used bed rails daily.</p> <p>Information retrieved from the web site, "www.fda.gov/cdrh/beds" on 6/13/13, indicted the risks for body part entrapment related to bed rails were: "Within the Rail: Zone 1 is the open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering A loosened bar or rail can change the size of the space. The HBSW (Hospital Bed Safety Workgroup) and IEC (International</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Electrotechnical Commission) recommended that the space be less than 120 mm (millimeters) (4 3/4 inches), representing head breath."</p> <p>Interview with the Administrator on 6/12/13 at 2:55 p.m., indicated the gap between the metal bars of the side rails were greater than 4 3/4 inches.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident with a PICC (Peripherally Inserted Central Catheter) line received the proper care and treatment related to routine dressing changes and routine flushes for 1 of 3 residents reviewed for central catheters. (Resident #29)</p> <p>Findings include:</p> <p>Resident #29 was observed on 6/13/13 at 11:45 a.m. He was seated in a wheelchair in his room. There was a transparent dressing on his right arm. Interview with LPN #1, at that time, indicated the dressing was covering the resident's PICC line.</p> <p>The record for Resident #29 was reviewed on 6/13/13 at 3:16 p.m. The resident had diagnoses that included, but were not limited to left below knee</p>	F000328	<p>The facility will ensure that residents receive appropriate care for PICC lines. Resident #29 has had his/her PICC line removed. Other residents requiring special services have been monitored to ensure compliance with care. No new issues notes. House Supervisor or designee will monitor care of residents who require special needs. Staff will be in-serviced special needs care administration and compliance with physicians' orders. Results of audits will be reported to the QA team monthly for 6 months or until considered resolved to ensure continued compliance. Other residents reviewed include residents with IV's, Injections, Ostomy Care, Respiratory Care, Foot Care, Prostheses, and Suctioning. All residents with special care needs were audited to ensure compliance with physician orders. No new issues noted. Monitoring tools will be completed at least weekly to ensure continued</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>amputation, dementia and osteomyelitis (infection of the bone).</p> <p>The resident was admitted to the facility on 1/30/13. The Admission Nursing Assessment dated 1/30/13, indicated the resident had a PICC line in his right arm for intravenous antibiotic therapy.</p> <p>The admission MDS (Minimum Data Set) assessment completed on 2/5/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 5, which indicated the resident was cognitively impaired. It also indicated the resident was receiving intravenous medication.</p> <p>Interview with LPN #1 on 6/14/13 at 9:30 a.m., indicated she cared for the resident often. She indicated he was admitted from the hospital on 1/30/13 with a PICC line in place for intravenous antibiotic therapy. She indicated a resident with a central line required monitoring of the site and flushing of the line to maintain patency. She indicated the dressing was to be changed weekly at the insertion site of the PICC line.</p> <p>Interview with the House Supervisor on 6/17/13 at 8:28 a.m., indicated PICC lines were to be flushed daily</p>		<p>compliance. Audits may stop if no new issues are identified within a 3 month period.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with Normal Saline and dressings were to be changed weekly.</p> <p>Review of the clinical record indicated there was no evidence the flushes for the PICC line were completed daily for February 2013, March 2013, April 2013, May 2013 and June 2013.</p> <p>Review of the clinical record indicated there was no evidence weekly dressings were completed for February 2013, April 2013, May 2013 and June 2013.</p> <p>The policy provided by the Restorative Nurse on 6/12/13 titled, "Central Venous Catheter (CVC) Flushing" dated January 15, 2004, was reviewed. The Restorative Nurse indicated the policy was current. The policy indicated: "To be performed By: Licensed nurses according to state laws and facility policy. The nurse shall be competent in the safe delivery of infusion therapy within her or his scope of practice. The nurse shall be accountable for attaining and maintaining competence with infusion therapy within her or his scope of practice. Considerations: Central Venous Catheters include: Peripherally Inserted Central</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p><b>Catheters (PICC)</b> Specific flush orders must be documented. (refer to Infusion Maintenance Table)"</p> <p>The Infusion Maintenance Table indicated a PICC line was to be flushed weekly.</p> <p>The policy provided by the Restorative Nurse on 6/12/13 titled, "Central Venous Catheter (CVC) Dressing Change" dated January 15, 2004, was reviewed. The Restorative Nurse indicated the policy was current. The policy indicated: "To be performed By: Licensed nurses according to state laws and facility policy. The nurse shall be competent in the safe delivery of infusion therapy within her or his scope of practice. The nurse shall be accountable for attaining and maintaining competence with infusion therapy within her or his scope of practice. Considerations: Central Venous Catheters include: Peripherally Inserted Central Catheters (PICC) Sterile dressing change using transparent dressings is performed weekly."</p> <p>Interview with the House Supervisor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on 6/17/13 at 8:28 a.m., indicated there was no evidence the PICC line was flushed daily with Normal Saline as required to maintain patency. She also indicated there was no evidence the dressing to the PICC line insertion site was changed weekly as required.</p> <p>3.1-47(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure gradual dose reductions were attempted for antipsychotic medications as well as monitoring behaviors and insulin administration for 7 of 10 residents reviewed for unnecessary medications. (Residents #39, #40, #41, #44, #61, #62, and #72)</p> <p>Findings include:</p>	F000329	The facility will ensure that gradual dose reductions are attempted for antipsychotic medications use. A review of previous GDR recommendations is being conducted by the pharmacy, physician and facility. Residents identified during the State Survey have had a review of their charts to identify where gradual dose reductions may be necessary. Those identified are under review by the physician, pharmacy and facility to determine if dose reduction should become permanent.	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. The record for Resident #62 was reviewed on 6/13/13 at 12:39 p.m. The resident's diagnosis included, but was not limited to, diabetes, depression, mood disorder, manipulative personality disorder, and psychotic disorder.</p> <p>A Physician's order dated 5/28/13, indicated the resident was to receive Lantus (insulin) 30 units subcutaneously (sq) every evening. Discontinue Lantus 20 units sq every evening.</p> <p>Review of the June 2013 Medication Administration Record (MAR), indicated the resident received Lantus 20 units every evening rather than 30 units on 6/1-6/8, 6/10, 6/11, and 6/13/13.</p> <p>Interview with LPN #3 on 6/14/13 at 11:25 a.m., indicated the resident should have been receiving the 30 units of insulin rather than 20.</p> <p>Review of the June 2013 Physician's order summary, indicated the resident was to receive Ambien (a sleeping pill) 5 milligrams (mg) at bedtime.</p> <p>Review of the Pharmacy recommendation dated 4/9/13, indicated the following: Repeated</p>		<p>Other residents on antipsychotic medications will have their charts reviewed to determine if gradual dose reduction should commence for evaluation. In-services will be conducted by the DON or designee with the physicians, psychologist, and psychiatrists on the need to follow through with gradual dose reduction recommendations or how to properly document a refusal. Nurse will be in-serviced on gradual dose reduction protocol and system monitoring. Audits will be conducted by the DON or designee at least weekly to ensure continued compliance. Results of audits will be reported to QA for 6 months or until problem is considered resolved. Blood sugars have been reviewed and monitored. No further issues noted. In-serviced nurses on policy and procedure for hypo/hyperglycemic residents and care administration Facility policy has been updated to address management of blood glucose related to insulin administration. Audit tool for monitoring blood glucose has been updated to ensure proper notification, administration and follow up on any critical blood sugar values. DON or designee will audit blood glucose administration at least weekly. The results of the audits will be reported to QA at least monthly for 6 months or until problem is considered resolved. Nurses were in-serviced</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>recommendation from 1/31/13. Please respond promptly to assure facility compliance with Federal regulations. (Resident name) has an order for Zolpidem (a hypnotic) 5 mg (milligrams) by mouth at bedtime since September 2012 for insomnia. Please consider a GDR (gradual dose reduction), perhaps decreasing to 2.5 mg by mouth at bedtime while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated.</p> <p>The Physician declined the recommendation on 4/16/13 and did not give a reason why.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the Physician should have documented a reason as to why the GDR was clinically contraindicated.</p> <p>2. The record for Resident #40 was reviewed on 6/12/13 at 1:22 p.m. The resident's diagnosis included, but was not limited to, vascular dementia with behavior disturbance.</p> <p>Review of the June 2013 Physician's order summary (POS), indicated the</p>		<p>on policy and procedure for insulin administration with an emphasis following physician orders. Monitoring may be discontinued if no new issues are identified within a 3 month period.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident received Risperdal (an antipsychotic) 0.5 milligrams daily.</p> <p>Review of the Pharmacy recommendation dated 4/9/13, indicated the following: Repeated recommendation from 1/31/13. Please respond promptly to assure facility compliance with Federal regulations. (resident name) has received Risperidone 0.5 mg via peg (percutaneous endoscopic gastrostomy tube) once daily since June 2012 for dementia with behaviors. Please consider GDR (gradual dose reduction), perhaps decreasing to 0.25 mg via peg once daily while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated.</p> <p>The Physician declined the recommendation due to prior history of decompensation. There was no documentation related to target behaviors during past GDR attempts.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the resident's Physician should have documented what behaviors occurred during previous GDR attempts.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3. The record for Resident #61 was reviewed on 6/11/13 at 2:58 p.m. The resident had diagnoses, that included but were not limited to, hyperkalemia (high potassium level), diabetes, depression, schizophrenia and dementia with delusional disturbance.</p> <p>There was a Pharmacy Consultant Report dated 5/22/13 that indicated: "Comment: Resident's name) has received Seroquel (an antipsychotic medication) 25 mg (milligrams) po (by mouth) q (every) 12 hours since 9/12 for schizophrenia along with mirtazapine (an antidepressant medication) 15 mg po at hs (hour of sleep) since 5/12 for depression. Recommendation: Please consider a gradual dose reduction, perhaps decreasing Seroquel to 12.5 mg po q 12 hours while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose please provide rationale describing a dose reduction as clinically contraindicated."</p> <p>The physician responded to the recommendation on 5/29/13. There</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was a physician order dated 5/29/13, that indicated, "Seroquel 12.5 mg 1 tablet po q 12 hours."</p> <p>Review of the clinical record and the behavior book indicated there was no evidence the facility was monitoring for re-emergence of target and/or withdrawal behaviors.</p> <p>Interview with the Social Service Director on 6/12/13 at 10:10 a.m., indicated she was not aware of the resident's targeted behaviors. She indicated she did not know what behaviors he had exhibited in the past. She indicated there was no system in place for monitoring the resident for specific behaviors while the medication was being reduced. She indicated there was no way to monitor the effectiveness of the medication.</p> <p>4. The record for Resident #72 was reviewed on 6/13/13 at 11:19 a.m. The resident had diagnoses that included, but were not limited to, depression, diabetes and anemia</p> <p>There was a care plan initiated on 4/17/12 and revised on 10/18/12, that indicated: "Resident at risk for hypo/hyperglycemic(low/high blood</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>glucose levels) reactions r/t (related to) Dx (diagnosis) of diabetes. Goal: Resident will remain without hypo/hyperglycemia episodes thru (through)next review -give medications as ordered by MD (physician) -monitor for s/s (signs and symptoms) of hypoglycemia i.e. thirst, excessive appetite or voiding, sweating, blurred vision and notify MD -assess and record blood glucose levels as ordered -diets supplements as ordered -educate resident on s/s of hypo/hyperglycemia"</p> <p>There was a Physician order dated 1/11/13, that indicated, "Novolin R per sliding scale prn (as needed) inject sub-q (subcutaneously) per sliding scale 1-150 0 units 151-200 2 units 201-250 4 units 251-300 6 units 301- 350 8 units 351-400 10 units &gt;400 call MD</p> <p>There was a Physician order dated 1/11/13 that indicated the resident was to receive Novolog 0-30 insulin 10 units daily.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>There was a Physician order dated 3/31/13, that indicated, "Monitor accuchecks (blood glucose levels) bid (twice daily)."</p> <p>Review of the May 2013 Medication Administration Record (MAR) indicated the accuchecks were obtained twice daily at 6:00 a.m. and 4:00 p.m., and were covered with insulin as per the sliding scale order.</p> <p>Review of the June 2013 MAR, indicated accuchecks were completed only once daily at 6:00 a.m., and the sliding scale insulin coverage was administered only once daily at 6:00 a.m. The accuchecks were not completed twice daily and there was no insulin administered per the sliding scale at 4 p.m.</p> <p>Interview with the House Supervisor on 6/13/13 at 1:25 p.m., indicated the resident was to have accuchecks twice daily. She indicated the accuchecks should have been done at 6:00 a.m. and 4:00 p.m. She indicated the resident's blood glucose monitoring was not completed as ordered. She indicated the resident's insulin administration was not monitored as ordered.</p> <p>5. The record for Resident # 39 was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reviewed on 6/12/13 at 10:06 a.m. The resident had diagnoses that included, but were not limited to, psychosis, delusional thinking and anxiety.</p> <p>The June 2013 Physician order summary (POS), indicated the resident had current physician's orders for risperidone (an antipsychotic medication) 1 mg (milligram) two times per day.</p> <p>The quarterly MDS (Minimum Data Set) assessment completed on 5/17/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated he was cognitively intact. It also indicated the resident received and antipsychotic medication on 7 of the last 7 days.</p> <p>There was a Pharmacy Consultant Report dated 5/22/13, that indicted: "Comment: (Resident's name) has received risperidone (an antipsychotic medication) 1 mg (milligram) po (by Mouth) BID (twice daily) since 1/12 for psychosis, Lexapro (an antidepressant medication) 20 mg po daily since 2/12 for depression along with Depakote ER ( a mood stabilizer medication) 500 mg po BID since</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1/12 for psychosis. Recommendation: Please consider a gradual dose reduction, perhaps decreasing risperidone to 0.5 mg po BID while concurrently monitoring for re-emergence of target and/or withdrawal symptoms, If therapy is to continue at the current dose please provide rationale describing a dose reduction as clinically contraindicated."</p> <p>The physician checked the box that indicated the following: "I decline the recommendations above because GDR (gradual dose reduction) is clinically contraindicated for this individual. The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior as documented below. Please provide CMS required patient-specific rationale describing why a GDR attempt is likely to impair function or increase behavior in this individual."</p> <p>There was no patient-specific rationale documented by the Physician that described why a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>gradual dose reduction was not attempted.</p> <p>Interview with the Restorative Nurse on 6/13/13 at 10:06 a.m., indicated the resident had been receiving risperidone 1 mg twice daily since January 2012. She indicated there had been no attempt to reduce the dose of the risperidone in more than one year.</p> <p>6. The record for Resident #41 was reviewed on 6/12/13 at 1:55 p.m. The resident's diagnoses included, but were not limited to, psychosis with hallucinations, seizure disorder, depression and alcohol related dementia.</p> <p>The June 2013 Medication Administration Record (MAR) indicated the resident was on psychotropic medications that included Depakote (anti-convulsant), lorazepam (anti-anxiety), Seroquel (anti-psychotic) and Elavil (anti-depressant).</p> <p>On 10/3/12, the Pharmacist recommended a gradual dose reduction (GDR) of Seroquel, Elavil and lorazepam. The Physician declined, referring to Psychologist's recommendations. There was no</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>documented rationale.</p> <p>Interview on 6/12/13 at 3:05 p.m., with the Restorative Nurse, indicated she did not believe there was any additional documentation related to target behaviors during past GDR attempts. She indicated there was no documentation of a GDR attempt for Resident #41.</p> <p>7. The record for Resident #44 was reviewed on 6/12/13 at 2:45 p.m. The resident had diagnoses that included, but were not limited to, dementia with behaviors, CVA (stroke) and depression.</p> <p>The June 2013 Medication Administration Record (MAR) indicated the resident was on psychotropic medications that included lorazepam (anti-anxiety), risperidone (anti-psychotic) and amitripyline (anti-depressant).</p> <p>On 11/21/12, the Pharmacist recommended a gradual dose reduction (GDR) for lorazepam and risperidone. No action was documented.</p> <p>On 2/26/13, the Pharmacist recommended a GDR for lorazepam and risperidone. The Physician</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>declined by checking box that indicated target symptoms returned or worsened after last GDR attempt and "a GDR attempt at this time is likely to impair this individuals function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW" There was no documentation provided to indicate why a GDR was not attempted.</p> <p>On 4/9/13 the pharmacy recommended a GDR for amitripyline. The Physician declined by checking the box that indicated target symptoms returned or worsened after last GDR attempt and, "a GDR attempt at this time is likely to impair this individuals function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW" There was no documentation provided to indicate why a GDR was not attempted.</p> <p>Interview on 6/12/13 at 3:05 p.m., with the Restorative Nurse, indicated she did not believe there was any additional documentation related to target behaviors during past GDR attempts. She indicated there was no</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of a GDR attempt for Resident #44.  3.1-48(a)(3) 3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 1 of 4 residents observed during medication pass. Two errors were observed during 29 opportunities for error during medication administration. This resulted in a medication error rate of 6.9%. (Resident #2).</p> <p>Findings include:</p> <p>On 6/13/13 at 8:37 a.m., LPN #5 was observed preparing medications for Resident #2. The resident received clonazepam (anti-anxiety medication) 1 mg (milligram) and Depakote (anti-seizure medication) 500 mg. The medications were crushed and were to be given through the resident's gastrostomy tube (g-tube). During the medication administration, a large amount of the crushed medication became clogged in the tip of the syringe. The LPN made several attempts to unclog the syringe by gently shaking. She then removed the syringe from the g-tube and attempted to dislodge the clog with</p>	F000332	<p>The facility will maintain a medication error of less than 5%. Resident #5's physician was notified during the survey that the entire dosage of medications could not be administered via peg tube. No new orders noted, no change in condition. Medication passes have been monitored by DON or designee to assure accuracy in medication passes. No new issues noted. Nurses/QMA's will be in-serviced on on proper medication administration techniques. DON or designee will monitor medication passes at least weekly to ensure compliance with medication administration. Results of audits will be reported to the QA team monthly for 6 months or until issue is considered resolved. Medication passes will be conducted with the DON or designee for every nurse or QMA in the facility during the of July. All shifts will be included. Monitoring may be discontinued if no new issues are noted within a 3 month period of time.</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the syringe plunger. The medication dislodged and spilled onto the bedside table. The LPN then flushed the resident's g-tube with water, cleaned up the spilled contents and preceded to the next resident.</p> <p>Interview with LPN #5 at 9:33 a.m., indicated she should have notified the Physician that the resident did not receive all of his medication. The LPN contacted the Physician and obtained a new order at 9:40 a.m.</p> <p>The House Supervisor was interviewed on 6/14/13 at 10:30 a.m. She indicated she would expect the Nurse to notify the Physician as soon as possible related to the medication error .</p> <p>3.1-25(b)(9)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000371 SS=C	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to hair restraints not worn correctly, food not labeled and dated, and an accumulation of dust on fan covers inside the reach in refrigerator as well as underneath the oven hood for 1 of 1 kitchens and for 2 of 3 nourishment pantries. This had the potential to affect the 62 residents who resided in the facility. (The Main kitchen, Unit 3 and Unit 4)</p> <p>Findings include:</p> <p>1. During the Initial kitchen sanitation tour on 6/10/13 at 8:55 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. An accumulation of dust was observed inside the oven hood located above the stove. Interview with the Dietary Food Manager at the time, indicated an outside company comes in to clean the oven hood.</p>	F000371	The facility will ensure that food is stored, prepared, and maintained under sanitary conditions. Issues noted during the survey have been corrected. The facility has hired an Sanitation Aide who will be responsible for sanitation, cleaning, dusting and maintenance of the kitchen environment to ensure that food is prepared in a sanitary environment. In-services will be conducted for the Dietary staff to educate on proper hair covering, cleaning protocol, food labeling and dating. Audits will be conducted weekly by the Dietary Manager/Dietician or designee to ensure continuous compliance. Results of the audits will be reported to QA team monthly for 6 months or until problem is considered resolved. Monitoring may be stopped if no new issues are identified within a 3 month period. However, monitoring would be continued on a random basis.	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>b. The reach in refrigerator had an accumulation of dust on the fan cover located in the middle of the refrigerator.</p> <p>c. The hair restraint worn by the Dietary Food Manager did not contain all of his hair. Hair was observed to be hanging out of the hair restraint and down his back.</p> <p>2. On 6/17/13 at 10:00 a.m. the nutritional refrigerator on the 300 Unit was observed. There was a heavy build up of frost in the freezer and the popsicles had a frost build up. There was a bag of frozen berries with no name and no date in the freezer. The boxes of nutritional supplement stored on the upper shelves of the refrigerator door were partially frozen. There was a bowl of cheese and crackers that were labeled with a resident's name, but it was undated.</p> <p>There was a sign on the refrigerator that indicated all opened items must have a resident name and a date on them. It further indicated the freezer was to be defrosted on Sunday midnight shift.</p> <p>On 6/17/13 at 10:10 a.m., the nutritional refrigerator on the 400 Unit</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was observed. There was a container of yogurt that was opened. It was not labeled with a name and was not dated.</p> <p>Review of the refrigerator cleaning log for June 2013, indicated the refrigerator was cleaned on 6/16/13 on the midnight shift.</p> <p>3.1-21(i)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Pharmacy recommendations were implemented as recommended related to gradual dose reductions for antipsychotic medications and initiating care plans for 2 of 10 residents reviewed for unnecessary medications. (Residents #11 and #62)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 6/11/13 at 2:54 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, anxiety, and acute psychosis.</p> <p>Review of the June 2013 Medication Administration Record (MAR), indicated the resident received Clozapine (an antipsychotic) 150 milligrams (mg) twice a day.</p> <p>Review of the Pharmacy</p>	F000428	<p>The facility will ensure that pharmacy recommendations are received and acted upon. The recommendations will be submitted to the physician and Director of Nursing for review. All recommendations from June 1st forward have been reviewed by the DON or Physician. Orders executed as needed. The Pharmacist has been notified that additional reviews are needed for other residents in the facility. Pharmacy review is scheduled. Recommendations from the pharmacy will be reviewed by the physician and Director of Nursing - the Administrator only when recommendations are declined. Audits will be conducted by Social Services Director or designee to ensure that pharmacy recommendations are acted upon. Results of audits will be reported to the QA Team monthly for 6 months or until problem is considered to be resolved. Residents #11 and #62 have had their recommendations reviewed by</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>recommendation dated 3/13/13, indicated the following: Please ensure this individual's care plan included ongoing monitoring for signs and symptoms of myocarditis, especially during the first month of therapy. Signs and symptoms consistent with presentation of myocarditis may include new onset tachycardia, unexplained fatigue, dyspnea, fever, chest pain, palpitations, signs of heart failure and/or cardiac arrhythmias. Rationale for recommendation: Product labeling for Clozapine included a BOXED warning describing an increased risk for fatal myocarditis especially during, but not limited to, the first month of Clozapine therapy.</p> <p>Documentation on the recommendation sheet by Nursing, indicated the resident was care planned for signs and symptoms of myocarditis. Documentation indicated this was completed on 3/26/13.</p> <p>Review of the current plan of care, indicated there was no care plan related to myocarditis.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 6/12/13 at 11:15 a.m., indicated the resident did not have a current care plan for risk of</p>		<p>the Pharmacist. Resident #11 has had an updated care plan and diagnosis. Resident #62 has had the GDR implemented and it was unsuccessful. No other issues noted. The physician and the DON will review recommendations from the pharmacy at least monthly during normal visits with an extra visit in July. Social Services Director or designee will review pharmacy recommendations at least monthly. Monitoring may be discontinued if no new issues are identified within a 3 month period.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>myocarditis based on the Pharmacy recommendation.</p> <p>2. The record for Resident #62 was reviewed on 6/13/13 at 12:39 p.m. The resident's diagnosis included, but was not limited to, diabetes, depression, mood disorder, manipulative personality disorder, and psychotic disorder.</p> <p>Review of the June 2013 Physician's order summary, indicated the resident was to receive Ambien (a sleeping pill) 5 milligrams (mg) at bedtime.</p> <p>Review of the Pharmacy recommendation dated 4/9/13, indicated the following: Repeated recommendation from 1/31/13. Please respond promptly to assure facility compliance with Federal regulations. (Resident name) has an order for Zolpidem (a hypnotic) 5 mg (milligrams) by mouth at bedtime since September 2012 for insomnia. Please consider a GDR (gradual dose reduction), perhaps decreasing to 2.5 mg by mouth at bedtime while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The Physician declined the recommendation on 4/16/13 and did not give a reason why.</p> <p>Interview with the House Supervisor on 6/17/13 at 12:00 p.m., indicated the Physician should have documented a reason as to why the GDR was clinically contraindicated based on the Pharmacy recommendation.</p> <p>3.1-25(j)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review and interview, the facility failed to ensure a controlled medication was properly destroyed for 1 of 4 narcotic records</p>	F000431	The facility will ensure that medications are destroyed per facility protocol. The issue cited by the State has been investigated and the nurse has	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reviewed. (Resident #45).</p> <p>Findings include:</p> <p>On 6/14/13 at 12:45 p.m., the Controlled Substance Records (CSR) and Medication Administration Records (MAR) for April, May and June of 2013 were reviewed for Resident #45.</p> <p>The MAR key indicated a medication was initialed when given to a resident, and initialed and circled when a resident refused a medication. Review of the April, May and June 2013 MARs, indicated Resident #45 refused the lorazepam (a controlled medication used to treat anxiety) on 4/23/13, 4/25/13, 5/9/13, 6/6/13, 6/8/13 and 6/11/13.</p> <p>Review of the CSR indicated the medications were signed out for on the dates the resident refused the medication. On 6/8/13 there was a notation on the CSR that the medication was refused. No notation was made for the remaining dates. Each entry in the CSR was initialed by one nurse. There was no documentation of a second nurse to witness the destruction of the refused medication.</p>		<p>been disciplined. Nurses will be in-serviced on the proper disposition of medications/controlled substances. An audit of the Control Substance Records will be conducted by the House Supervisor or designee to ensure no other improper destruction has occurred. The results of the audit will be reported to the QA team for 6 months or until problem is considered resolved. Audits will be conducted on a weekly basis. Audits will include completion of nursing signature log, narcotic count is accurate, refusal of narcotics is charted in the nurses notes, narcotic disposition have two signatures, documentation of administered PRN medications are including in nursing notes. Audits may be discontinued if no new issues are noted within a 3 month period.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A policy titled "8.2 Disposal/Destruction of Expired or Discontinued Medication" was provided by the Restorative Nurse on 6/14/13 at 2:50 p.m., and was identified as current. The policy indicated, "...10. Facility should record destruction of controlled substances on: Medication Disposition/Destruction form; Controlled Substance Count Form or Medication Destruction Log Book."</p> <p>Interview with the House Supervisor on 6/14/13 at 3:20 p.m., indicated nurses were required to destroy controlled medications in the presence of another nurse when a resident refused a medication and they were to document the refusal.</p> <p>3.1-25(s)(6) 3.1-25(s)(8)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure personal</p>	F000441	The facility will maintain an Infection Control Program the	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care items were correctly stored related to unlabeled toothbrushes and a unlabeled drinking cup and uncovered urine collection devices for 2 of 3 units observed during the environmental tour. (300 Unit and 400 Unit)</p> <p>Findings include:</p> <p>1. On 6/17/13 at 1:15 p.m. during an Environmental tour with the Maintenance Supervisor, the following were observed:</p> <p>On the 300 Unit:</p> <p>a. In the bathroom of Room 302, there were two unlabeled toothbrushes and an unlabeled drinking cup in the shared bathroom. Two resident's shared the bathroom.</p> <p>b. In the bathroom of Room 310, there was an unwrapped container used to collect urine in the bathtub. An interview with the Maintenance Supervisor at that time indicated urine collection containers were to be wrapped in plastic when not in use. Three residents resided in the room and shared the bathroom.</p> <p>c. . In the bathroom of Room 402, there was an unwrapped urine</p>		<p>prevents the spread of infections throughout the facility. Per the survey, toothbrushes, unlabeled drinking cups, unwrapped urinals have been disposed of and reissued. A facility wide audit has been conducted. Other items identified as unlabeled have been disposed of and reissued. Audits will be conducted at least weekly by the House Supervisor or designee to ensure that personal items are stored in a manner that is consistent with the facility Infection Control Protocol.</p> <p>The results of the audits will be reported to QA team monthly for 6 months or until problem is considered to be resolved. Audits may be stopped if no issues are identified within a 3 month period.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>collection container on the bathroom floor. Five resident's shared the bathroom.</p> <p>3.1-18(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000456 SS=F	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to maintain electrical equipment in a safe operating condition related to torn dryer vent screens for 2 of 2 clothes dryers observed. This had the potential to effect 62 of the 62 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 6/17/13 at 2:00 p.m., the laundry room was observed with the Maintenance Supervisor and Laundry Aide #1 present. The lint screens for both dryers were observed to have torn loose from their frames, leaving large gaps in the screens. Interview with Laundry Aide #1 at that time, indicated she had reported the torn screens to Maintenance Employee #2, "about two months ago." An interview at that time with the Maintenance Supervisor indicated he was aware the screens were torn and that new ones had been ordered.</p> <p>A burning smell was then noted in the laundry room, there was no obvious fire, no flames noted. Laundry Aide</p>	F000456	<p>The facility will ensure that essential equipment operates and is maintained in a manner that is safe and secure for the facility. The lint screens have been replaced. They have been monitored by the Environmental Director and have been found to be in working order. Additional lint screens have been ordered and received. Additional lint screens have been acquired so if there is a problem in the future with lint screens, they can be readily replaced. Staff have been in-serviced on the new protocol for monitoring the lint screens. New protocol involves checking lint screens at least daily to ensure proper functioning. Audits will be conducted by the Environmental Director or designee at least weekly to ensure continued compliance. Results of the audits will be reported to the QA Team monthly for 6 months or until problem is considered resolved. Monitoring may be stopped if no further issues are identified within a 3 month period.</p>	07/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#1 turned off the dryers and the Maintenance Supervisor investigated. The Maintenance Supervisor removed all the lint from the dryer.</p> <p>Interview with Maintenance Supervisor and Maintenance Employee #2 on 6/17/13 at 2:45 p.m., indicated the lint screens for the dryers had not been ordered.</p> <p>On 6/17/13 at 2:50 p.m., the Maintenance Supervisor left the facility with the lint screens to have them repaired locally.</p> <p>On 6/17/13 at 4:00 p.m., the Maintenance Supervisor returned with the repaired lint screens.</p> <p>3.1-19(b)(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a comfortable and sanitary environment related to dust on the outside of the oven hood, dusty screens, cracked windows, lime build up on floor tile, missing bathroom tiles, chipped paint, marred walls and doors, stained ceiling tiles, and scratched and marred bedside stands, rusted heating units for 1 of 1 kitchen areas and for 3 of 3 units throughout the facility. This had the potential to affect the 62 residents residing in the facility. (The main kitchen, Units 3, 4, and 5)</p> <p>Findings include:</p> <p>1. During the Initial kitchen sanitation tour on 6/10/13 at 8:55 a.m., the following was observed:</p> <p>a. The outside of the oven hood had an accumulation of dust. Interview with the Dietary Food Manager at the time, indicated an outside company comes in to clean the oven hoods.</p> <p>b. An accumulation of lime build up</p>	F000465	<p>The facility will maintain a comfortable and sanitary environment. All items identified during the survey are in process of being corrected. The Environmental Director or designee will complete repair of the listed items. Rounds will be made by the Environmental Director or designee to identify other areas of noncompliance. All items identified will be corrected. Staff will be in-serviced on the use of the Green Book, Maintenance Repair Request Log to ensure continued compliance and identification of repair issues. The Environmental Director or designee will make rounds at least weekly to identify other areas of noncompliance. Results of audits will be reported to the QA Team monthly for 6 months or until the issue is considered resolved. Monitoring may be stopped is no issues are identified within a 3 month period.</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was observed on the ceramic floor tile located underneath the dishwasher.</p> <p>c. The window screen located above the reach in refrigerator had an accumulation of dust and debris.</p> <p>d. The window pane located above the reach in refrigerator was cracked in two places.</p> <p>e. The door handle on the far right reach in refrigerator door was loose and had to be held a certain way to ensure the door would close.</p> <p>Interview with the Dietary Food Manager at the time, indicated all of the above areas were in need of cleaning or repair.</p> <p>2. On 6/17/13 at 1:15 p.m. during an Environmental tour with the Maintenance Supervisor, the following were observed:</p> <p>On the 300 Unit:</p> <p>a. In Room 302 the bathroom walls were dirty and splattered with a yellowish substance. Two resident's shared the bathroom.</p> <p>b. In Room 303, the window frame was broken and secured with duct</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>tape. One resident resided in the room.</p> <p>c. In Room 306, the ceiling tile over bed C was stained and the tiles around the air vent were marred. There were broken tiles on the bathroom floor and the call light cover was missing. Three residents resided in the room and six residents shared the bathroom.</p> <p>d. In Room 307, the ceiling tiles were stained. In the bathroom, the wall under the sink had yellow stains and the shelf below the mirror was loose. There was one resident in the room and three residents shared the bathroom.</p> <p>e. In Room 308, the floor was soiled near bed C and there were stains on the floor. There were three residents residing in the room.</p> <p>f. In Room 309, the bathroom door was marred and scratched, and the nightstand was marred. The plastic trim around the doorframe was loose and the privacy curtain runner was loose from the ceiling. There were two residents residing in the room.</p> <p>g. In Room 310, the inside of the heat lamp was loose, there was dust</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>inside the vent, the bathroom door was chipped and marred, and the mirror was discolored. All three nightstands were marred and chipped, the window screen was behind the wardrobe, and laminate was peeling away from wardrobe's base. Three residents resided in the room and shared the bathroom.</p> <p>h. In Room 311, the nightstands was scratched and marred. The base of the bathroom door was marred and there was no drain stop in the bathroom sink. One resident resided in the room and three residents shared the bathroom.</p> <p>i. In Room 312, there was dust in bathroom ceiling vent and the heat lamp and the bedroom door was splintered on the top corner. Three residents resided in the room and shared the bathroom.</p> <p>j. In Room 314, the privacy curtain was missing hooks, the nightstand was marred and scratched, and the bathroom door was marred and scratched. Two residents resided in the room.</p> <p>k. In Room 316, the tub faucet was leaking and there was water on the floor next to the toilet. There were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>stained ceiling tiles and the bathroom door was marred. One resident resided in the room.</p> <p>On the 400 unit:</p> <p>a. In Room 402, the bathroom call light was missing the cord and the sink was loose. Five resident's shared the bathroom.</p> <p>b. In Room 403, there were marred walls and doors. Two residents resided in the room.</p> <p>c. In Room 412, there were marred walls and baseboards. The bedside tables were marred. Two residents resided in the room.</p> <p>On the 500 unit:</p> <p>a. In Room 502, the wall behind bed B was marred and the metal on the bottom of the heating unit had areas of rust. Two residents resided in the room.</p> <p>b. In Room 503, the bathroom floor had broken tiles. Four residents shared the bathroom.</p> <p>c. In Room 504, there were mars on the floor near the bed, there were stained ceiling tiles and the metal on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
---	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the bottom of the heating unit had areas of rust. Two residents resided in the room.</p> <p>d. In Room 505, there were mars on the bathroom door and the bedside table. One resident resided in the room.</p> <p>e. In Room 507, there were stained ceiling tiles. One resident resided in the room.</p> <p>f. In Room 510, there was a half inch hole in the plaster wall that divides the room, there were mars on the floor and on the heating unit. Two residents resided in the room.</p> <p>g. In Room 512, the metal on the bottom of the heating unit had rust, there were stained ceiling tiles, the bathroom threshold had chipped paint, and the nightstands were marred. There was lime buildup on the faucet in the bathtub. Two residents resided in the room and four residents shared the bathroom.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered for 2 of 10 residents reviewed for unnecessary medications. (Residents #11 and #61)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 6/11/13 at 2:54 p.m. The resident's diagnoses included, but were not limited to, electrolyte imbalance and seizure disorder.</p> <p>Review of the laboratory results for 5/15/13, indicated the resident's ammonia level was critically high at 67. Normal level 11-50.</p> <p>A Physician's order dated 5/15/13, indicated a repeat serum ammonia and valproic acid (level to monitor anti-seizure medications) was to be done on 5/22/13.</p> <p>Review of the May 2013 laboratory results indicated there was no ammonia or valproic acid level</p>	F000502	<p>The facility will ensure that it provides laboratory testing and results in a manner consistent with the facility policy. Resident #11 and Resident #61 have both had labs drawn since the survey. Results have been received and physicians have been notified. No new orders noted. Lab books have been reviewed to ensure that all residents have received labs per orders. The orders have been reviewed to ensure that all lab orders were recorded in the lab book. No new issues noted. Nurses will be in-serviced on the facility laboratory policy and the need to maintain compliance. Audits will be performed at least weekly by the DON or designee to ensure that labs continue to be drawn per physician order. The results of the audits will be reported to the QA team on a monthly basis for 6 months or until problem is considered to be resolved. Monitoring may be discontinued if no further issues are identified within a 3 month period. '</p>	07/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>available for review on 5/22/13.</p> <p>There was no documentation in the Nursing progress notes on 5/22/13, to indicate why the lab had not been drawn.</p> <p>Interview with LPN #3 on 6/17/13 at 2:30 p.m., indicated the resident's lab was not drawn due to he refused and the test was not rescheduled by the lab.</p> <p>2. The record for Resident #61 was reviewed on 6/11/13 at 2:58 p.m. The resident had diagnoses, that included but were not limited to, hyperkalemia (high potassium level), diabetes and dementia with delusional disturbance.</p> <p>There was a physician order dated 2/27/13, that indicated: "1.) d/c (discontinue) current Kayexelate (a medication to reduce potassium levels) order 2.) Kayexelate 60 grams po (by mouth) qd (daily) for dx (diagnosis) of hyperkalemia 3.) recheck CMP (complete metabolic profile - a lab test that included potassium levels) on 3/1/13."</p> <p>Review of the laboratory results indicated no CMP results were noted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>for 3/1/13.</p> <p>There was no documentation in the Nursing progress notes on 3/1/13, to indicate why the lab had not been drawn.</p> <p>Interview with the Restorative Nurse on 6/12/13 at 1:10 p.m., indicated the CMP with the potassium level was not obtained as ordered by the Physician.</p> <p>3.1-49(a)</p>				