

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00192767.</p> <p>Complaint IN00192767-Substantiated. Federal/State deficiencies related to the allegations are cited at F425.</p> <p>Survey dates: March 10, 11, 14, 15, & 16, 2016</p> <p>Facility number: 000369 Provider number: 155530 AIM number: 100275190</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 7 Medicaid: 55 Other: 2 Total: 64</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 3283 on</p>	F 0000	N/A	

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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F 0225 SS=D Bldg. 00	<p>3/21/16.</p> <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</p>				

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	<p>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 interview, the facility failed to ensure the Administrator was notified immediately of an allegation of verbal abuse for 1 of 1 allegations of abuse reviewed of the 1 resident who met the criteria for abuse. (Resident #89)</p> <p>Finding includes:</p> <p>Interview with Resident #89 on 3/10/16 at 10:47 a.m., indicated a CNA told her to shut up about one week ago. The resident indicated it was in the evening right after her shower, but since she had trouble with her vision she did not know who it was. The resident indicated she told staff about the incident but did not remember who she told.</p> <p>Interview with the Social Service Director (SSD) on 3/10/16 at 2:04 p.m., indicated she was unaware a staff member had told the resident to shut up. LPN #4 was sitting at the Nurses' station during the interview with the SSD. LPN #4 indicated she was aware of the verbal abuse allegation. She indicated the resident told her about it one week ago</p>	F 0225	<p>F225- ACTION TAKEN: Resident # 89 was interviewed immediately on 03/10/16 by Social Service Director, Activity Director and Director of Nurses. Upon investigation a Incident report was submitted to ISDH (reportable #21). Staff (including LPN #4) was in-serviced immediately on 03/10/16 Abuse, Resident Rights and Elder Justice Act. Further investigation indicated that the resident may have misinterpreted an statement of "Sit up" and not "Shut up" during care due to resident is hard of hearing. LPN #4 and Social Service Director was interviewed. Corrective action for LPN #4 was initiated.</p> <p>IDENTIFICATION OF OTHER RESIDENTS: Randomly chosen resident's were further interviewed by the Social Service Director and no effect noted.</p> <p>MEASURES IN PLACE: Abuse prevention reporting in-servicing and in orientation on policy and procedure completed. Will continue as required and as needed. Posting of abuse reporting is located in a predominate area of the facility. An updated investigation form has been initiated as of 03/25/16. A audit of staff</p>	04/15/2016

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	<p>and that it happened when it was dark outside. The LPN indicated she completed a green sheet and slid it under the SSD's door.</p> <p>Interview with LPN #4 at that time, indicated the green sheets were to be completed when a resident had a concern or behavior that required someone to look into.</p> <p>Interview with the SSD at that time, indicated she was still unaware of the situation, but was going to go to her office and look to see if there was any written documentation of the incident.</p> <p>Continued interview with the SSD on 3/10/16 at 2:30 p.m., indicated she did not have any paper or any other information regarding the allegation of verbal abuse.</p> <p>Interview with LPN #4 at that time, indicated she had told the Director of Nursing (DON) and she had also interviewed the resident and she did not say anything about a staff member telling her to shut up.</p> <p>On 3/10/16 at 2:45 p.m., the Administrator was informed of the allegation of verbal abuse. She indicated she was not aware of the allegation but</p>		<p>in-service on Abuse was conducted at 100% compliance. There is a new hire checklist for file completion for required training on Abuse.</p> <p>MONITORING OF CORRECTIVE ACTION: Social Service Director, HR Director and Administrator will track and monitor compliance weekly x 3 months and through ongoing in-service attendance with current staff list every 6 months ongoing and during orientation for new hire (checklist). Finding will be reviewed per QA Committee monthly.</p>		

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	<p>would start an investigation immediately. The DON was also in the room and indicated LPN #4 had just informed her 5 minutes ago of the allegation of verbal abuse. The DON indicated she had interviewed the resident regarding another issue during a shower incident that involved her tattoo. The resident never mentioned that any staff member had told her to shut up.</p> <p>Interview with the Administrator at that time, indicated she was not immediately made aware of the allegation of verbal abuse for Resident #89. She indicated LPN #4 should have reported it immediately to her after she was informed by the resident.</p> <p>The record for Resident #89 was reviewed on 3/14/16 at 2:56 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, generalized weakness, hard of hearing, and blindness.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 2/4/16, indicated the resident had minimal difficulty hearing. The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was alert and oriented.</p>			

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F 0226 SS=D Bldg. 00	<p>Interview with the Administrator on 3/11/16 at 9:30 a.m., indicated the allegation of verbal abuse had been investigated. She indicated CNA #1 (the CNA who gave the resident a shower that evening) had taken the resident back to her room after the shower. The CNA realized the resident was not sitting up in the chair and told the resident to "sit up." The Administrator indicated the resident was extremely hard of hearing and the DON and SSD had inserviced the staff on their choice of words they should use for residents with hearing difficulty.</p> <p>3.1-28(c) 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. Based on record review and interview, the facility failed to follow their abuse policy regarding immediately notifying the Administrator of an allegation of verbal abuse for 1 of 1 allegations of abuse reviewed of the 1 resident who met the criteria for abuse. (Resident #89)</p> <p>Finding includes: Interview with Resident #89 on 3/10/16</p>	F 0226	F226- ACTION TAKEN: Resident # 89 was interviewed immediately on 03/10/16 by Social Service Director, Activity Director and Director of Nurses. Upon investigation a Incident report was submitted to ISDH (Reportable#21). Staff (including LPN #4) was in-serviced immediately on 03/10/16 Abuse, Elder Justice act. Resident's careplan was updated to include hearing deficit. Further	04/15/2016

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	<p>at 10:47 a.m., indicated a CNA told her to shut up about one week ago. The resident indicated it was in the evening right after her shower, but since she had trouble with her vision she did not know who it was. The resident indicated she told staff about the incident but did not remember who she told.</p> <p>Interview with the Social Service Director (SSD) on 3/10/16 at 2:04 p.m., indicated she was unaware a staff member had told the resident to shut up. LPN #4 was sitting at the Nurses' station during the interview with the SSD. LPN #4 indicated she was aware of the verbal abuse allegation. She indicated the resident told her about it one week ago and that it happened when it was dark outside. The LPN indicated she completed a green sheet and slid it under the SSD's door.</p> <p>Interview with LPN #4 at that time, indicated the green sheets were to be completed when a resident had a concern or behavior that required someone to look into.</p> <p>Interview with the SSD at that time, indicated she was still unaware of the situation, but was going to go to her office and look to see if there was any written documentation of the incident.</p>		<p>investigation indicated that the resident may have misinterpreted an statement of "Sit up" and not "Shut up" during care due to resident is hard of hearing. LPN #4 and Social Service Director was interviewed. Corrective action for LPN #4 was initiated. IDENTIFICATION OF OTHER RESIDENTS: Randomly chosen resident's were further interviewed by the Social Service Director and no affect noted.</p> <p>MEASURES IN PLACE: Abuse prevention reporting in-servicing and in orientation on policy and procedure completed. Will continue as required and as needed. Posting of abuse reporting is located in a predominate area of the facility. An updated investigation form has been initiated as of 03/25/16. A audit of staff in-service on Abuse was conducted at 100% compliance. There is a new hire checklist for file completion for required training on Abuse. MONITORING OF CORRECTIVE</p>				

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	<p>Continued interview with the SSD on 3/10/16 at 2:30 p.m., indicated she did not have any paper or any other information regarding the allegation of verbal abuse.</p> <p>Interview with LPN #4 at that time, indicated she had told the Director of Nursing (DON) and she had also interviewed the resident and she did not say anything about a staff member telling her to shut up.</p> <p>On 3/10/16 at 2:45 p.m., the Administrator was informed of the allegation of verbal abuse. She indicated she was not aware of the allegation but would start an investigation immediately. The DON was also in the room and indicated LPN #4 had just informed her 5 minutes ago of the allegation of verbal abuse. The DON indicated she had interviewed the resident regarding another issue during a shower incident that involved her tattoo. The resident never mentioned any staff member had told her to shut up.</p> <p>Interview with the Administrator at that time, indicated she was not immediately made aware of the allegation of verbal abuse for Resident #89. She indicated LPN #4 should have reported it</p>		<p>ACTION: Social Service Director, HR Director and Administrator will track and monitor compliance weekly x 3 months and through ongoing in-service attendance with current staff list every 6 months ongoing and during orientation for new hire (checklist). Finding will be reviewed per QA Committee monthly.</p>	

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F 0279 SS=D Bldg. 00	<p>immediately to her after she was informed by the resident.</p> <p>The current and undated Abuse Prevention Program Facility Policy provided by the Administrator on 3/14/16 at 3:35 p.m., indicated "Supervisors shall immediately inform the Administrator or designee of all reports of potential mistreatment. Upon learning of the report, the Administrator or designee shall initiate an incident investigation."</p> <p>3.1-28(a)</p> <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,</p>			

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	<p>including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to develop care plans related to tube feeding, urinary incontinence and dental status for 3 of 20 records reviewed. (Residents #58, #61 and #80)</p> <p>Findings include:</p> <p>1. On 3/14/16 at 8:34 a.m., Resident #58 was observed in her room. LPN #5 was giving the resident a bolus feeding through her gastrostomy (a tube in the stomach) tube.</p> <p>The record for Resident #58 was reviewed on 3/14/16 at 8:38 a.m. The resident's diagnoses included, but were not limited to, stroke and gastroesophageal reflux disorder (GERD).</p> <p>A Physician's order dated 12/5/15, indicated the resident was to receive Fibersource HN (a tube feeding solution) 500 milliliters (ml) every 8 hours.</p> <p>The 8/10/15 Annual Minimum Data Set (MDS) assessment, indicated the resident had a feeding tube and was receiving a mechanically altered diet. The Care Area Assessment (CAA) Summary indicated</p>	F 0279	<p>F279- ACTION TAKEN: The individuals noted were discussed per the IDT team and care-plans initiated for residents #58, #61 and #80. IDENTIFICATION OF OTHER RESIDENTS: The facility conducted an audit and no other residents were identified at risk. MEASURES IN PLACE: The facility already has a policy in place per the manual for care-planning per the RAI manual. MONITORING OF CORRECTIVE ACTION: The Director of Nurses and the MDS Coordinator will continue monitor the care-planning process on Tuesday and Thursdays (2x)weekly x 3 months as assigned per care plan/ MDS schedule and daily clinical meeting by the IDT team and as needed for updates by each responsible IDT member of the MDS process based/audited on the triggers(CAAS) . Then his will be ongoing with the MDS/Careplan process. Finding will be reviewed per QA Committee monthly.</p>	04/15/2016

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F 0282 SS=D Bldg. 00	<p>the resident's feeding tube was going to be addressed on the care plan.</p> <p>The Quarterly MDS assessment dated 1/13/16, indicated the resident had a feeding tube and was receiving a mechanically altered diet.</p> <p>The current plan of care which had been updated in 1/2016, indicated there was no care plan related to the resident's tube feeding.</p> <p>Interview with the MDS Coordinator at 3/16/16 at 10:50 a.m., indicated the resident's tube feeding was not addressed on the current plan of care.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure care plans were followed related to hand splint use for 1 of 20 records reviewed. (Resident #11)</p> <p>Finding includes:</p>	F 0282	F282- ACTION TAKEN: The Occupational Therapist conducted a screening of all residents with splints was initiated on 03/29/2016 for clarification of time frame that each individual should have their splints applied and removed. Physicians notified and clarification orders written. Programs reflective of changes. Resident #11 program was	04/15/2016

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	<p>On 3/11/16 at 9:41 a.m., Resident #11 was observed with a contracture to her left hand. At that time, she was observed wearing a left hand splint.</p> <p>On 3/14/16 at 8:07 a.m., the resident was observed sitting in her wheelchair in the main dining room. At that time, Restorative CNA #1 was observed performing passive range of motion to her left arm, hand, and fingers. The Restorative CNA donned the splint to her left hand. At that time, the CNA indicated the splint usually stays on for about 6 to 8 hours and then she removed it.</p> <p>On 3/14/16 at 1:30 p.m., the resident was observed in bed. At that time, her hand splint was not on and was located in the bedside drawer.</p> <p>On 3/15/16 at 8:00 a.m., the resident was observed in the main dining room with the splint on her left hand.</p> <p>On 3/15/16 at 1:55 p.m., the resident was observed in bed. At that time, her hand splint was not on and was located in the bedside drawer.</p> <p>The record for Resident #11 was reviewed on 3/14/16 at 8:21 a.m. The resident's diagnoses included, but were</p>		<p>addressed and corrected. All Restorative Aides and CNAs inserviced 03/15/16 by Restorative Nurse on splinting. IDENTIFICATION OF OTHER RESIDENTS: Facility assessed residents and no other residents were identified at risk. MEASURES IN PLACE: Restorative Nurse follow physician orders as written for each individual splinting program. MONITORING OF CORRECTIVE ACTION: The Restorative Nurse will audit weekly each splinting program, restorative grid/minutes and plan of care with summaries on the restorative program with referrals to Occupational therapy if needed. The new Care-plan Coordinator, New MDS Nurse and /or Director of Nurses will audit/ monitor all plans of care weekly x 4 weeks then monthly x2 with the weekly care plan audit form. All pertinent staff will be inserviced on all plans of care. Findings will be reviewed by the QA committee monthly.</p>		

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F 0329 SS=D	<p>not limited to, intracranial bleed, stroke with left hemiparesis (weakness), edema, osteoporosis, arthritis, and vascular dementia.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 1/17/16, indicated the resident had range of motion impairments to one side of her upper and lower extremities.</p> <p>The current and updated restorative care plan dated 1/2016, indicated the resident had a contracture. The approaches were to apply the splint to the left upper extremity after range of motion. Range of motion was to be performed six times a week and the splint was to be put on in the a.m. and off in the p.m.</p> <p>Interview with LPN #2 on 3/15/16 at 1:58 p.m., indicated the word p.m. meant 5:00 p.m. or after.</p> <p>Interview with the Restorative Nurse on 3/15/16 at 2:10 p.m., indicated the hand splint should not be taken off the resident until the evening time on the 3-11 shift.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM</p>			

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Bldg. 00	<p>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 sliding scale insulin was given as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident #44)</p> <p>Finding includes:</p> <p>The record for Resident #44 was reviewed on 3/14/16 at 9:41 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus.</p> <p>A Physician's order dated 12/3/15,</p>	F 0329	F0329- ACTION TAKEN: A assessment/investigation of the resident #44 was conducted on 03/15/16, which included Mediation error report. The Physician / Medical Director was notified of the occurrence. No new orders. The Director of Nurses provided immediate staff training which included policy and procedure of Blood sugar monitoring, Insulin administration and documentation. A blood sugar monitoring in-service and competency exams were completed for each nurse on 03/29/16 by Professional Medical Incorporated and Director of	04/15/2016

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	<p>indicated the resident was to receive Novolog insulin by the way of a flexpen subcutaneously (sq) twice a day based on a sliding scale at 6:00 a.m. and 4:00 p.m.</p> <p>The sliding scale dose was as follows:</p> <p>0-150=0 units 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units Above 400=12 units</p> <p>The March 2016 Medication Administration Record (MAR), indicated the following:</p> <p>3/8/16 at 6:00 a.m. the resident's blood sugar was 167, documentation indicated the resident received insulin in his "abd" (abdomen). There was no documentation to indicate how many units of insulin the resident received. The resident should have received two units of insulin.</p> <p>3/13/16 at 6:00 a.m. the resident's blood sugar was 153, documentation indicated the resident received insulin in his "abd." There was no documentation to indicate how many units of insulin the resident received. The resident should have</p>		<p>Nurses. Corrective action for each nurse responsible along with education was completed. IDENTIFICATION OF OTHER RESIDENTS: The facility did an audit of other residents with Blood Sugar monitoring and no other residents were noted at risk. MEASURES IN PLACE: The facility has a policy in place for Blood sugar monitoring and documentation. MONITORING OF CORRECTIVE ACTION: The Director of Nurses and or designee, Medical Director and Pharmacy consultant will continue to do Monitoring of Blood Sugar results per policy. The blood sugar monitoring tool for compliance will be done by the Director of Nurses and or designee and will be done x3 a week for 3 months then monthly x 2 then quarterly. All results will be reported to the QA committee monthly.</p>		

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	<p>received two units of insulin.</p> <p>3/14/16 at 6:00 a.m. the resident's blood sugar was 142, documentation indicated the resident received insulin in his "abd." The resident should not have received any insulin at this time.</p> <p>The February 2016 MAR indicated the following:</p> <p>2/2/16 at 6:00 a.m., the resident's blood sugar was 152 and no insulin was given. The resident should have received two units of insulin.</p> <p>2/23/16 at 6:00 a.m., the resident's blood sugar was 151 and no insulin was given. The resident should have received two units of insulin.</p> <p>2/27/16 at 6:00 a.m., the resident's blood sugar was 222 and the resident received two units of insulin instead of four units.</p> <p>The January 2016 MAR indicated the following:</p> <p>1/6/16 at 6:00 a.m., the resident's blood sugar was 158 and no insulin was given. The resident should have received two units of insulin.</p> <p>1/7/16 at 6:00 a.m., the resident's blood</p>			

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F 0363 SS=E Bldg. 00	<p>sugar was 183 and no insulin was given. The resident should have received two units of insulin.</p> <p>1/20/16 at 6:00 a.m., the resident's blood sugar was 171 and no insulin was given. The resident should have received two units of insulin.</p> <p>1/21/16 at 6:00 a.m., the resident's blood sugar was 173 and no insulin was given. The resident should have received two units of insulin.</p> <p>Interview with the Director of Nursing on 3/16/16 at 9:05 a.m., indicated the resident's sliding scale insulin was given incorrectly.</p> <p>3.1-48(a)(3)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and</p>	F 0363	F0363- ACTION TAKEN: Upon notification of finding,	04/15/2016			

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	<p>interview, the facility failed to follow the menu related to serving sausage for the breakfast meal for 1 of 2 meals observed.</p> <p>Finding includes:</p> <p>On 3/15/16 at 7:45 a.m., the posted menu indicated two grilled sausage links were to be served for the breakfast meal.</p> <p>Observation in the kitchen on 3/15/16 at 7:45 a.m., indicated there was not a pan of sausage on the steam table.</p> <p>Dietary Cook #1 indicated at that time, all she had for the breakfast meal was scrambled eggs, toast, hot cereal and hard boiled eggs. She indicated there was no sausage available for the meal and it would not be there until tomorrow.</p> <p>On 3/16/16 at 8:40 a.m., the residents in the main dining room were served their breakfast trays. There was no sausage on the plates, the residents received a bowl of hot cereal, scrambled eggs, and toast.</p> <p>Interview with the Dietary Food Manager on 3/15/16 at 1:15 p.m., indicated that he was unaware there was no sausage available for the breakfast meal.</p> <p>3.1-20(i)(4)</p>		<p>Administrator reviewed the findings with the Dietary Supervisor. It was also stated as well to the Administrator that the sausage was not available. Per interview with the kitchen staff, it was not ordered. A corrective action was completed with the Dietary Supervisor.</p> <p>IDENTIFICATION OF OTHER RESIDENTS: On the day of the finding, no resident received the sausage per the planned menu.</p> <p>MEASURES IN PLACE: The New Dietary Supervisor started 03/30/16. The menu items (food items/inventory) will be checked for availability the day before and on Fridays for Saturday, Sunday and Monday. MONITORING OF CORRECTIVE ACTION: A new menu substitution log was initiated on 04/01/16. The inventory will be checked against the order invoice and the delivery invoice for correct ordered inventory by the Dietary Aide every delivery day and the Dietary Supervisor will recheck the invoices for completion by verifying each item is checked on on each form. This will be a ongoing process. The Dietary Supervisor will weekly x3 months ,then monthly x 2 months complete the Kitchen sanitation audit to monitor for compliance then randomly quarterly by the Administrator. Also new Temperature sanitizer log was initiated that tests after Breakfast, lunch and dinner daily. (This will</p>				

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F 0365 SS=E Bldg. 00	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure the recipe for pureed scrambled eggs was followed correctly for 1 of 1 meal preparation observed. This had the potential to affect the 5 residents who received a pureed diet.</p> <p>Finding includes:</p> <p>On 3/15/16 at 8:00 a.m., Dietary Cook #1 was observed preparing the pureed scrambled eggs for the breakfast meal. At that time, she indicated there were 5 residents who received pureed diets.</p> <p>The Dietary Cook used a #10 scoop which was 3/4 cup and scooped 2 and 1/2 scoops of the scrambled eggs into a bowl. She added the eggs to the food processor and poured 1 scoop of thickened powder and 2 scoops of instant puree bread mix into the scrambled eggs. She added water, which was not measured, into the</p>	F 0365	<p>be ongoing and is a part of the Kitchen quick rounds and Kitchen sanitation audit). Finding will be reviewed per QA committee monthly .</p> <p>F365- ACTION TAKEN: Upon notification of findings the staff was instructed per the Dietary Supervisor of the policy and procedure for the preparation of scrambled eggs. The Dietary Supervisor was issued a corrective action in regarding to the findings. The dietary staff was in service on 03/30/2016 and 03/31/2016. IDENTIFICATION OF OTHER RESIDENTS: The facility assessed the finding upon notification and no other residents besides the ones with a pureed diet were affected. MEASURES IN PLACE: The facility already has a policy and procedure manual in place for food preparation. A New Dietary supervisor started 03/30/2016. MONITORING OF CORRECTIVE ACTION: The new dietary Manager will observe meal preparation (at least 2 meals per day) and educate the dietary staff as needed going forward on a ongoing basis. The Administrator will randomly observe the meal preparation on a ongoing basis.</p>	04/15/2016

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	<p>food processor over the eggs. She turned on the processor to cream the mixture. She stopped the processor and stirred the eggs. At that time, she added more water which was again not measured. She turned the processor back on and creamed the mixture together. She stopped the processor stirred the mixture and added a little more water which was not measured.</p> <p>The Dietary Cook indicated she wanted a smooth texture and did not want to make the eggs too "tight", because when the eggs sat on the steam table for awhile they got stiff and too thick. The Dietary Cook further indicated she was trained by the previous cook that used to work at the facility on how to puree scrambled eggs.</p> <p>The pureed recipe was reviewed for scrambled eggs. The recipe was as follows for 5 servings:</p> <p>Two #8 scoops of scrambled eggs and 5 tablespoons of 2% milk. Place cooked egg portion in food processor and blend. Add hot milk as needed to reach desired consistency.</p> <p>Interview with the Dietary Food Manager on 3/15/16 at 10:30 a.m., indicated the pureed scrambled egg recipe was not followed as written.</p>		Both will observe and monitored for compliance. Finding will be reviewed per QA Committee.		

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F 0371 SS=F Bldg. 00	<p>3.1-21(a)(3)</p> <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, record review, and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to lack of chemicals in the dish machine, sanitation buckets not at the proper concentration, undated food in the cooler and unit refrigerators, dirty ovens, and dirty and dusty storage racks for 1 of 1 kitchens. This had the potential to affect 61 of 64 residents who received their food from the kitchen. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. The following was observed during the Brief Kitchen Sanitation tour on 3/10/16 at 8:15 a.m., with Dietary Cook #1:</p> <p>a. The sanitation bucket was observed sitting on the counter by the three</p>	F 0371	<p>F371- ACTION TAKEN: Dietary-Upon immediately notification of the findings the remedies were done: staff was instructed on proper use (policy and procedure) on mixing of chemical for sanitation, undated items were discarded and redone/prepared, oven and storage racks cleaned (3/15/16). ECOLAB was called per the Administrator and will be out the first full week in April to extend the thermometer and turn the housing for ability to reach the primer button on the dishwasher. staff was also instructed on keeping the lid on the garbage can when not in use. The Dietary Supervisor was issued a corrective action regarding findings. Dietary staff was in serviced on 03/28/16, 03/30/16 and 03/31/16. The nursing staff - was immediately instructed per the Director of Nurses to discard any undated applesauce they may have on</p>	04/15/2016

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	<p>compartment sink. Dietary Aide #1 removed a test strip and placed it into the bucket. The strip measured 500 parts per million (ppm) of quaternary solution (a sanitizing solution).</p> <p>Interview with Dietary Aide #1 at that time, indicated the solution was to be between 200 ppm and 400 ppm.</p> <p>Dietary Cook #1 indicated the solution was already premixed and all they had to do was fill up the buckets from the hose in the sink. The Cook indicated the premixed solution was too hot so she only had filled the bucket up about 1/8 full of the quaternary solution and then filled the rest of the bucket with cold water due to the temperature of the premixed solution.</p> <p>b. The doors of the convection oven were dirty. The inside of the oven was dirty with a black burned substance noted on the bottom shelf.</p> <p>c. The racks on the transportation carts, that were used to transport meal trays, were dirty.</p> <p>d. The lid to the garbage can was on the floor and the garbage was uncovered.</p> <p>2. The following was observed during</p>		<p>the unit. All nurses staff will be in serviced by 04/10/16 on food receiving and storage and dating open food items.</p> <p>IDENTIFICATION OF OTHER RESIDENTS: The facility assessed by the Director of Nurses and the Nurse Managers and their was no residents affected by findings. MEASURES IN PLACE: The facility has a policy and procedure for food storage and dating open items, sanitation instructions on chemical mixing and dish washing machine usage.</p> <p>MONITORING OF CORRECTIVE ACTION: A new Temperature sanitation log was initiated 04/13/16 with the dietary staff inserviced on 04/13/16 and 04/14/16. The new Dietary Supervisor (as of 03/30/16) will be responsible for auditing the dishwasher for proper function and use by staff, mixing of chemical cleanliness of the dietary department and food storage with a ongoing process 5 x a week with the Kitchen Quick round form x 3 months then weekly x 2 months. The Director of Nurses and nurse managers will check the refrigerators on the units for appropriate dates 5x week for compliance x 3 months then ongoing. The Administrator and/or Director of Nurses will do random audits on either the a.m.</p>				

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	<p>the Full Kitchen tour on 3/15/16 at 1:15 p.m., with the Dietary Food Manager (DFM):</p> <p>a. The lid to the garbage can was on the floor and the garbage was uncovered.</p> <p>b. Dietary Aide #1 and Dietary Aide #2 were observed in the dish room. At that time, Dietary Aide #1 was observed placing a rack of dishes in the dish machine and then shut the door. The dish machine started. After the wash and rinse cycles were completed, Dietary Aide #1 removed a white test strip from the container and tested the water for chemicals. The strip did not turn a color to indicate there were chemicals in the water. The thermostat for the dish machine was located on the bottom of the machine under the counter and in the back. The DFM was observed to get down on his hands and knees to see the thermometer. He wanted to see if the heat of the water was reaching 120 degrees. After 4 attempts of running the dish machine, which indicated no chemicals were in the water after testing with the strips, the DFM called in Maintenance Employee #1 to look at the dish machine.</p> <p>Maintenance Employee #1 ran the dish machine 3 more times. After the third</p>		<p>and p.m. shift for compliance weekly x 03 months then ongoing. the Dietary Supervisor and Maintenance Director or designee will do temperature checks weekly x 3 months then per policy on a ongoing basis. The Dietitian will do a Kitchen sanitation round bi monthly x 3 months then ongoing randomly. Finding will be reviewed per QA committee.</p>	

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	<p>time, the water was tested for chemicals, in which the water tested 100 ppm of bleach solution. The thermostat was also reaching 120 degrees for the wash and rinse cycles.</p> <p>Interview with Maintenance Employee #1 at that time, indicated there was a primer button located on the back of the machine that he pressed and held for about 2 minutes before starting the machine. He indicated this allowed the machine to be primed with the chemicals to complete the wash and rinse cycles.</p> <p>Interview with Dietary Aide #1 and Dietary Aide #2, at that time, indicated they were unaware the machine had a primer button and if it was located in the back of the machine, they could not reach the primer button anyway. They further indicated they were not able to see the thermostat due to it being under the dish machine. Dietary Aide #1 indicated they only record the chemical solution on the paper and have not been recording the temperature of the water.</p> <p>The current 2010 Mechanical Cleaning and Sanitizing policy provided by the DFM on 3/15/16 at 2:40 p.m., indicated the final rinse will have 50 parts per million hypochlorite (chlorine) on dish surface or per manufactures guidelines.</p>			

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	<p>c. There were 4 wire storage racks that had cans and boxes of food on them in the food storage room that were dirty, sticky and dusty. The shelves that housed the spices were also dirty and dusty.</p> <p>d. There were 14 bologna sandwiches sealed in plastic bags in the reach cooler with no date or label on them.</p> <p>Interview with the DFM at that time, indicated the sandwiches should have been labeled.</p> <p>Interview with the Dietary Food Manager at the time, indicated all the above areas were in need of cleaning and/or repair.</p> <p>3. Observation on 3/16/16 at 8:30 a.m., the 300 unit refrigerator was observed. Inside there were 2 containers of strawberry yogurt that were opened but not dated and one container of pudding that was not dated.</p> <p>Interview with LPN #2 at that time, indicated the food should be dated after opening.</p> <p>4. Observation on 3/16/16 at 8:50 a.m., indicated there were containers of applesauce that were open but not dated.</p>			

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F 0412 SS=D Bldg. 00	<p>Interview with LPN #3 at that time, indicated the applesauce should be dated after opening.</p> <p>The current 3/15/16 Food Receiving and Storage policy provided by the DFM on 3/16/16 at 8:30 a.m., indicated all foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date).</p> <p>3.1-21(i)(3)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident saw the dentist on a yearly basis for 1 of 3 residents reviewed for dental services of the 9 residents who met the criteria for dental services. (Resident #61)</p>	F 0412	F412- ACTION TAKEN: Upon notification of finding with resident #61 on 03/15/16, the Social Service Director notified Primesource of need for Dental Appointment. Scheduled and exam completed on 03/28/16. Referral received for extraction of all remaining teeth. Appointment	04/15/2016

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	<p>Finding includes:</p> <p>On 3/10/16 at 2:10 p.m., Resident #61 was interviewed. The resident indicated he wanted dentures and his sister was looking into it because he had to go to the Veteran's hospital. At that time, the resident was observed with missing and broken teeth.</p> <p>The record for Resident #61 was reviewed on 3/15/16 at 9:28 a.m. The resident's diagnoses included, but were not limited to, stroke, bilateral above the knee amputation, heart disease, and high blood pressure.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 10/20/15, indicated the resident had no natural teeth or teeth fragments.</p> <p>The Quarterly MDS assessment dated 1/19/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 indicating he was alert and oriented. The resident had no problems with his oral health.</p> <p>The current and updated care plan dated 1/2016 was reviewed. There was no care plan for the resident's dental status.</p>		<p>set for 04/05/16 at 10:15am with an Oral Surgeon at "Kool Smiles" dentistry. Transportation set with Prompt ambulance Service.</p> <p>IDENTIFICATION OF OTHER RESIDENTS:The facility did an audit of all current residents and no other residents were affected.</p> <p>MEASURES IN PLACE:The facility already has a policy on treatment of the resident's dental problems. The Social Service Director, the Primesource scheduler and Director of Nurses or designee will monitor all appointments for timeliness , referrals and follow up. A audit book was created for all appointments/schedule. A inservice of Nursing staff was done on 03/30/16 regarding dental referrals follow up.</p> <p>MONITORING OF CORRECTIVE ACTION: A audit of the facility will be done as follows two charts per unit per week x 3 months then q 6 months ongoing by the Social Service Director, Director of Nurses and /or designee. Finding will be reviewed per QA committee.</p>	

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	<p>A dental consent signed and dated 2/3/14 by the resident's responsible party, indicated the resident agreed for dental services provided by the facility.</p> <p>An undated dental assessment indicated the resident had no dentures and had some natural teeth missing.</p> <p>A dental exam dated 3/28/14 by the dentist, indicated the resident had multiple broken teeth. There were no visible signs of infection. The dentist recommended extractions for the remaining lower and broken teeth. A Referral was written on that day.</p> <p>The resident had no other dental visits for review.</p> <p>Nursing Progress Notes dated 3/28/14 at 2:00 p.m., indicated "Seen by dentist. Attempted to make appointment with Dr. (name), office closed."</p> <p>There were no further Nursing Progress Notes or Social Service Notes (3/29/2014 through 3/16/2016) regarding any more attempts for the resident to see an oral surgeon for the removal of his remaining teeth.</p> <p>Interview with the Social Service Director (SSD) on 3/15/16 at 2:40 p.m.,</p>			

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F 0425 SS=D Bldg. 00	<p>indicated the resident had not been seen by the dentist since 2014. She indicated she just put him on the list to be seen on 3/28/16.</p> <p>Continued interview with the SSD on 3/16/16 at 10:16 a.m., indicated the facility did not follow up on the dental referral for the resident to have his teeth extracted back in 2014.</p> <p>3.1-24(a)(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview,</p>	F 0425	F425- ACTION TAKEN: Resident	04/15/2016

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	<p>the facility failed to ensure pain medications were provided by the Pharmacy as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident #B)</p> <p>Finding includes:</p> <p>The Closed Record for Resident #B was reviewed on 3/14/16 at 1:25 p.m. The resident's diagnoses included, but were not limited to, chronic pain.</p> <p>An admission Physician's order dated 8/13/15, indicated the resident was to have a Fentanyl (narcotic pain medication) patch 100 micrograms (mcg) per hour placed onto the skin every 3 days for chronic pain.</p> <p>An admission Physician's order dated 8/13/15, indicated the resident was to receive Tylenol 500 milligrams (mg) by mouth every 4 hours as needed (prn) for pain.</p> <p>The August 2015 Medication Administration Record (MAR), indicated the Fentanyl patch had not been signed out as given while the resident resided at the facility from 8/13-8/17/15.</p> <p>The resident had received the prn Tylenol 500 mg on 8/14/15 at 2:00 p.m. for</p>		<p>#B no longer resides in the facility. the R.N.s and LPNS and QMA in serviced by 04/06/16 on the Policy and Procedure for notification of orders to the pharmacy, administration of medications and pain management and assessment. IDENTIFICATION OF OTHER RESIDENTS: A audit of pain medications and meds on hand was by the Director of Nurses on 03/15/16 and no other residents were affected. MEASURES IN PLACE: Re-Education of nursing staff will be completed by 04/06/16 on the policy and procedure for physician orders, documentation and pain management within standards of practice. MONITORING OF CORRECTIVE ACTION: All new orders or clarifications and the 24 hour report sheets are reviewed in clinical meeting by the Director of Nurses and/or Nurse managers 5 x a week x 3 months then by the Medical Records coordinator ongoing. The followup is done by the Nurse Managers in conjunction with the floor nurses. New admit charts are reviewed in the next clinical meeting after admission for completion with the 24-72 hour chart audit form. This will be done 5 x a week with a ongoing process for compliance. Finding will be reviewed per QA committee monthly.</p>	

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F 0465 SS=E Bldg. 00	<p>complaints of pain and on 8/16/15 at 4:35 p.m. for complaints of left hip pain and a headache.</p> <p>Interview with LPN #1 on 3/15/16 at 1:27 p.m., indicated the resident did not receive the Fentanyl patch while she resided at the facility. The LPN indicated the patch had never been delivered by the Pharmacy.</p> <p>This Federal tag relates to Complaint IN00192767.</p> <p>3.1-25(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to stained ceiling tiles, marred doors, chipped and stained caulking, urine odors, an accumulation of dust and dirt along baseboards and behind stoves and sinks on 4 of 4 units throughout the facility as well as 1 of 1 kitchen areas. (Units 2, 3, 4 and 5 and the Main Kitchen)</p>	F 0465	F465- ACTION TAKEN: Upon notification of findings on the following remedies were completed. 03/15/16-room 206-dust and cobwebs removed; room 205-dust, cobwebs and hair removed; Room 306- Overbed light cover replaced; room 310-hooks to privacy curtain replaced; room 312- stained ceiling tile in bathroom replaced, urine odor in floor removed; room 511- privacy curtain cleaned; Kitchen /dietary department- Ice buildup on freezer floor; dirt on PVC pipe	04/15/2016

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. On 3/10/16 at 11:27 a.m., an accumulation of dust and cobwebs were observed in the corners next to the closet and underneath the floor register in Room 206. The white caulking around the sink in the bathroom was also cracked. One resident resided in this room. 2. On 3/10/16 at 10:55 a.m., an accumulation of cobwebs and dust along with clumps of the resident's hair were observed on the floor in Room 205. One resident resided in this room. 3. During the Environmental Tour on 3/15/16 at 1:42 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed on Unit 2: <ol style="list-style-type: none"> a. The white caulking around the bathroom sink in Room 201 was cracked and peeling. One resident resided in this room. 4. The following was observed on Unit 3: <ol style="list-style-type: none"> a. The white caulking around the bathroom sink in Room 301 was cracked. The plastic light cover for the over bed light of bed "A" was cracked. Three 		<p>under three compartment sink cleaned; dirt and dust under hand washing sink; dirt, grease and paper debris behind juice and coffee machine; food and dirt along wall behind the stove and convection oven; dirt and food crumbs observed behind the dish machine and baseboards, white PVC pipes under dish machine; Bottom of cabinets above three compartment sink cleaned; dirt on floor between steam table and the wall cleaned along with wheels; dirt and dust on floor under the storage racks and baseboards in the storage room. On 03/16/16 the following findings were remedied: Room 206-caulk repaired around sink; room 201-caulk repaired around sink; room 301- plastic light cover replaced; room 508-plastic face plate replaced over cable outlet; room 512- gaps in ceiling tile repaired; On 03/18/16 the following findings were remedied: room 302- the linoleum floor tile and caulk was replaced in the bathroom, rust on hinge corrected. On 03/22/16 the following finding were remedied: Room 404- ceiling tile replaced in bathroom; room 501- ceiling tile replaced above bed A; room 505-tile strip repainted. On 03/23/16 the following findings were remedied: The white brink wall behind dish machine along with the entire kitchen wall was cleaned and painted. On 03/29/16 the following findings were remedied: room 505 floor tile</p>		

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	<p>residents resided in this room.</p> <p>b. The linoleum floor tile in the bathroom of Room 302 was warped and lifting up in sections. The white caulking located at the base of the bath tub was discolored and cracked. The hinge to the bathroom door was rusted. Three residents resided in this room.</p> <p>c. The over the bed light cover was observed on the floor behind the head of the bed for bed "C" in Room 306. One resident resided in this room.</p> <p>d. The linoleum floor tile in the bathroom of Room 310 was warped and lifting up in sections. The base of the mirror in the bathroom was discolored and the white caulk around the base of the toilet was discolored. Hooks were missing from the privacy curtain for bed "B." Three residents resided in this room.</p> <p>e. A strong urine odor was noted throughout the room as well as the bathroom of Room 312. There was a stained ceiling tile located above the sink in the bathroom, the bathroom mirror was discolored at the base and the white caulk located at the base of the toilet was discolored. Three residents resided in this room.</p>		<p>scrubbed and buffed. on 03/30/16 the following findings were remedied: room 310- The linoleum floor was replaced; room 312- caulk at base of toilet repaired; room 406- bathroom door painted. On 03/31/16 the following findings were remedied: room 310- Mirror replaced; room 312- Mirror replaced; room 404 - door painted. IDENTIFIED OTHER RESIDENTS: The facility was visually assessed based on the findings by the Maintenance Director, Administrator and Environmental Director for any further issues and no residents were identified at risk. MEASURES IN PLACE: The cleaning schedule including the deep clean schedule has been revised by the Administrator and Environmental Director on 03/28/16. Also added was a privacy curtain check twice a week. The Dietary Supervisor was issued a Corrective Action and a new Dietary Supervisor started 03/30/16. He will be meeting with the dietary staff and formulating a deep clean schedule for the Dietary department with assistance from the environmental department. MONITORING OF CORRECTIVE ACTION: The Environmental Director will do random observation of rooms 5 days a week and the Dietary Supervisor will monitor the dietary/kitchen areas 5 days a week ongoing with random inspections by the</p>	

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	<p>5. The following was observed on Unit 4:</p> <p>a. The base of the bathroom door was scratched and marred in Room 404. The ceiling tile located in the bathroom was peeling around the edges. Two residents resided in this room.</p> <p>b. The bathroom door was scratched and marred in Room 406. One resident resided in this room.</p> <p>6. The following was observed on Unit 5:</p> <p>a. There was a stained ceiling tile located above bed "A" in Room 501. Two residents resided in this room.</p> <p>b. The tile strip located in the entry way of the bathroom in Room 505 was paint chipped and marred. The floor tile throughout the room was also scuffed and marred. Two residents resided in this room.</p> <p>c. The plastic face plate which covered the cable television outlet in Room 508 was loose and pulled away from the wall. Two residents resided in this room.</p> <p>d. The privacy curtain located next to</p>		Administrator and Director of Nurses. Finding will be reviewed per QA committee monthly.	

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	<p>bed "A" in Room 511 was stained. One resident resided in this room.</p> <p>e. There were gaps around the bathroom ceiling vent in Room 512. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the above were in need of cleaning and/or repair.</p> <p>7. The following was observed during the Brief Kitchen Sanitation tour on 3/10/16 at 8:15 a.m., with Dietary Cook #1:</p> <p>a. There was a large amount of ice build up on the freezer floor.</p> <p>b. There was a large amount of adhered dirt noted under the three compartment sink and on the white PVC pipes under the sink.</p> <p>c. There was a large amount of adhered dirt and dust on the white PVC pipes under the handwashing sink.</p> <p>d. There was a large amount of adhered dirt and grease and paper debris, cups and napkins behind the juice and coffee machines.</p> <p>e. There was a large amount of food and</p>			

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	<p>dirt along the wall behind the stoves and convection ovens. The wheels on the convection ovens were dirty and greasy.</p> <p>f. There was a large amount of dirt and food crumbs observed behind the dish machine and along the baseboard. The white PVC pipes were dirty under the dish machine. The white brick wall behind the dish machine was rusty.</p> <p>g. The bottom of the cabinets above the three compartment sinks were rusty and dirty.</p> <p>8. The following was observed during the Full Kitchen tour on 3/15/16 at 1:15 p.m., with the Dietary Food Manager (DFM):</p> <p>a. There was a large amount of dirt on the floor between the steam table and the wall. The wheels on the food prep table were dirty and greasy.</p> <p>b. There was a large accumulation of dirt and dust on the floor under the storage racks and along the baseboard in the dry food storage room.</p> <p>Interview with the DFM at that time, indicated all the above was in need of cleaning and/or repair.</p>			

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F 0469 SS=E Bldg. 00	<p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview, the facility failed to ensure it was free of pests related to ants and water bugs on 2 of 4 units throughout the facility. (Units 2 and 3)</p> <p>Findings include:</p> <p>1. On 3/11/16 at 9:39 a.m., live ants were observed near the bathtub in the bathroom of Room 302. Three residents resided in this room.</p> <p>On 3/14/16 at 12:58 p.m., a 3 inch black water bug was observed in the bathroom. The live ants also remained in the bathroom.</p> <p>Interview with the Maintenance Supervisor on 3/14/16 at 1:20 p.m., indicated that he would take care of the issue.</p> <p>2. On 3/10/16 at 10:55 a.m., there were dead ants under the floor register in Room 205. At this time, live ants were</p>	F 0469	<p>F469: ACTION TAKEN: Upon notification of findings. The noted areas were treated and /or cleaned of any ants or waterbugs. Monroe Pest Control came out on 03/25/16 and treated noted areas and other areas of the facility. A sweep of the facility was done on 03/15/16, 03/16/16 , 03/25/16(Monroe Pest Control) and 03/26/16. IDENTIFICATION OF OTHER RESIDENTS: Facility assessed residents and no other residents were identified at risk. MEASURES IN PLACE: The facility already has a policy and procedure for pest control. The contract with Monroe Pest Control has been terminated and the new Pest Control company of Orkin has been established effective 03/31/16. MONITORING OF CORRECTIVE ACTION: Maintenance Director and the Environmental Director will continue to observe for any further issues and address daily ongoing. The contract with the pest control company will continue to monitor 2x a month and address monthly ongoing. Finding will be</p>	04/15/2016

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 03/16/2016
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER			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>also observed underneath the resident's bed and by the night stand located next to the resident's bed. One resident resided in this room.</p> <p>On 3/14/16 at 12:55 p.m., the dead ants under the floor register as well as live ants were still observed in the room.</p> <p>Interview with the Maintenance Supervisor on 3/14/16 at 1:20 p.m., indicated that he would take care of the issue.</p> <p>3.1-19(f)(4)</p>		<p>reviewed per QA committee.</p>		