PRINTED: 02/20/2024 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS FOR | R MEDICARE & MEDIC   | AID SERVICES   |  |  | OMB NO. 0938-039                            |  |
|-------------|--|--|--|--|---|--|
|             | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155530  | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING | 00   | (X3) DATE SURVEY<br>COMPLETED<br>01/30/2024 |  |
|             | PROVIDER OR SUPPLIEF   | REHABILITATION CENTER  | 353 TY                                     | address, city, state, zip cod<br>LER ST<br>IN 46402                    | <b></b>                                     |  |
| (X4) ID     | SUMMARY  | STATEMENT OF DEFICIENCIE   | ID   | PROVIDER'S PLAN OF CORRECTION  | (X5)  |  |
| PREFIX      | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL  | PREFIX                                     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION                                  |  |
| TAG         | REGULATORY OF  | R LSC IDENTIFYING INFORMATION  | TAG  | DEFICIENCY)  | DATE  |  |
| F 0000      |  |  |  |  |   |  |
| Bldg. 00    | IN00423872, IN00<br>visit included a CO<br>Control Survey.<br>Complaint IN00422<br>related to the allega<br>Complaint IN00424<br>the allegations are of<br>Complaint IN00422<br>related to the allega<br>Survey dates: Janu<br>Facility number: 00<br>Provider number: 1<br>AIM number: 1002<br>Census Bed Type:<br>SNF/NF: 81<br>Total: 81<br>Census Payor Type<br>Medicare: 1<br>Medicaid: 74<br>Other: 6<br>Total: 81 | 5781 - Federal/State deficiencies<br>tions are cited at F692.<br>ary 29 and 30, 2024<br>00369<br>55530<br>75190<br>:<br>reflect State Findings cited in<br>0 IAC 16.2-3.1. | F 0000                                     |  |   |  |
| SS=D        |  | ed of Room/Roommate  |  |  |   |  |
|             | <u> </u>   |  |  | <u> </u>   |   |  |
|             |  | VIDER/SUPPLIER REPRESENTATIVE'S S  |  | TITLE  | (X6) DATE                                   |  |
| Philip Birn |  |  | Administ                                   | rator  | 02/14/2024                                  |  |

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000369

|                          | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155530   |   | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING | ONSTRUCTION <u>00</u>  | (X3) DATE SURVEY<br>COMPLETED<br>01/30/2024 |                            |
|--------------------------|--|---|---|--|---|----------------------------|
|                          | NAME OF PROVIDER OR SUPPLIER<br>SOUTH SHORE HEALTH & REHABILITATION CENTER   |   |   | address, city, state, zip cod<br>/LER ST<br>, IN 46402   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)  | Ē   | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00                 | Change<br>§483.10(e)(4) The<br>his or her spouse<br>in the same facilit<br>consent to the arr<br>§483.10(e)(5) The<br>his or her roomma<br>practicable, when<br>same facility and<br>the arrangement.<br>§483.10(e)(6) The<br>notice, including t<br>before the resider<br>facility is changed<br>Based on record re<br>failed to notify the<br>Responsible Party<br>transfer, as well as<br>roommate, for 2 of<br>infection control. (f<br>Findings include:<br>1. The record for R<br>1/29/24 at 12:00 p.<br>not limited to, dem<br>Alzheimer's disease<br>failure to thrive, me<br>blood pressure.<br>The 12/27/23 Annu<br>assessment, indicat<br>moderately impaired | e right to share a room with<br>when married residents live<br>y and both spouses<br>angement.<br>e right to share a room with<br>ate of choice when<br>both residents live in the<br>both residents consent to<br>e right to receive written<br>the reason for the change,<br>nt's room or roommate in the<br>f.<br>view and interview, the facility<br>resident and/or the resident's<br>in writing of an intrafacility<br>the lack of notification of a new<br>4 residents reviewed for<br>Residents B and H)<br>estident B was reviewed on<br>m. Diagnoses included, but were<br>entia with behaviors,<br>e, depressive disorder, adult<br>ood disorder, anxiety and high<br>aal Minimum Data Set (MDS) | F 0559                                    | F 559 Choose/Be Notified of<br>Room/Roommate Change<br>Based on record review and<br>interview, the facility failed to n<br>the resident and/or the residen<br>Responsible Party in writing of<br>intrafacility transfer, as well as<br>lack of notification of a new<br>roommate, for 2 of 4 residents<br>reviewed for infection control.<br>(Residents B and H)<br>What corrective action(s) will<br>be accomplished for those<br>residents found to have been<br>affected by the deficient<br>practice.<br>Both residents / resident's<br>responsible party were notified<br>writing and orally, of current roo | t's<br>an<br>the                            | 02/15/202                  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TIVH11

Facility ID: 000369

If continuation sheet Page 2 of 8

PRINTED: 02/20/2024

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155530 |                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | DNSTRUCTION (X.<br>00 | (X3) DATE SURVEY<br>COMPLETED<br>01/30/2024   |            |  |  |
|--|------------------------------|--|-----------------------|---|------------|--|--|
|  | IAME OF PROVIDER OR SUPPLIER |  |                       | STREET ADDRESS, CITY, STATE, ZIP COD<br>353 TYLER ST<br>GARY, IN 46402                  |            |  |  |
| (X4) ID  | SUMMAR                       | Y STATEMENT OF DEFICIENCIE                 | ID                    | PROVIDER'S PLAN OF CORRECTION   | (X5)       |  |  |
| PREFIX   | (EACH DEFICIE                | ENCY MUST BE PRECEDED BY FULL              | PREFIX                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | COMPLETION |  |  |
| TAG  | REGULATORY O                 | OR LSC IDENTIFYING INFORMATION             | TAG                   | DEFICIENCY)   | DATE       |  |  |
|  | On 12/7/23, the re           | esident received a new roommate,           |                       | and voiced satisfaction with  |            |  |  |
|  | however, there wa            | as no documentation in the                 |                       | current room.   |            |  |  |
|  | clinical record, int         | forming the resident she was               |                       | Both residents and residents  | ;          |  |  |
|  | getting a new room           | mmate.                                     |                       | receiving room mates were   |            |  |  |
|  |                              |  |                       | notified, in writing and orally, of   |            |  |  |
|  | On 12/8/23, the ro           | pommate tested positive for                |                       | current roommate and voiced   |            |  |  |
|  |                              | ney moved Resident B to a                  |                       | satisfaction with current   |            |  |  |
|  | different room, ho           | owever, there was no                       |                       | roommate.   |            |  |  |
|  | documentation in             | the clinical record she was                |                       |   |            |  |  |
|  | moved, nor was th            | nere an intrafacility transfer form        |                       |   |            |  |  |
|  | completed at the t           | ime of the move.                           |                       | How other residents having the  | e          |  |  |
|  |                              |  |                       | potential to be affected by the   |            |  |  |
|  | During an intervie           | ew on 1/29/24 at 3:38 p.m., the            |                       | same deficient practice will be   |            |  |  |
|  | Infection Preventi           | onist, indicated a resident on             |                       | identified and what corrective  |            |  |  |
|  | another unit was s           | sent out to the hospital and               |                       | action(s) will be taken.  |            |  |  |
|  | tested positive for          | COVID-19, so she started                   |                       | All residents have the  |            |  |  |
|  | testing the residen          | ts on her unit. After several              |                       | potential to be affected by the   |            |  |  |
|  | residents tested po          | ositive, she decided to test the           |                       | alleged deficient practice.   |            |  |  |
|  | entire facility, and         | Resident B's roommate tested               |                       | Audit of all intrafacility room   | n l        |  |  |
|  | positive. She calle          | ed the resident's Responsible              |                       | transfers in the past 30 days will  |            |  |  |
|  | Party and told her           | they were moving her to a                  |                       | be conducted to ensure that the   |            |  |  |
|  | different room due           | e to COVID-19, however, it was             |                       | intrafacility policy was followed   |            |  |  |
|  | not documented in            | n the clinical record.                     |                       | and that all residents / residents  |            |  |  |
|  |                              |  |                       | responsible parties were notified   | 3          |  |  |
|  | During an intervie           | ew on 1/30/24 at 11:00 a.m., the           |                       | in writing, of the room move  |            |  |  |
|  | Director of Nursir           | ng indicated there was no                  |                       | Audit of all residents who  |            |  |  |
|  | documentation the            | e resident was to receive a new            |                       | received a new roommate in the  |            |  |  |
|  | roommate, nor wa             | s there an intrafacility transfer          |                       | past 30 days will be completed to   | ο          |  |  |
|  | form completed for           | or the room change on $12/8/23$ .          |                       | ensure that all residents /   |            |  |  |
|  |                              |  |                       | residents responsible parties we  | re         |  |  |
|  | 2. The record for            | Resident H was reviewed on                 |                       | notified, in writing, of a new  |            |  |  |
|  | -                            | m. Diagnoses included but were             |                       | roommate.   |            |  |  |
|  |                              | oke, heart disease, type 2                 |                       | SS will be educated on the  |            |  |  |
|  |                              | od pressure, major depressive              |                       | change of room or roommate  |            |  |  |
|  | disorder, pressure           | ulcers, and adult failure to               |                       | policy  |            |  |  |
|  | thrive.                      |  |                       | Nursing will be educated or   | ו ו        |  |  |
|  |                              |  |                       | the change of room or roommate  | e          |  |  |
|  | The 12/19/23 Qua             | rterly Minimum Data Set (MDS)              |                       | policy  |            |  |  |
|  | assessment, indica           | ated the resident was severely             |                       |   |            |  |  |
|  | impaired for decis           | ion making.                                |                       | What measures will be put into  |            |  |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/30/2024 155530 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 353 TYLER ST SOUTH SHORE HEALTH & REHABILITATION CENTER GARY. IN 46402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE place and what systemic Nurses' Notes, dated 12/15/23 at 12:27 p.m., changes will be made to indicated the resident tested positive for COVIDensure that the deficient practice does not recur. 19. The resident's sister was called and a message was left to return the phone call for an update on a SS will be educated on the status change. change of room or roommate policy and documentation Nurses' Notes, dated 12/15/23 at 2:02 p.m., requirements. indicated the resident was transferred to a private Nursing will be educated on room on another unit, related to testing positive the change of room or roommate for COVID-19 policy and documentation requirements. The resident was moved from that private room to another room on 12/19/23, still due to COVID-19, How the corrective action(s) and then moved back to her own/original room will be monitored to ensure the after she was out of isolation. deficient practice will not recur, i.e., what quality There was no documentation the resident's assurance program will be put Responsible Party was notified of the second into place. room transfer and when she was sent back to her DON / Designee will original room. There was no documentation of an complete an audit of 5 intrafacility intrafacility transfer form when the resident was transfers to ensure that the moved to the second private room and then when change of room or roommate she was moved back to her original room. policy was followed ie.. all residents / residents responsible During an interview on 1/30/24 at 12:00 p.m., the parties were notified, in writing, of Director of Nursing (DON) indicated the resident's the room move prior to move Responsible Party was not made aware of the DON / Designee will be second transfer to the private room on 12/19/23 or complete an audit of 5 residents when she was sent back to her own room, and receiving a new roommate to there was no intrafacility transfer form completed ensure that the change of room or for both room changes. roommate policy was followed ie: ensure that all residents / A current and undated "Change of Room or residents responsible parties were notified, in writing, of a new Roommate" policy, provided as current by the DON on 1/30/24 at 11:00 a.m., indicated, prior to roommate prior to new roommate. making a room change or roommate assignment, Above audits will be all persons involved in the change, such as completed daily x5, weekly x4 residents and their representatives, will be given weeks, bi-monthly for 2 advance notice of such change as was possible. months, monthly x6 and then

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Event ID: TIVH11

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If continuation sheet

Page 4 of 8

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |  | x1) provider/supplier/clia<br>identification number<br>155530  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | COM  | (X3) DATE SURVEY<br>COMPLETED<br>01/30/2024 |                            |  |  |
|---|--|--|--|--|---|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER |  |  | 353 TY                                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>353 TYLER ST<br>GARY, IN 46402   |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | ' STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)  | ECTION<br>ULD BE<br>PROPRIATE               | (X5)<br>COMPLETION<br>DATE |  |  |
|   | be provided in wri   | ange in room or roommate will<br>ting and/or verbal notification,<br>ason why the move or change   |  | quarterly to encompass<br>shifts until continued<br>compliance is maintain<br>consecutive quarters.  |   |                            |  |  |
|   | This citation relate<br>3.1-12(a)(15)(A)<br>3.1-12(a)(16)(A)   | rs to Complaint IN00423872.  |  | The results of the<br>audits will be reviewed<br>CQI committee oversee<br>ED. If the threshold of<br>not achieved, an action<br>will be developed to en<br>compliance. | by the<br>en by the<br>95% is<br>plan       |                            |  |  |
|   |  |  |  | By what date the system<br>changes for each defic<br>will be completed. 2/1<br>Facility request per sug<br>exit paper compliance is<br>requested.                      | <b>iency</b><br>5/24<br>gestion at          |                            |  |  |
| <sup>=</sup> 0692<br>SS=D<br>Bldg. 00                                   | §483.25(g) Assis<br>(Includes naso-g<br>tubes, both percu<br>gastrostomy and<br>jejunostomy, and<br>resident's compre- | on Status Maintenance<br>ted nutrition and hydration.<br>astric and gastrostomy<br>utaneous endoscopic<br>percutaneous endoscopic<br>enteral fluids). Based on a<br>chensive assessment, the<br>ure that a resident- |  |  |   |                            |  |  |
|   | parameters of nu<br>usual body weigh<br>range and electro<br>resident's clinical                                       | aintains acceptable<br>tritional status, such as<br>at or desirable body weight<br>blyte balance, unless the<br>condition demonstrates<br>ssible or resident<br>cate otherwise;                                      |  |  |   |                            |  |  |

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| OMB | NO. | 0938-039 |
|-----|-----|----------|

| AND PLAN | ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155530   |  |      | A. BUILDING <u>00</u><br>B. WING |  | completed<br>01/30/2024 |           |
|----------|--|--|------|----------------------------------|--|-------------------------|-----------|
|          | NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER                              |  |      | 353 TY                           | address, city, state, zip cod<br>'LER ST<br>IN 46402                                       |                         |           |
| (X4) ID  | SUMMAR   | Y STATEMENT OF DEFICIENCIE   |      | ID                               | PROVIDER'S PLAN OF CORRECTIO   | N                       | (X5)      |
| PREFIX   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION               |  |      | PREFIX                           | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)            | BE<br>PRIATE            | COMPLETIO |
| TAG      |  |  |      | TAG                              | DEFICIENCY)  |                         | DATE      |
|          |  | offered sufficient fluid intake<br>er hydration and health;  |      |                                  |  |                         |           |
|          | when there is a<br>health care prov<br>Based on record r<br>failed to ensure m<br>completed for a re | offered a therapeutic diet<br>nutritional problem and the<br>ider orders a therapeutic diet.<br>eview and interview, the facility<br>real consumption logs were<br>esident with a history of a<br>t loss, for 1 of 3 residents | F 00 | 592                              | F 692 Nutrition/Hydration S<br>Maintenance<br>Based on record review an                    |                         | 02/15/202 |
|          |  | mificant change in condition.  |      |                                  | interview, the facility failed<br>ensure meal consumption I<br>were completed for a reside | to<br>ogs               |           |
|          | Finding includes:  |  |      |                                  | a history of a significant we<br>loss, for 1 of 3 residents rev                            | ight                    |           |
|          |  | sident C was reviewed on   |      |                                  | for a significant change in  |                         |           |
|          |  | m. Diagnoses included, but were  |      |                                  | condition. (Resident C)  |                         |           |
|          | -  | ht humerus fracture, heart   |      |                                  |  |                         |           |
|          | -  | d pressure, heart failure,   |      |                                  |  |                         |           |
|          | -  | the sacrum, cardiac pacemaker,   |      |                                  | What corrective action(s)  |                         |           |
|          | vision loss of bou   | n eyes, and a history of falls.  |      |                                  | be accomplished for those residents found to have b  |                         |           |
|          | The Admission M  | linimum Data Set (MDS)   |      |                                  | affected by the deficient  | een                     |           |
|          |  | 11/21/23, indicated the resident   |      |                                  | practice.  |                         |           |
|          |  | npaired for decision making, and   |      |                                  | This resident no longe   | r                       |           |
|          | -  | ds. The resident needed partial  |      |                                  | resides in the facility.   |                         |           |
|          |  | ights were as follows:   |      |                                  | How other residents havin<br>potential to be affected by                                   | the                     |           |
|          | 11/14/23 - 88 pou  |  |      |                                  | same deficient practice w  |                         |           |
|          | 11/22 - 94 pounds<br>11/22 - 94 pounds   |  |      |                                  | identified and what correct  | tive                    |           |
|          | 11/22 - 94 pounds<br>11/29 - 101 pound   |  |      |                                  | action(s) will be taken.   | ficant                  |           |
|          | 11/29 - 101 pound<br>11/29 - 101 pound   |  |      |                                  | All residents with sign<br>weight loss have the poten                                      |                         |           |
|          | 12/6 - 99 pounds   | 10   |      |                                  | be affected by the alleged of  |                         |           |
|          | 12/0 - 99 pounds<br>12/13 - 100 pound  | ls   |      |                                  | practice.  | IGHOIGHT                |           |
|          | 12/13 - 100 pound  |  |      |                                  | An audit of all resident   | ł                       |           |
|          | 12/14 - 100 pound<br>12/20 - 101 pound   |  |      |                                  | weights will be completed to   |                         |           |
|          | 12/30 - 88 pounds  |  |      |                                  | identify residents with signi  |                         |           |
|          | 1/3/24 - 84 pound  |  |      |                                  | weight loss.   |                         |           |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155530 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING  |                     | (X3) DATE SURVEY<br>COMPLETED<br>01/30/2024   |   |
|--|--|---|---------------------|---|---|
|  | PROVIDER OR SUPPLII  | ER<br>& REHABILITATION CENTER   | 353 TY              | address, city, state, zip cod<br>LER ST<br>IN 46402   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIE<br>ENCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETIC<br>DATE                 |
|  | The meal consum<br>breakfast meal wa<br>11/27, 12/5, 12/8,<br>and 1/3/24. The lu<br>on 11/17, 11/20, 1<br>12/17, 12/19, 12/2<br>meal was not docu<br>11/28, 12/9, 12/12<br>12/28, and 12/31/2<br>During an intervic<br>Director of Nursir<br>consumption logs<br>every meal. | ption logs indicated the<br>is not documented on 11/20,<br>12/11, 12/7, 12/19, 12/24, 12/25/23,<br>inch meal was not documented<br>1/27, 12/4, 12/8, 12/10, 12/11,<br>24, and 12/25/23, and the dinner<br>immented on 11/15, 11/17, 11/26,<br>2, 12/17, 12/19, 12/20, 12/21, 12/24, |                     | An audit of meal<br>consumption logs of residents wi<br>significant weight loss will be<br>completed to ensure compliance<br>with documentation.<br>Education to nursing staff of<br>the need / importance of<br>compliance with documentation of<br>meal logs will be provided.<br>Education to nursing staff of<br>the meal consumption policy will<br>be provided.<br>What measures will be put into<br>place and what systemic<br>changes will be made to<br>ensure that the deficient<br>practice does not recur.<br>Education to nursing staff of<br>the need / importance of<br>compliance with documentation of<br>meal logs will be provided.<br>Education to nursing staff of<br>the need / importance of<br>compliance with documentation of<br>meal logs will be provided.<br>Education to nursing staff of<br>the meal consumption policy will<br>be provided.<br>UMs will be educated on the<br>need to monitor meal consumption<br>documentation on their unit<br>How the corrective action(s)<br>will be monitored to ensure the<br>deficient practice will not<br>recur, i.e., what quality<br>assurance program will be put<br>into place.<br>DON / designee will<br>complete audits on 5 random<br>residents with significant weight | th<br>F<br>of<br>n<br>F<br>of<br>n<br>Son |

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|           | F OF HEALTH AND HU                                  |                               |            |   |  |            | RM APPROVED                   |  |
|-----------|---|-------------------------------|------------|---|--|------------|-------------------------------|--|
|           | R MEDICARE & MEDIC                                  | X1) PROVIDER/SUPPLIER/CLIA    | (V2) MI II | TIDI E CC   | NETRICTION   |            | IB NO. 0938-039               |  |
|           | AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155530 |                               |            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u> |  |            | (X3) DATE SURVEY<br>COMPLETED |  |
|           |   |                               |            | G   | 00   | 01/30      |                               |  |
|           |   | 100000                        |            |   |  | 01/00      | 7202-1                        |  |
| NAME OF F | PROVIDER OR SUPPLIE                                 | R                             |            |   | ADDRESS, CITY, STATE, ZIP COD  |            |                               |  |
| 0011711   |   |                               |            |   | LER ST   |            |                               |  |
| SOUTHS    | SHORE HEALTH &                                      | REHABILITATION CENTER         |            | GARY,   | IN 46402   |            |                               |  |
| (X4) ID   | SUMMARY   | STATEMENT OF DEFICIENCIE      |            | ID  | PROVIDER'S PLAN OF CORRECTION  | I          | (X5)                          |  |
| PREFIX    | (EACH DEFICIEN                                      | NCY MUST BE PRECEDED BY FULL  | P          | REFIX   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | E<br>RIATE | COMPLETION                    |  |
| TAG       | REGULATORY O  | R LSC IDENTIFYING INFORMATION |            | TAG   | DEFICIENCY)  |            | DATE                          |  |
|           |   |                               |            |   | loss to ensure that the meal   |            |                               |  |
|           |   |                               |            |   | consumption policy is being  |            |                               |  |
|           |   |                               |            |   | followed and documented pe   | -          |                               |  |
|           |   |                               |            |   | policy. Above audits will be   |            |                               |  |
|           |   |                               |            |   | completed daily x5, weekly x   |            |                               |  |
|           |   |                               |            |   | eeks, bi-monthly for 2 months,   |            |                               |  |
|           |   |                               |            |   | monthly x6 and then quarter  | ly to      |                               |  |
|           |   |                               |            |   | encompass all shifts until   |            |                               |  |
|           |   |                               |            |   | continued compliance is<br>maintained for 2 consecutive                            | ~          |                               |  |
|           |   |                               |            |   | quarters.  | 5          |                               |  |
|           |   |                               |            |   | quarters.  |            |                               |  |
|           |   |                               |            |   | The results of these au  | dits       |                               |  |
|           |   |                               |            |   | will be reviewed by the CQI  | ano        |                               |  |
|           |   |                               |            |   | committee overseen by the  | ED. If     |                               |  |
|           |   |                               |            |   | the threshold of 95% is not  |            |                               |  |
|           |   |                               |            |   | achieved, an action plan will  | be         |                               |  |
|           |   |                               |            |   | developed to ensure complia  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   | -  |            |                               |  |
|           |   |                               |            |   | By what date the systemic  |            |                               |  |
|           |   |                               |            |   | changes for each deficiend   | ;y         |                               |  |
|           |   |                               |            |   | will be completed.   |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   | 2/15/23  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |
|           |   |                               |            |   |  |            |                               |  |

TIVH11 Facility ID:

Facility ID: 000369 I

If continuation sheet Pag

Page 8 of 8

PRINTED: 02/20/2024