

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  03/17/2012
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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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F0000	<p>This visit was for the Investigation of Complaint IN00105351 and IN00105428. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint number IN00105351 substantiated, Federal/State deficiencies related to the allegations are cited at F 250, F 279, and F 323.</p> <p>Complaint IN00105428 substantiated no deficiencies related to the allegations are cited.</p> <p>Survey dates: March 13, and 14, 2012 Partial extended survey dates: March 15, 16, and 17, 2012</p> <p>Facility number: 000369 Provider number: 155530 AIM number: 100275190</p> <p>Survey Team: Janelyn Kulik, RN, TC Kitty Vargas, RN (March 15 and 16, 2012) Heather Tuttle, RN (March 15, 2012)</p> <p>Census bed type: SNF/NF: 82 Total: 82</p>	F0000		

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>Census payor type: Medicare: 6 Medicaid: 72 Other: 4 Total: 82</p> <p>Sample: 11 Supplemental Sample: 3</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/22/12 Cathy Emswiler RN</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure medically-related social services were provided for 2 of 7 residents reviewed with behaviors to maintain the highest practicable physical, mental and psychosocial well being of the residents related to not documenting or initiated interventions for a resident who wandered into other resident's rooms and for a resident who threw a cup of melted ice water at a resident. (Resident #B and Resident #M)</p> <p>Finding include:</p> <p>The closed record of Resident #B was reviewed on 3/13/12 at 7:14 p.m. Her diagnoses included, but were not limited to, atrial fibrillation, Alzheimer's Disease, Dementia, Depression, kyphosis (curvature of the spine) and psychotic disorder. The resident was admitted to the facility on 1/16/12.</p> <p>A nursing note dated 1/18/12 at 3:40 a.m., indicated the resident was redirected from wandering into other resident's rooms and off of the unit during sleeping hours.</p>	F0250	F250 Resident B cannot receive any corrective action as she is no longer in the facility. Resident M has been met with. She has no current behaviors. A black carpet has been placed in front of her door to keep other residents from going into her room. All residents with wandering behavior have the potential to be affected by this difficult practice. Nurses will be re-educated by DON/designee with an in-service on types of behaviors and interventions. All nursing staff will have time within the orientation on dementia, behaviors, and interventions by DON/designee. During the morning nursing management meeting, all residents are reviewed per 24 hour report. Any behaviors such as wandering are noted and the intervention will be reviewed. If necessary, intervention can be changed. The intervention is placed on the care card. There is a list of references for immediate interventions if the first redirection did not work. The nursing management meeting occurs 4-5 days weekly. All behaviors will be assessed for documentation, assessment, and intervention by DON/designee 2-3 times per	04/12/2012			

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	<p>A nursing note dated 1/27/12 at 5:00 p.m., indicated the resident was observed wandering in other resident's rooms on the unit. The resident's behavior was re-directed by staff at this time.</p> <p>A nursing note dated 2/9/12 at 1:15 p.m., indicated the resident continued to wander throughout the facility and in co-resident's rooms. The resident was redirected and diversions attempted with temporary results.</p> <p>A nursing note dated 2/13/12 at 9:30 p.m., indicated the resident was observed wandering on Unit 200 going in and out of other resident's room. The resident was redirected several times back to her room.</p> <p>A nursing note dated 2/14/12 at 12:00 p.m., indicated the resident requires constant redirection related to wandering often in other resident's room.</p> <p>A nursing note dated 2/17/12 at 5:30 p.m., indicated the resident was observed wandering in other resident's room on Unit 200. The resident was redirected by staff at this time.</p> <p>A nursing note dated 2/18/12 at 4:30 p.m., indicated the resident was noted</p>		<p>week. There will be a weekly behavior management meeting presented by the Social Services Director/designee where all behaviors will be reviewed for compliance and appropriateness of interventions. Indications for change will be noted and followed up by the Social Services Director/Designee within 24 hours of the meeting. A monthly compliance report with noted changes and behaviors will be presented by Admin/designee and reviewed at the monthly QI meeting for recommendations. As the facility has multiple behaviors, these meetings will continue for at least 6 months prior to being evaluated for any reduction which will be at a maximum of every other month. An audit of 50% of recommendations compliance will be audited and corrected if indicated by the Adm/designee. QI will be mandatorily monthly, if necessary the date can be changed. Initial compliance 4/12/12.</p>		

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	<p>wandering in other resident's room at this time. The resident was redirected to her room.</p> <p>A nursing note dated 2/19/12 at 6:00 p.m., indicated the resident was observed wandering towards Unit 300 and had attempted to go into another resident's room. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/4/12 at 6:00 p.m., indicated the resident was observed wandering into room on Unit 300. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/6/12 at 4:00 a.m., indicated resident received in bed asleep and slept the duration of the night until 3:50 a.m. The resident ambulated with a steady gait, no agitation was noted. at 6:30 a.m. a late entry was made for 4:15 a.m. indicating the resident was ambulating in the hallway in a pleasant mood. Care was provided by staff with no problems. The resident was given a toy doll and she began to talk to it, smile and sit with the baby. The resident was offered a puzzle, snacks and water and cooperated completely with staff. Some redirection was needed to keep the resident in eye sight of staff. At 6:30 a.m. the resident was observed laying on the</p>			

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	<p>ground in front of (Resident #C's room number) in the hallway on her left side. She did not respond to her name being called. Carotid pulse was palpable and emergency response was called (911). Pupils were fixed at 5. The resident remained unresponsive for 45 seconds. The resident began to make sounds that were not words and continued to do so for approximately 30 seconds. The resident then began to speak in complete sentences. The resident's right ear was observed to be bright red and warm to touch. The resident complained of pain to her ear. After the resident was responsive she began to try and get up but was directed to lay still. The resident complained of pain to the left side. The resident was taken to the hospital by ambulance for evaluation. The physician and family were notified.</p> <p>A social service note dated 3/5/12 indicated a mood/behavioral sheet for 3/2/12 was received indicating that the resident was wandering into other resident's rooms and cursing staff for re-directing her. A second mood behavior sheet indicated the resident was exit seeking and cursing at others. A third mood/behavior sheet indicated the resident was wandering into other rooms and cursing at CNA's. Re-direction and 1:1 were used with the resident.</p>				

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	<p>An Institute for Health Behavior Change, Clinical Assessment form dated 2/13/12 and signed by the Psychologist indicated a problem of the resident reportedly had been displaying altered mental status, she had been displaying irritable mood, was argumentative and was insensitive to others. She also intruded into the privacy of other residents. The approach was for behavioral interventions to manage problem behavior.</p> <p>An admission Minimum Data Set (MDS) Assessment dated 1/24/12, indicated The resident could be understood and understands others. She scored a 3 on her Brief Interview for Mental Status which indicated she was severely impaired cognitively. She had disorganized thinking and wandering occurred daily.</p> <p>Interview with the Social Service Director on 3/15/12 at 2:15 p.m., indicated Resident #B did wander into other resident's rooms. She indicated the resident was to be monitored, redirected, and one on one if possible. She indicated she would meet with the CNAs and discuss the issue but it was not documented. She could not educate Resident #B because she would not remember. She further indicated Resident #B did not wander at specific</p>			

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	<p>times of day it was all of the time. She also indicated Resident #B did not attempt to open doors she went into rooms where the door was open. She further indicated Resident #B had an incident with Resident # M when Resident #B entered Resident #M's room. At this time Resident #M yelled at Resident #B and when Resident #B would not leave her room Resident #M threw a cup of water with melted ice at Resident #B. The Social Service Director indicated at that time she indicated to staff to have a watchful eye on the resident. The Social Service Director indicated this was the same plan that was in place prior to the incident. She also indicated there was usually one CNA on the unit and sometime a nurse but other times a nurse floats between Units 200 and 300. She indicated if there was only one nurse and she was on Unit 300 and the CNA was in a room with another resident there would be no one to monitor Resident #B.</p> <p>There was no documentation in the resident's records of the incident of the resident entering another resident's room and having water thrown at her or of any interventions being put in place in regards to the resident wandering into other resident's rooms.</p> <p>The record for Resident #M was reviewed</p>						

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	<p>on 3/14/12 at 2:50 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, gout and hypertension.</p> <p>A quarterly Minimum Data Set Assessment Dated 1/26/12, indicated the resident made herself understood and had the ability to understand. She scored a 15 on the Brief Interview of Mental Status indicating she was cognitively intact.</p> <p>Interview with Resident #M on 3/15/12 at 2:30 p.m. with the Social Service Director present, indicated the resident self propelled her wheelchair to her room which was located at the end of Unit 200 by the exit door. She was the only resident in the room. Resident #M indicated she had a lot of pain in her feet due to gout. She indicated they hurt very much, she also indicated that she had just quit smoking and she wanted to smoke so being frustrated with all of her issues, "I was getting tired of residents coming in my room." Resident #M stated that one day Resident #B entered my room and she came all the way in my room, the door was always open, so she would always walk in my room. She would walk towards my bed and closet and say "that's not your s--- those are my clothes, this is not your room, this is my room". One day when I was so frustrated and in</p>						

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	<p>pain, I just got tired of her coming in so there was a cup of melted ice and water in it. I Took the cup of water and threw it at her. Resident #M state, "I did not hit her with the water." The water was just enough to make her "shutter' and get scared enough that she left the room. Resident #M indicated the Social Service Director was the only person who came down after the incident and talked to her about it. After the incident Resident #B would still come in the room but would talk to her and they offered each other food. Both Resident #M and the Social Service Director indicated the incident took place on approximately 1/24/12. Upon exiting the room of Resident #M, the Social Service Director indicated she had not documented the incident between Resident #B and Resident #M.</p> <p>There was no documentation in the resident's record of the incident between Resident #M and Resident #B.</p> <p>The Federal tag relates to complaint IN00105351.</p> <p>3.1-34(a)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 record review and interview, the facility failed to ensure a care plan was developed for 1 of 7 residents reviewed with behaviors in a sample of 11 related to resident wandering into other resident's rooms. (Resident #B)</p> <p>Findings included:</p> <p>The closed record of Resident #B was reviewed on 3/13/12 at 7:14 p.m. Her diagnoses included, but were not limited to, atrial fibrillation, Alzheimer's Disease, Dementia, Depression, kyphosis</p>	F0279	Plan of Correction F279 The care plan of resident B cannot be corrected as she is no longer in the facility. Resident M did not trigger any behaviors per her MDS. She is cognitively alert. All residents with behaviors, i.e. wandering have the possibility of being affected by this deficient practice. All residents with wandering triggers per the MDS or any documented new behaviors are having their care plan immediately updated for accuracy by the SSD/designee Care plans are going to be audited by the DON/designee weekly for compliance. A	04/12/2012	

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	<p>(curvature of the spine) and psychotic disorder. The resident was admitted to the facility on 1/16/12.</p> <p>A nursing note dated 1/18/12 at 3:40 a.m., indicated the resident was redirected from wandering into other resident's rooms and off of the unit during sleeping hours.</p> <p>A nursing note dated 1/27/12 at 5:00 p.m., indicated the resident was observed wandering in other resident's rooms on the unit. The resident's behavior was re-directed by staff at this time.</p> <p>A nursing note dated 2/9/12 at 1:15 p.m., indicated the resident continued to wander throughout the facility and in co-resident's rooms. The resident was redirected and diversions attempted with temporary results.</p> <p>A nursing note dated 2/13/12 at 9:30 p.m., indicated the resident was observed wandering on Unit 200 going in and out of other resident's room. The resident was redirected several times back to her room.</p> <p>A nursing note dated 2/14/12 at 12:00 p.m., indicated the resident requires constant redirection related to wandering often in other resident's room.</p>		<p>minimum of 5 will be done weekly with some old and some new behaviors which occurred during the week. The continuation of care plan audits will be for the next 90 days. Every 30 days, they will be reviewed at the QI committee for recommendations. If audits are positive, then for the next 90 days, two will be completed by DON/designee and upon recommendations, QI will be quarterly. This will be completed by 4/12/12.</p>		

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	<p>A nursing note dated 2/17/12 at 5:30 p.m., indicated the resident was observed wandering in other resident's room on Unit 200. The resident was redirected by staff at this time.</p> <p>A nursing note dated 2/18/12 at 4:30 p.m., indicated the resident was noted wandering in other resident's room at this time. The resident was redirected to her room.</p> <p>A nursing note dated 2/19/12 at 6:00 p.m., indicated the resident was observed wandering towards Unit 300 and had attempted to go into another resident's room. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/4/12 at 6:00 p.m., indicated the resident was observed wandering into room on Unit 300. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/6/12 at 4:00 a.m., indicated resident received in bed asleep and slept the duration of the night until 3:50 a.m. The resident ambulated with a steady gait, no agitation was noted. at 6:30 a.m. a late entry was made for 4:15 a.m. indicating the resident was ambulating in the hallway in a pleasant mood. Care was provided by staff with</p>			

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	<p>no problems. The resident was given a toy doll and she began to talk to it, smile and sit with the baby. The resident was offered a puzzle, snacks and water and cooperated completely with staff. Some redirection was needed to keep the resident in eye sight of staff. At 6:30 a.m. the resident was observed laying on the ground in front of (Resident #C's room number) in the hallway on her left side. She did not respond to her name being called. Carotid pulse was palpable and emergency response was called (911). Pupils were fixed at 5. The resident remained unresponsive for 45 seconds. The resident began to make sounds that were not words and continued to do so for approximately 30 seconds. The resident then began to speak in complete sentences. The resident's right ear was observed to be bright red and warm to touch. The resident complained of pain to her ear. After the resident was responsive she began to try and get up but was directed to lay still. The resident complained of pain to the left side. The resident was taken to the hospital by ambulance for evaluation. The physician and family were notified.</p> <p>A social service note dated 3/5/12 indicated a mood/behavioral sheet for 3/2/12 was received indicating that the resident was wandering into other</p>				

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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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	<p>resident's rooms and cursing staff for re-directing her. A second mood behavior sheet indicated that the resident was exit seeking and cursing at others. A third mood/behavior sheet indicated the resident was wandering into other rooms and cursing at CNA's. Re-direction and 1:1 were used with resident.</p> <p>An Institute for Health Behavior Change, Clinical Assessment form dated 2/13/12 and signed by the Psychologist indicated a problem of the resident reportedly had been displaying altered mental status, she had been displaying irritable mood, was argumentative and was insensitive to others. She also intruded into the privacy of other residents. The approach was for behavioral interventions to manage problem behavior.</p> <p>An admission Minimum Data Set (MDS) Assessment dated 1/24/12, indicated The resident could be understood and understands others. She scored a 3 on her Brief Interview for Mental Status which indicated she was severely impaired cognitively. She had disorganized thinking and wandering occurred daily. Review of the Care Area Assessment Summary the care area of behavioral symptoms was marked as triggered. There was a "N" marked in the box to addressed in a care plan. There was no</p>						

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	<p>indication as to why the behavior symptoms were not addressed in a care plan.</p> <p>Review of the Behavior Weekly Meet dated 2/24/12 and provided by the Social Service Director on 3/15/12 at 2:45 p.m. indicated Resident #B with a behavior problem of wandering and wandering into rooms. The current intervention was Psychiatrist and Psychologist.</p> <p>A Behavioral Management Documentation for March 2012 provided by the Social Service Director on 3/15/12 at 2:45 p.m., indicated 3/6/12 on the 11-7 shift a behavior of continuous pacing or wandering in the hallway. The interventions provided were re-direction, one-on-one, and gave food or snack. The interventions had a positive outcome.</p> <p>The resident's care plans were reviewed and there were no care plans regarding the resident's wandering into other resident's room. The resident's care plans included: taking medication for depression, adjustment to nursing home placement, potential for increasing confusion secondary to dementia, potential for increasing confusion secondary to Alzheimer's disease which was initiated on 1/16/12, potential to exhibit signs or emotional distress and verbally abusive</p>			

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	<p>which were initiated on 1/23/12, at nutritional risk and alteration in skin integrity which were initiated on 1/24/12, and elopement risk which was initiated on 1/25/12.</p> <p>Interview with the Administrator on 3/15/12 at 9:00 a.m., indicated she would have to see if Resident #B had a care plan for wandering into other resident's rooms. The Administrator did not provided any additional information during the survey process.</p> <p>Interview with the Social Service Director on 3/15/12 at 2:15 p.m., indicated Resident #B did wander into other resident's rooms. She indicated the resident was to be monitored, redirected, and one on one if possible. She indicated she would meet with the CNAs and discuss the issue but it was not documented. She could not educate Resident #B because she would not remember. She further indicated Resident #B did not wander at specific times of day it was all of the time. She also indicated Resident #B did not attempt to open doors she went into rooms where the door was open. She further indicated Resident #B had an incident with Resident # M when Resident #B entered Resident #M's room. At this time Resident #M yelled at</p>			

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	<p>Resident #B and when Resident #B would not leave her room she threw a cup of water with melted ice at Resident #B. The Social Service Director indicated at that time she indicated to staff to have a watchful eye on the resident. The Social Service Director indicated this was the same plan that was in place prior to the incident. She also indicated there was usually one CNA on the unit and sometime a nurse but other times a nurse floats between Units 200 and 300. She indicated if there was only one nurse and she was on Unit 300 and the CNA was in a room with another resident there would be no one to monitor Resident #B.</p> <p>There was no documentation in the resident's records of the incident of the resident entering another resident's room and having water thrown at her or of any interventions being put in place in regards to the resident wandering into other resident's rooms.</p> <p>Interview with the Administrator on 3/16/12 at 10:40 a.m., indicated the one-on-one intervention on the Behavior Documentation Form was for "a moment in time". The one-on-one would be stopped once the behavior ceases.</p> <p>Interview with the MDS Coordinator on 3/16/12 at 2:17 p.m., indicated when the</p>			

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	<p>resident's MDS was completed she did not understand if areas triggered it was her responsibility to make sure a care plan was in place. She further indicated different sections of the MDS are completed by different staff members such as Social Service. She also indicated when the MDS for 1/24/12 was completed and the wandering triggered she did not know she needed to complete a care plan or provide a reason as to why the care plan was not completed.</p> <p>The record for Resident #M was reviewed on 3/14/12 at 2:50 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, gout and hypertension.</p> <p>A quarterly Minimum Data Set Assessment Dated 1/26/12, indicated the resident made herself understood and had the ability to understand. She scored a 15 on the Brief Interview of Mental Status indicating she was cognitively intact.</p> <p>This Federal tag relates to complaint IN00105351.</p> <p>3.1-35(a)</p>				

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F0323 SS=J	<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.</p> <p>Based on record review and interview the facility failed to ensure residents received adequate supervision for 3 of 7 residents reviewed for behaviors in a sample of 11 related to a resident wandering into other resident's room with no interventions provided and a resident with territorial behavior to residents approaching his room with no interventions provided resulting in Resident #B approaching Resident #C's room, a confrontation between Resident #C and Resident #B, resulting in Resident #B falling, being taken to the hospital with multiple ecchymosis (bruises) on the face and a bilateral brain contusion (bruise) and subarachnoid hemorrhage (brain bleed) and subsequently dying. (Resident #B, Resident #C, and Resident #M)</p> <p>The Immediate Jeopardy began on 3/6/12 when Resident #B was walking past Resident #C's room, CNA #1 heard Resident #C yelling, heard a slap and thump and walked around the pulled room curtain to find Resident #B lying on the floor in the doorway of Resident #C's</p>	F0323	F323 The facility must develop and implement written policies and procedures that provide safety for all residents. On the morning of 3/6/12 at approximately 6:45 a.m. RC, per his normal routine, was sitting at his doorway before breakfast. RB was noted to be wandering in the hall. On the same unit, a CNA was preparing RC's roommate for a room change when she heard a noise and went in to the area where RC and RB were identified. RB was lying on the floor outside RC's room and he was standing over her. The CNA immediately alerted staff that she required assistance and other staff did arrive. An assessment was done on RB and 911 was called. She was immediately transported to the local ER. RC was assessed and went to the local ER for evaluation. Two police officers were here and appraised of the situation. The Administrator was immediately notified and appropriate notification of physicians, POA's, local police and the state. An investigation as to the circumstances of the event was initiated. Steps that were taken:	04/12/2012			

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	<p>room. CNA #1 asked Resident #C what he had done and Resident #C, stated "you ain' t s---). The Administrator was notified of the immediate jeopardy at 11:55 a.m. on 3/15/12. The immediate jeopardy was removed on 3/17/12 at 11:15 a.m., but non compliance remained at the lower scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings included:</p> <p>The closed record of Resident #B was reviewed on 3/13/12 at 7:14 p.m. Her diagnoses included, but were not limited to, atrial fibrillation, Alzheimer's Disease, Dementia, Depression, kyphosis (curvature of the spine) and psychotic disorder. The resident was admitted to the facility on 1/16/12.</p> <p>A nursing note dated 1/18/12 at 3:40 a.m., indicated the resident was redirected from wandering into other resident's rooms and off of the unit during sleeping hours.</p> <p>A nursing note dated 1/27/12 at 5:00 p.m., indicated the resident was observed wandering in other resident's rooms on the unit. The resident's behavior was re-directed by staff at this time.</p>		<p>A. On 3/6/12 RC and RB were both sent to the local hospital for evaluation. 911 was called and two police officers were dispatched. B. On 3/6/12 RB was admitted to the hospital for treatment of a head injury. C. On 3/6/12 RC was returned to the facility after evaluation with no specific instructions or treatment. When RC was returned to the facility, he was placed on close constant supervision (Attachment A). D. On 3/6/12 interviews were conducted with staff and residents in the area. It was reported that both residents were engaged in their normal morning activity and there was no change in with RC or RB prior to the event. The event was not witnessed. (Attachment B). E. On 3/6/12 RC was evaluated by the IDT to determine appropriateness for continued placement at the facility (Attachment D). It was determined that further evaluation was needed so the resident would remain on constant supervision until placement could be found for a Geri-psych review. F. On 3/6/12 RC's care plan was reviewed and found to be accurate but additional appropriate interventions were added (Attachment E). G. On 3/6/12 RC's behavior tracking was reviewed and there have been no new behaviors or issues observed prior to the event (Attachment F). H. On 3/8/12 RC was transferred to a Geri-psych</p>				

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	<p>A nursing note dated 2/9/12 at 1:15 p.m., indicated the resident continued to wander throughout the facility and in co-resident's rooms. The resident was redirected and diversions attempted with temporary results.</p> <p>A nursing note dated 2/13/12 at 9:30 p.m., indicated the resident was observed wandering on Unit 200 going in and out of other resident's room. The resident was redirected several times back to her room.</p> <p>A nursing note dated 2/14/12 at 12:00 p.m., indicated the resident requires constant redirection related to wandering often in other resident's room.</p> <p>A nursing note dated 2/17/12 at 5:30 p.m., indicated the resident was observed wandering in other resident's room on Unit 200. The resident was redirected by staff at this time.</p> <p>A nursing note dated 2/18/12 at 4:30 p.m., indicated the resident was noted wandering in other resident's room at this time. The resident was redirected to her room.</p> <p>A nursing note dated 2/19/12 at 6:00 p.m., indicated the resident was observed wandering towards Unit 300 and had</p>		<p>unit for evaluation. I. On 3/9/12 staff was in-serviced on appropriate behavior tracking, interventions and wandering residents (Attachment G). J. On 3/13/12 staff initiated a review of all resident with behaviors or a diagnosis related to possible behaviors for appropriateness in care planning interventions and monitoring. K. Resident b cannot receive corrective action as she is no longer a resident in the facility. L. Resident M has been reassessed. A black carpet has been placed in her doorway to dissuade other resident from going into her room. M. Resident C has been reassessed. He had an emergency ER evaluation on 3/6/12. He was seen by a psychiatrist on 3/6/12 at the facility. He was sent out to the geropsych unit at Methodist Hospital from 3/8/12 to 3/12/12. Upon his return, we have placed a nursing assistant to monitor him continuously. He is following up with a psychiatrist. N. Care plans needing behavior interventions are being updated by SSD/designee. O. Care cards are in place for all residents. They will be updated as indicated, but no less than quarterly during the care plan meeting. All new admissions will have the care card initiated and audited by the care plan team. At first care plan audit, compliance will be audited at first care plan meeting &amp; presented to admin/designee for</p>		

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	<p>attempted to go into another resident's room. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/4/12 at 6:00 p.m., indicated the resident was observed wandering into room on Unit 300. The resident was redirected by staff at this time back to Unit 200.</p> <p>A nursing note dated 3/6/12 at 4:00 a.m., indicated resident received in bed asleep and slept the duration of the night until 3:50 a.m. The resident ambulated with a steady gait, no agitation was noted. at 6:30 a.m. a late entry was made for 4:15 a.m. indicating the resident was ambulating in the hallway in a pleasant mood. Care was provided by staff with no problems. The resident was given a toy doll and she began to talk to it, smile and sit with the baby. The resident was offered a puzzle, snacks and water and cooperated completely with staff. Some redirection was needed to keep the resident in eye sight of staff. At 6:30 a.m. the resident was observed laying on the ground in front of (Resident #C's room number) in the hallway on her left side. She did not respond to her name being called. Carotid pulse was palpable and emergency response was called (911). Pupils were fixed at 5. The resident remained unresponsive for 45 seconds.</p>		<p>follow up. P. The behaviors of all residents receiving specific interventions will be reviewed weekly for appropriateness by the behavioral care plan team. Q. An audit will be maintained to note residents with behaviors and those needing adjustments and interventions. This will be reviewed in the monthly QI meeting. R. This audit will continue minimally monthly x 6 and maximally bi-monthly. The audits will be presented by Adm/designee for recommendations and/or change for improvement. Dates of completion 4/12/12. Residents with dementia with behaviors or psychiatric conditions exhibiting behaviors have the potential to be affected by the alleged deficient practice for residents with known behaviors; however due to the implementation of the 1A-H, the alleged deficient practice will not reoccur. Residents have been reevaluated to be territorial to their specific space at any specific time. However, this does not occur daily. It is care planned. Care cards are being initialized for all residents effective 3/16/12 at 3:00 p.m., with an in-service instructing pertinent staff. Wandering or territorial behavior is noted with interventions. Any change in care needs is the responsibility of the nurse noting the change. The following systematic measures have been implemented to</p>				

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	<p>The resident began to make sounds that were not words and continued to do so for approximately 30 seconds. The resident then began to speak in complete sentences. The resident's right ear was observed to be bright red and warm to touch. The resident complained of pain to her ear. After the resident was responsive she began to try and get up but was directed to lay still. The resident complained of pain to the left side. The resident was taken to the hospital by ambulance for evaluation. The physician and family were notified.</p> <p>A hospital records provided by the facility and reviewed on 3/15/12 at 2:00 p.m., indicated on the H &amp; P (History and Physical) Note on 3/7/12 the chief complaint of a subarachnoid hemorrhage. "(Resident #B's name and age) female admitted with history of Alzheimer's disease at present he (sic) was at the nursing home was pushed by another resident and fell down she was noted to have multiple ecchymosis on the face she was brought to the ER (emergency room) where she was noted to have bilateral brain contusion and a subarachnoid hemorrhage she is now admitted to the ICU (Intensive Care Unit) for further treatment and already been seen by neurosurgeon. A physician Discharge Summary</p>		<p>ensure alleged deficient practice does not recur. The care cards will be monitored weekly post behavioral meeting within 24 hours by DON/designee.A. The facility has reviewed the existing pre-screening practice and has implemented a Pre-Screening Questionnaire and Assessment to be completed prior to admission for review by IDT. The form will be initiated by marketing/designee, completed, and returned to medical records/designee for compliance. B. Any change of new behavior will be reviewed at the morning meeting. The intervention noted on the care card will be reviewed for immediate effectiveness by Social Services/designee C. The Administrator, Director of Nursing, and SSD will review all residents with behaviors and behavior tracking issues at the weekly Quality Improvement Behavior meeting to monitor appropriateness of placement and care for the residents with behaviors and make recommendations as needed. (attachement) D. All residents were reviewed focusing on behaviors. Behaviors were identified and interventions placed on care cards. These interventions will be updated for evaluations of behaviors (Attachment H). Care plans will be reviewed by SSD/designee post completion of behavior meeting as indicated.</p>				

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	<p>indicated an admission date of 3/6/12. The hospital course: "patient was seen and evaluated in the ER, found to have brain contusion and SAH (subarachnoid hemorrhage), admitted to ICU, no intervention was recommended by neuro surgery service, patient was made DNR (Do Not Resuscitate), and started on comfort care, expired 3/11/12, 11:11 a.m.</p> <p>A social service note dated 3/5/12 indicated a mood/behavioral sheet for 3/2/12 was received indicating that the resident was wandering into other resident's rooms and cursing staff for re-directing her. A second mood behavior sheet indicated that the resident was exit seeking and cursing at others. A third mood/behavior sheet indicated the resident was wandering into other rooms and cursing at CNA's. Re-direction and 1:1 were used with resident.</p> <p>An Institute for Health Behavior Change, Clinical Assessment form dated 2/13/12 and signed by the Psychologist indicated a problem of the resident reportedly had been displaying altered mental status, she had been displaying irritable mood, was argumentative and was insensitive to others. She also intruded into the privacy of other residents. The approach was for behavioral interventions to manage problem behavior.</p>		<p>Administrator/designee will audit 3 behaviors for compliance. E. The form of behavior management has been updated for clarification (Attachment I). F. The SSD/designee will contact appropriate psychiatric resources as needed for residents with identified issues. G. The facility continues to educate new staff on how to interact with residents with behaviors during the orientation process by DON/designee. H. Existing staff will be continually in-serviced at the monthly meeting with regards to a specific behavior/dementia process and interventions by Administrator/designee. I. A contact has been made with Total Care Solutions to provide all psychiatric services. They have initiated seeing the residents and once all visits are initiated, a schedule will be maintained. The following Quality Assurance Programs have been implemented to ensure the alleged deficient practice does not reoccur: A. The Director of Nursing/designee will review the 24 -hour nursing report five times per week to ensure behaviors are dealt with appropriately (medically or with psychiatric services) and report concerns and issues to the Administrator and SSD for required action. B. The IDT will review concerns related to behaviors weekly during the Quality Improvement Behavior Meeting and will continue to</p>				

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	<p>An admission Minimum Data Set (MDS) Assessment dated 1/24/12, indicated The resident could be understood and understands others. She scored a 3 on her Brief Interview for Mental Status which indicated she was severely impaired cognitively. She had disorganized thinking and wandering occurred daily.</p> <p>Review of the Behavior Weekly Meet dated 2/24/12 and provided by the Social Service Director on 3/15/12 at 2:45 p.m. indicated Resident #B with a behavior problem of wandering and wandering into rooms. The current intervention was Psychiatrist and Psychologist.</p> <p>A Behavioral Management Documentation for March 2012 provided by the Social Service Director on 3/15/12 at 2:45 p.m., indicated 3/6/12 on the 11-7 shift a behavior of continuous pacing or wandering in the hallway. The interventions provided were re-direction, one-on-one, and gave food or snack. The interventions had a positive outcome.</p> <p>The resident's care plans were reviewed and there were no care plans regarding the resident's wandering into other resident's room. The resident's care plans included: taking medication for depression, adjustment to nursing home placement,</p>		<p>review services provided. <i>This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.</i></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  03/17/2012
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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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	<p>potential for increasing confusion secondary to dementia, potential for increasing confusion secondary to Alzheimer's disease which was initiated on 1/16/12, potential to exhibit signs or emotional distress and verbally abusive which were initiated on 1/23/12, at nutritional risk and alteration in skin integrity which were initiated on 1/24/12, and elopement risk which was initiated on 1/25/12.</p> <p>Interview with the Administrator on 3/15/12 at 9:00 a.m., indicated she would have to see if Resident #B had a care plan for wandering into other resident's rooms. The Administrator had no additional information to add during the survey process.</p> <p>Interview with the Social Service Director on 3/15/12 at 2:15 p.m., indicated Resident #B did wander into other resident's rooms. She indicated the resident was to be monitored, redirected, and one on one if possible. She indicated she would meet with the CNAs and discuss the issue but it was not documented. She could not educate Resident #B because she would not remember. She further indicated Resident #B did not wander at specific times of day it was all of the time. She also indicated Resident #B did not</p>			

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	<p>attempt to open doors she went into rooms where the door was open. She further indicated Resident #B had an incident with Resident # M when Resident #B entered Resident #M's room. At this time Resident #M yelled at Resident #B and when Resident #B would not leave her room she threw a cup of water with melted ice at Resident #B. The Social Service Director indicated at that time she indicated to staff to have a watchful eye on the resident. The Social Service Director indicated this was the same plan that was in place prior to the incident. She also indicated there was usually one CNA on the unit and sometime a nurse but other times a nurse floats between Units 200 and 300. She indicated if there was only one nurse and she was on Unit 300 and the CNA was in a room with another resident there would be no one to monitor Resident #B.</p> <p>There was no documentation in the resident's records of the incident of the resident entering another resident's room and having water thrown at her or of any interventions being put in place in regards to the resident wandering into other resident's rooms.</p> <p>Interview with the Administrator on 3/16/12 at 10:40 a.m., indicated the one-on-one intervention on the Behavior</p>				

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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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	<p>Documentation Form was for "a moment in time". The one-on-one would be stopped once the behavior ceases.</p> <p>Interview with the MDS Coordinator on 3/16/12 at 2:17 p.m., indicated when the resident's MDS was completed she did not understand if areas triggered it was her responsibility to make sure a care plan was in place. She further indicated different sections of the MDS are completed by different staff members such as Social Service. She also indicated when the MDS for 1/24/12 was completed and the wandering triggered she did not know she needed to complete a care plan or provide a reason as to why the care plan was not completed.</p> <p>The record for Resident #M was reviewed on 3/14/12 at 2:50 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, gout and hypertension.</p> <p>A quarterly Minimum Data Set Assessment Dated 1/26/12, indicated the resident made herself understood and had the ability to understand. She scored a 15 on the Brief Interview of Mental Status indicating she was cognitively intact.</p> <p>Interview with Resident #M on 3/15/12 at 2:30 p.m. with the Social Service Director</p>						

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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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(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>present, indicated the resident self propelled her wheelchair to her room which was located at the end of Unit 200 by the exit door. She was the only resident in the room. Resident #M indicated she had a lot of pain in her feet due to gout. She indicated they hurt very much, she also indicated that she had just quit smoking and she wanted to smoke so being frustrated with all of her issues, "I was getting tired of residents coming in my room." Resident #M stated that one day Resident #B entered my room and she came all the way in my room, the door was always open, so she would always walk in my room. She would walk towards my bed and closet and say "that's not your s--- those are my clothes, this is not your room, this is my room". One day when I was so frustrated and in pain, I just got tired of her coming in so there was a cup of melted ice and water in it. I Took the cup of water and threw it at her. Resident #M state, "I did not hit her with the water." The water was just enough to make her "shutter' and get scared enough that she left the room. Resident #M indicated the Social Service Director was the only person who came down after the incident and talked to her about it. After the incident Resident #B would still come in the room but would talk to her and they offered each other food. Both Resident #M and the Social</p>			

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	<p>Service Director indicated the incident took place on approximately 1/24/12. Upon exiting the room of Resident #M, the Social Service Director indicated she had not documented the incident between Resident #B and Resident #M.</p> <p>There was no documentation in the resident's record of the incident between Resident #M and Resident #B.</p> <p>The record for Resident #C was reviewed on 3/13/12 at 6:55 p.m. His diagnoses included, but were not limited to, congestive heart failure, hypertension ,encephalopathy (dysfunction of the brain), and dementia. The resident was admitted to the facility on 10/17/09.</p> <p>A nursing note dated 3/6/12 at 6:30 a.m., indicated the resident was observed in the doorway yelling and cursing at another resident. The resident became aggressive with staff with fists clenched. When the resident was directed to have a seat the resident refused but after 2 more attempts at redirection the resident sat down and calmed down. The physician and family were made aware and the resident was sent to the hospital. There was nothing observed to have caused agitated state in resident. Staff did not see or hear any provocation. At 6:55 a.m. the resident was calm and in his room. There were no</p>				

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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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	<p>aggressive behaviors noted.</p> <p>A social service note dated 2/13/12 indicated a quarterly note for 2/7/12 to 2/13/12. The resident does get highly agitated at times. The triggers are not yet identified. He appears to show agitation infrequently.</p> <p>A social service note dated 3/6/12 indicated, the Social Service Director was informed that the resident pushed another resident which caused her fall on the floor and hit her head. the Social Service Director met with the resident after he had come back from being sent to the ER. the resident was informed that he hurt someone. The resident said, "So what, I don't care." The resident had a 1:1 with staff. The resident met with the Psychiatrist and was given a diagnosis of dementia with delusions.</p> <p>An activity note dated 2/13/12 indicated, Resident #C had to be redirected because he is territorial. He likes to have things his way.</p> <p>Review of Resident #C's care plans, indicated a problem of being very prone to belligerence and combative behavior towards staff and other patients related to his dementia. The care plan was dated 2/23/12. The interventions included, but</p>			

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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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	<p>were not limited to, approach calmly and be aware of sudden belligerence, listen to the resident attentively. Encourage the resident to discuss his interest of concerns, attempt to refocus behaviors to something positive, inform the resident when the behavior is inappropriate, and document all inappropriate conversations with the resident.</p> <p>The quarterly Minimum Data Set Assessment dated 2/24/12, indicated the resident could understand others and could be understood. He scored a 5 on his Brief Interview of Mental Status which indicated he was severely cognitively impaired. He had no behaviors.</p> <p>An Initial Reportable Incident form reviewed on 3/14/12 at 2:00 p.m., indicated the incident took place on 3/6/12 at 6:30 a.m. involving residents involved were Resident #B and Resident #C. Resident #C was cursing and yelling while standing over Resident #B and pushed her and she fell to the floor hitting her head. Staff went to her assistance and Resident #C was redirected to sit down while staff attended to Resident #B. Both residents were sent to the hospital to be evaluated.</p> <p>Type of injury/injuries: Possible head injury to Resident #B and Resident #C's</p>				

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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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	<p>injuries were unknown.</p> <p>Immediate Action Taken: Both patients were separated and provided medical assistance.</p> <p>Prevention Measure taken: Monitor patients at all times and monitor for changes in behavior.</p> <p>A follow up Reportable incident form was reviewed on 3/14/12 at 2:10 p.m., indicated the incident occurred on 3/6/12 at 6:30 a.m. The resident's involved were Resident #B and Resident #C. A brief description of the incident: Resident #B was on the ground in front of (Room number of Resident #C) in the hall. She was non-responsive for under one minute. Her right ear was red and she complained of pain to the left side. Resident #C was standing over her yelling and cursing. CNA #1 was in Resident #C's room packing the other resident's belongings. There were no witnesses to the occurrence. 911 was called and two police officers were sent out with paramedics. The police were appraised of the situation.</p> <p>Type of Injury/Injuries: Resident #B was evaluated at the hospital with a diagnosis of a subdural hematoma.</p> <p>Immediate action taken: Resident #C was put on behavior watch until a bed was available in the Geropsych unit so he could have further evaluation.</p>			

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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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	<p>Preventive Measures Taken: All staff were re-in-serviced on behavior and wander management as part of dementia training.</p> <p>A written interview provided with the reportable incidents from CNA #1 indicated, I was in Resident #C's room packing his roommates clothes into boxed. "I hear (sic) when (Resident #B's name) hit the floor by (Resident #C's name) pushing her down. He kept used (sic) bad words and stand over her until I got more help to help me sit him down." I did not hear Resident #B say anything to Resident #C. He had been in a bad mood ever since I washed him up and got him dressed.</p> <p>A written interview provided with the reportable incident form by LPN #3 for Resident #B, indicated " I saw the aid (sic) come to the end of the hallway of Unit 2 and call for help. Both (Maintenance Manager's name) and I ran over and saw (Resident #B's name) laying on the ground on her left shoulder. She did not respond when I called her name. I felt her pulse and ran to call 911. The CNA stayed with (Resident #B's name) at that time. When assessing her she began to babble and try (sic) to get up. She was instructed to remain still and cooperated with staff. She began to talk clearly and</p>						

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	<p>tried to get up more and became agitated. The pain in her left side kept her down. Ambulance arrived &amp; (and) resident was confused &amp; agitated.</p> <p>A separate written interview provided with the reportable incident forms by LPN #3 for Resident #C, indicated "Resident was observed standing up in his doorway with fists clenched, cursing and yelling at (Resident #B's name) who was laying on the ground unresponsive. (Maintenance Manager's name) ran over to assist and (Resident #C's name) continued to be aggressive with him. (Resident #C's name) was directed to sit down and close his door while staff attended to (Resident #B's name). At first he refused but after stern direction he did sit down and close (sic) his door. Resident was taken to (name of hospital)."</p> <p>Interview with CNA #1 on 3/14/12 at 12:50 p.m., indicated she was in the room of Resident #C helping his roommate pack his belongings. The curtain was pulled and she had her back to the door. She indicated she did not see Resident #C touch or make any contact with Resident #B. She heard Resident #C said, "you ain't s---." She then heard a "slap or clap" sound she went around the curtain and (Resident #B) was on the floor. She further indicated she thought the sound</p>				

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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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	<p>she heard was Resident #C making contact with Resident #B not Resident #B hitting the floor. She asked Resident #C what did you do and the resident responded "you ain' t s---." She also indicated Resident #C had been fussy that morning. She indicated he would get irate at time and he would cuss and fuss. She never saw him out of control.</p> <p>Interview with LPN #1 on 3/13/12 at 7:35 p.m., indicated Resident #C was very territorial about his room. He would sit in a chair by the door and when residents would get near his door he would yell. Resident #B yelled and used profanity. She would exit seek and go into other resident's room. She had tried to get into Resident #C's room and he would yell and she would move away or staff would come and redirect. She never saw Resident #C touch anyone.</p> <p>Interview with LPN #2 on 3/15/12 at 11:41, indicated Resident #C was very territorial and did not like other resident's by his door. She also indicated Resident #B would wander and go into resident's rooms and when she would get to Resident #C's room he would yell at her. She then indicated staff would go to her and redirect her. She never saw Resident #C touch anyone.</p>			

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	<p>Interview with the Administrator on 3/15/12 at 9:00 a.m., in regard to the resident's care plan related to combativeness, indicated she would provided additional information. The Administrator provided no additional information during the survey process.</p> <p>Interview with the MDS Coordinator on 3/16/12 at 12:00 p.m. indicated the care plan related to combativeness for Resident #C was completed after the incident on 3/6/12. However, when she was going to obtained the care plans she was told a date needed to be in place and she put the date of his last review which was 2/23/12.</p> <p>The Behavior Management Policy identified by the Social Service Director as current on 3/28/12 was reviewed on 3/6/12 at 9:30 a.m. The policy indicated: "The program is designed to assess and monitor the residents when they are acting out of character. There will be mood/behavior report sheets on the units and on the Social Service door. These half forms can be filled out by all staff: dietary, housekeeping and etc. The form should be turned into nursing. Once nursing is aware of the behavior, a behavior assessment form will be completed and placed in the resident's</p>						

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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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	<p>chart with documentation from nursing. The green sheet will then be attached to the 24 Hour Report for Social Services. There will be a behaviors book, in which every resident on the Behavior Management program will have a behavior management documentation form what twill need to be filled out every shift.</p> <p>Nursing will document behaviors every shift in resident's chart. (No exceptions) Once all medical concerns are ruled out the resident will be placed on a behavior program.</p> <p>If there has been no behavior after thirty days the resident will be dropped from the program.</p> <p>After three months, it may be determined that the behavior is a part of the resident's life style and we will continue to use appropriate resources.</p> <p>The Immediate Jeopardy began on 3/6/12 when Resident #B was walking past Resident #C's room, CNA #1 heard Resident #C yelling, heard a slap and thump and walked around the pulled room curtain to find Resident #B lying on the floor in the doorway of Resident #C's room. CNA #1 asked Resident #C what he had done and Resident #C, stated "you ain' t s---). The Administrator was notified of the immediate jeopardy at 11:55 a.m. on 3/15/12. The immediate</p>			

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	<p>jeopardy was removed on 3/17/12 at 11:15 a.m., but non compliance remained at the lower scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>The immediate jeopardy that began on 3/6/12 was removed on 3/17/12 when through observations, interviews and record reviewed, the facility had completed all staff in-service on appropriate behavior tracking, interventions and wandering residents which included but was not limited to, interventions on wandering, long-term interventions in response to wandering, how to manage behaviors, behavior management documentation record, residents with new or worsening behavioral symptoms, reviewed all resident with behaviors or a diagnosis related to possible behaviors for appropriateness in care planning interventions and monitoring. Resident #C was put on one-on-one monitoring. Care cards were initialized for residents and staff was in-serviced on the care cards. The Care cared include behaviors and interventions to be used in regards to the behaviors. The facility reviewed the existing pre-screening practice and implemented a pre-screening questionnaire and assessment to be</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  03/17/2012	
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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	<p>completed prior to admission, any change or new behavior will be reviewed at the daily morning meeting. The Administrator, Director of Nursing, and Social Service Director will review all residents with behaviors at weekly Quality Improvement Behavior meeting to monitor appropriateness of placement and care for the residents with behaviors and make recommendations as needed.. The behavior management form was updated. The Director of Nursing or designee will review the 24-hour nursing report 5 times per week to ensure behaviors are dealt with appropriately. The Behavior Management Policy was updated. Interviews were conducted with nursing staff, activity staff, dietary staff, housekeeping staff, and administrative staff on the process of responding to resident's with behaviors, how to and whom to report resident behaviors, and what would be done when behaviors continues or new behaviors were exhibited.</p> <p>This Federal tag relates to complaint IN00105351.</p> <p>3.1-45(a)(2)</p>						