

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
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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
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F000000	<p>This visit was for the Investigation of Complaint IN00130175.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00130175 - Substantiated. Federal and State deficiencies related to the allegation are cited at F225 and F226.</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</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.

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	<p>Other: 0 Total: 62</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 23, 2013, by Janelyn Kulik, RN.</p>				

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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>	F000225	The facility will ensure that all	07/17/2013			

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	<p>Based on record review and 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</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. 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.</p>		

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	<p>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 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 was first voiced.</p> <p>Review of the check off form for the</p>		<p>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>				

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	<p>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.</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>This Federal tag relates to Complaint IN00130175.</p> <p>3.1-28(c) 3.1-28(d)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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</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. 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</p>	07/17/2013			

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	<p>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. 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 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</p>		<p>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.</p> <p>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>		

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	<p>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 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.</p> <p>The policy titled "Abuse Prevention {Program Facility Policy" revised on 6/1/12 was provided by the Business Office Manger 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>			

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	<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>This Federal tag relates to Complaint IN00130175.</p> <p>3.1-28(a)</p>				