CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155530	B. WING		09/28/2023	
		155550	b. wind		09/26/2023	
			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R	353 TY	LER ST		
SOLITH 6	SHUDE HEVI TH &	REHABILITATION CENTER		IN 46402	ļ	
3001113	SHOIL HEALIH &	THE HABILITATION CENTER	GAIXI,	111 40402		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWDERIC DLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	REGULATORT OF	R ESC IDENTIFTING INFORMATION	IAG		DATE	
F 0000						
Bldg. 00						
	This visit was for the	he Investigation of Complaints	F 0000			
	IN00415264, IN00	415780, IN00417740 and				
	IN00417823.					
	11,00117025.					
	Comm1-1-4 D10041	5264 No deficiencia 1 / 1/				
	•	5264 - No deficiencies related to				
	the allegations are	cited.				
	Complaint IN0041:	5780 - Federal/State deficiency				
	related to the allega	ations are cited at F684.				
	Č					
	Complaint IN0041	7740 - No deficiencies related to				
	-					
	the allegations are	citea.				
	-	7823 - No deficiencies related to				
	the allegations are	cited.				
	Unrelated deficience	cies are cited.				
	Cumiari datasi Canti	omah om 27 % 29 2022				
	Survey dates: Septe	ember 27 & 28, 2023				
	Facility number: 0					
	Provider number: 1	55530				
	AIM number: 1002	275190				
	Census Bed Type:					
	SNF/NF: 86					
	Total: 86					
	Census Payor Type	e:				
	Medicare: 9					
	Medicaid: 73					
	Other: 4					
	Total: 86					
	10141. 00					
		a . a . 				
		reflect State Findings cited in				
	accordance with 41	0 IAC 16.2-3.1.				

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

(X6) DATE

TITLE

Philip Marc Birn Administrator 10/17/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
		155530	A. BUILDING <u>00</u> COMPLETED B. WING 09/28/2023				
			CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER			'LER ST			
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		IN 46402			
(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 CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Quality review com	pleted on 10/2/23.					
F 0602 SS=D Bldg. 00	Free from Misappi §483.12 The resident has tabuse, neglect, mproperty, and explosubpart. This inclustreedom from corpinvoluntary seclus chemical restraint resident's medical Based on record revialled to ensure a remisappropriation of missing narcotics/coresidents reviewed approperty. (Resident The deficient practipation of past noncompliance investigated the miswell as notified the by the police departemployed by the faceducated on the polsubstances and shift access to the missin Audits were compleand for residents which days. Unit Manager policy compliance. Finding includes:	ropriation/Exploitation the right to be free from isappropriation of resident obtation as defined in this udes but is not limited to boral punishment, ion and any physical or not required to treat the symptoms. Free and interview, the facility sident was free from the resident property, related to controlled medication, for 1 of 2 for misappropriation of E) ce was corrected by 8/18/23, the survey, and was therefore the facility thoroughly using narcotic medication, as police. A report was initiated ment. LPN 4 is no longer cility. Nurses and QMA's were iver for receiving controlled to shift counting. Staff with a g narcotics were interviewed. Setted on all medications carts no had narcotics in the past 30 as are to monitor their Units for	F 0602	The deficient practice was corrected by 8/18/23, prior to start of the survey, and was therefore past noncompliance facility thoroughly investigated missing narcotic medication, well as notified the police. A rowas initiated by the police department. LPN 4 is no long employed by the facility. Nursuand QMA's were educated or policy for receiving controlled substances and shift to shift counting. Staff with access to missing narcotics were interviewed. Audits were completed on all medications carts and for residents who haracotics in the past 30 days. Managers are to monitor their Units for policy compliance.	e. The d the as report er ses n the the unit		
		ed 8/14/23, indicated a hydrocodone-acetaminophen					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A. BUIL		NSTRUCTION 00	(X3) DATE : COMPL		
155530		B. WINC	·		09/28/	2023	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	;	353 TYL	DDRESS, CITY, STATE, ZIP COD LER ST IN 46402		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(narcotic pain med that belonged to Re	ication), 5-325 mg (milligrams), esident E, was missing from the twer located on the medication					
	ending on 8/18/23, shift, the narcotic d counted by the one staff counted the nu then counted each count with the narcoinitialed the Shift C	of the missing medication card, indicated before and after each drawer medications were coming and off going staff. The number of cards in the drawer, medication and compared the cotic sign out record. They Change Accountability Record stances if all of the medication t.					
	LPN 3 counted all had two cards of hy	the narcotics for Resident E and the narcotics for Resident E. He ydrocodone-acetaminophen d had seven tablets and one					
	hydrocodone-aceta	p.m., LPN 3 indicated the minophen card with 22 tablets the medication cart.					
	maybe four cards o (countable medicat Pharmacy. He coul	t from LPN 4 indicated three or of scheduled medications tions) were delivered from the ld not remember exactly, but e at least three cards delivered.					
	verification of whe	been notified for the en and the amount of the red, as well as which nurse had ications.					
		eked and the 22 count card of minophen was not found.					

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 $ZZPV11 \qquad {\tt Facility\ ID:} \quad 000369$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155530		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/28 /	ETED	
	PROVIDER OR SUPPLIER SHORE HEALTH &	REHABILITATION CENTER	353 TYL	DDRESS, CITY, STATE, ZIP COD LER ST IN 46402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	All count forms we interviewed.	re audited and staff were				
	The count sheet for hydrocodone-aceta	the 22 minophen was also missing.				
		was reviewed on 9/28/23 at 8 included, but were not limited ase and dementia.				
		um Data Set assessment, dated a severely impaired cognitive was present.				
	A Physician's Order, dated 4/17/23, indicated hydrocodone-acetaminophen, 5-325 mg every six hours as needed for pain.					
	8/2023, indicated the	lministration Record, dated ne as needed minophen had not been				
		ss Notes, dated 8/1/23 to he resident had not had any s of pain.				
	Nurse on 9/28/23 at Hospice Nurse and resident's medication cards for the hydron night before the me countable medication facility. LPN 4 place the narcotic drawer cards. When the nature of cards we LPN 4 not recording	w with the Corporate Regional t 8:25 a.m., she indicated the LPN 3 had checked the on cards and both had seen the codone-acetaminophen. The dication card was missing, four ons were delivered to the ted the four medication cards in though only logged in three recotics were counted, the total are correct in the cart due to g the fourth card of the delivered. The count form for				

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ZZPV11

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155530	B. WING		09/28/2023
	PROVIDER OR SUPPLIED	R REHABILITATION CENTER	353 TY	address, city, state, zip c LER ST IN 46402	OD
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		NECTION (X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE	HOULD BE COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE DATE
		as also missing and that is			
	· ·	edication card had not been			
		counted the cards and			
		unt was correct then realized			
		drocodone-acetaminophen			
		rom the narcotic drawer later on			
	_	medication cart had been			
	1	olice were notified. LPN 4 was			
		on and is no longer employed			
	at the facility.	on and is no longer employed			
	at the facility.				
	A parcotic policy	dated 5/25/22 and received from			
		as current, indicated when a			
		ce arrived at the facility it was			
		locked in the narcotic			
		and the sign out sheet was to			
		nder. Two nurses must count			
	-	ginning and end of each shift.			
		gn the narcotic count record			
		s should be the incoming and			
	_	he narcotic count record log			
		nat the count for number of			
		individual count for each			
		for the oncoming/outgoing			
		a discrepancy in the narcotic			
		of Nursing was to be notified			
	immediately.	or reasoning was to so mounted			
	3.1-28(a)				
F 0684	483.25				
SS=G	Quality of Care				
Bldg. 00	§ 483.25 Quality	of care			
-	-	a fundamental principle that			
	1	tment and care provided to			
	facility residents.	· · · · · · · · · · · · · · · · · · ·			
		ssessment of a resident, the			
		re that residents receive			
	1	re in accordance with			

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professional standards of practice, the

Event ID:

ZZPV11

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AND PLANGE CORRECTION IDENTIFICATION NUMBER 155300 NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER (A) ID SEMMARY STATEMENT OF DEPICIENCE (A) ID SEMMARY STATEMENT OF DEPICIENCE (A) ID SEMMARY STATEMENT OF DEPICIENCE TAG RECOLATORY OR LEE DEPETTYNO MORNATION Comprehensive person-centered care plan, and the residents rotices. Based on record review and interview, the facility failed to ensure a resident who received a left float/ore injury had thorsugh and accurate assessments of the area and failed to treat the area as ordered by the Physician, which resulted in the resident being admitted into the hospital with diagnoses of left great to infection, cellulits of the left float and a MRI of the foot that indicated a result of suspicious for sectemylistis of the left great toe for 1 of 2 residents reviewed for injuries. (Resident C's record was reviewed on 9/27/23 at 10-42 a.m. The diagnoses included, but were not limited to, fracture of the left femur and stroke. A Quarterly Minimum Dafa Set assessment, dated 7/19/23, indicated an intact cognitive status and required supervision for transfers and locomotion. A Care Plan, dated 8/10/23, indicated an open area was present on the left great toe. The interventions included, custion would be used for all transfers, retainments would be completed as ordered by the Physician was to be insolited. A Nusse's Progress Note, dated 8/1/23 at 11 a.m., indicated the resident reported on 7/31/23 mother resident accidentally mm over his right great toe with a wheelchair. The toe was assessed as swollen, discolored, and painful to touch. The Physician was notified and an arder for an x-ray of the right foot was received.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
STRIET ADDRESS, CITY, STATE, ZIP COD 383 TYLER ST GARY, IN 46402 (X4) ID SLAMMARY STATIMENT OF DEFICIENCIE PREFIX TAG Comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident who received a left foot/tie finjury had through and accurate assessments of the area and failed to treat the area as ordered by the Physician, which resulted in the resident being admitted into the hospital with diagnoses of left great toe infection, cellulitis of the left foot, and a MRI of the foot that indicated a result of suspicious for ostcomyclitis of the left great toe for 1 of 2 residents reviewed for injuries. (Resident C's record was reviewed on 9/27/23 at 10/24 am. The diagnoses included, but were not limited to, fracture of the left fermur and stroke. A Quarterly Minimum Data Set assessment, dated 7/19/23, indicated an inact cognitive status and required supervision for transfers and locomotion. A Care Plan, dated 8/10/23, indicated an open area was present on the left great toe. The interventions included, caution would be used for all transfers, treatments would be completed as ordered by the Physician was to be notified. A Narse's Progress Note, dated 8/1/23 at 11 a.m., indicated the resident reported on 7/31/23 another resident and whelchair. The toe was assessed as swollen, discolored, and painful to touch. The Physician was notified and an order for an x-ray of the right for was received.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		
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Oct Department	NAME OF P	ROVIDER OR SUPPLIEF	C		353 TY	LER ST		
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident who received a left foothice injury had thorough and accurate assessments of the area and failed to treat the area as ordered by the Physician, which resulted in the resident being admitted into the hospital with diagnoses of left great toe infection, cellulitis of the left foot, and a MRI of the foot that indicated a result of suspicious for ostcomyelities of the left great toe for 1 of 2 residents reviewed for injuries. (Resident C) Finding includes: Resident C's record was reviewed on 9/27/23 at 10-42 a.m. The diagnoses included, but were not limited to, fracture of the left fermur and stroke. A Quarterly Minimum Data Set assessment, dated 7/19/23, indicated an intact cognitive status and required supervision for transfers and locomotion. A Care Plan, dated 8/10/23, indicated an open area was present on the left great toe. The interventions included, caution would be used for all transfers, treatments would be completed as ordered by the Physician, and signs and symptoms of infection or abnormalities would be monitored and the Physician was to be notified. A Nurse's Progress Note, dated 8/1/23 at 11 a.m., indicated the resident reported on 7/31/23 another resident accidentally ran over his right great toe with a wheelchair. The toe was assessed as swollen, discolored, and painful to touch. The Physician was notified and an order for an x-ray of the right foot was received.	SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		GARY,	IN 46402		
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Physician was notified and an order for an x-ray of the right foot was received. practice will not recur? Nursing staff will be		swollen, discolored	, and painful to touch. The					
the right foot was received. Nursing staff will be						practice will not recur?		
re-educated on the policy and						l -		
						re-educated on the policy and		

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Event ID:

ZZPV11

Facility ID: 000369

If continuation sheet Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155530	B. W	ING		09/28/	2023
		L		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			LER ST		
SOUTHS	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
			_		1010 <u>L</u>		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	-	der, was dated 8/2/23 for an			procedure of identifying and		
	x-ray of the right fo	oot and toes.			assessing wounds / injuries.		
	A Dissert of the	1-4-10/2/22 :1' 4 1.1			Nursing staff will be		
	-	er, dated 8/3/23, indicated the			re-educated in the process of		
	-	e monitored and skin prep with			entering physician orders /		
	a dry dressing was	to be applied every shift.			treatments in the MAR and	41	
	A	are of the might foot			ensuring that they are comple	etea	
		ws of the right foot was . The results indicated soft			and signed in the MAR as		
					ordered.	_	
	tissue swelling of the	ne amerior ioot.			Nursing leadership will b		
	The order for the	ght foot to be monitored and			re-educated on IDT procedure		
		e skin prep and dry dressing			post resident wound / injury b identified.	eirig	
		cked initials that indicated the					
	_	completed as ordered on the			Nursing leadership will b		
		eatment Administration			re-educated on IDT procedure new order verification to ensu		
	Records (MAR/TA				order is correctly placed on M		
	Accords (IVIAN/IA	110, dated 0/2023.					
	The Nurses! Progre	ess Notes, dated 8/3/23 at 10:11			Nursing leadership will b re-educated on IDT / UM	-	
		3 p.m., 8/5/23 at 2:45 a.m.			procedure of daily verification	of	
	-	orep and dry dressing treatment			completion of treatment order		
	continued to the rig				the MAR.	J 111	
	Tommaca to the fig	5			4 How the corrective		
	There were no asse	essments of the injury from			action(s) will be monitored t	0	
		d no documentation the			ensure the deficient practice		
	0. 2. 20 12 0. 2. 20 112	applied every shift as ordered.			will not recur, i.e., what qual		
					assurance program will be p	-	
	A Nurse's Progress	Note, dated 8/5/23 at 10:54			in place?	-	
	_	right toe still looked swollen			DON / designee will		
	-	complaints from the resident.			complete audits to ensure tha	t	
					nursing staff have followed po		
	A Skin Assessment	t Form, dated 8/5/23, indicated			and procedure for identifying	-	
	the skin was intact,	the right great toe was			assessing wounds / injuries.		
	swollen, the treatm	ents to all affected areas			DON / designee will		
	continued, and ther	re were no new open areas.			complete audits to ensure tha	t	
					nursing staff have entered all		
	_	Note, dated 8/6/23 at 1:41 a.m.,			physician orders / treatments		
	indicated a new ord	der for a dry dressing with skin			correctly in the MAR and all		
	prep to the right too	es every shift and to monitor			treatments are being signed		
	the area was obtain	ed.			correctly in the MAR.		

		X1) PROVIDER/SUPPLIER/CLIA	r í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155530	B. W		00	09/28	
NAME OF P	PROVIDER OR SUPPLIE	3	-		ADDRESS, CITY, STATE, ZIP COD LER ST		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	indicated skin prep the right great toe, bruised, and was re	Note, dated 8/6/23 at 2:19 p.m., and a dressing was applied to the foot remained swollen, ddened at the nail bed.			designee will complete audits ensure that nursing leadership following IDT policy and procedures of new order verification, wound / injury posidentification and daily verification	o is st	
	documentation the until 8/10/23.	treatment had been completed			of completion of treatment ord in the MAR. Audits will be completed		
	11:37 a.m., indicate great toe. The area (cm) by 2.8 cm x 0 sero-purulent (serur faint odor. The Phyorder for a culture a toe was received. During an interview 9/27/23 at 11:41 a.m. on the left foot and	ogress Note, dated 8/10/23 at ed a ruptured blister to the left measured at 2.4 centimeters and depth. There was moderate and pus) drainage with a risician was notified and an end sensitivity of the left great with the Wound Nurse on m., she indicated the injury was had taken a picture of the left med by the Nurse there was a			daily x5, weekly x4 weeks, bi-monthly for 2 months, mont x6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audi will be reviewed by the CQI committee overseen by the El the threshold of 95% is not achieved, an action plan will be developed to ensure complian	its D. If	
	blister. There were assessment on 8/1/2 assessed to still be assessments had incomplete that was assessed in should have been in first found. The Phytreatment of the sk had not been transcibeen placed on the no documentation to completed. The Left Great Toe	the area it was an opened no other assessments after the 23 and then on 8/5/23 it was swollen. The documented dicated it was the right foot of the left. She indicated she offied when the blister was ysician's Order for the in prep and the dry dressing ribed correctly, so it had not 8/2023 MAR/TAR. There was he treatment had been			5 By what date will the systemic changes for each deficiency be completed? October 24, 2023		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155530		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY IPLETED 28/2023	
	PROVIDER OR SUPPLIER SHORE HEALTH &	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CO LER ST IN 46402)D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION of the area.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	cleanse the left greathry, and then calcius was to be applied at three times a week.	was received on 8/10/23 to at toe with normal saline, pat m alginate (wound treatment) and covered with a dry dressing				
	p.m., indicated the	Note, dated 8/10/23 at 12:45 Wound Nurse completed a ity of the right great toe.				
	a.m. indicated the re (Emergency Medica	Note, dated 8/12/23 at 9:46 esident had called EMS al Services) due to pain in his arrived at the facility and lent to the hospital.				
	_	Note, dated 8/12/23 at 9:05 vas admitted to the hospital for t.				
	the left great toe wa	2023, indicated the treatment to is completed on 8/11/23 and as admitted into the Hospital				
	dated 8/12/23 at 10: toe pain. The reside run over by a wheel facility. He indicate an odor was present completed on 8/10/2 assessed and it was and had redness of the left foot indicate swelling, negative f culture from 8/10/2.	om Physician Progress Note, 26 a.m., indicated left foot great nt indicated his toe had been chair at the long term care d there had been drainage and a. A wound culture had been 23. The left great toe was malodorous (bad smelling) the toe and foot. An x-ray of ed first digit soft tissue for a fracture. The wound 3 had indicated MRSA at staphylococcus aureus) of				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	ETED
		155530	B. W			09/28	
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
OOUT!!	NIODE LIEALTU A	DELIABILITATION OF TER			LER ST		
SOUTHS	SHORE HEALTH &	REHABILITATION CENTER		GARY,	IN 46402		
(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 CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the left great toe. The	he resident would be admitted					
	into the facility for	treatment. The diagnoses					
	included, but were i	not limited to, infection of the					
	toe and cellulitis of	the foot.					
	A MRI of the left for	oot, dated 8/13/23, indicated,					
	"suspicious for de	eveloping acute					
	osteomyelitis"						
	A Hospital Wound	Nurse assessment, dated					
	8/13/23, indicated the	he left hallux was pink and					
	looked like a blister	was present that sloughed off.					
	The picture taken w	vas of the left foot.					
	_						
	During an interview	y on 9/27/23 at 3:58 p.m., LPN 1					
	indicated she had do	ocumented the wrong foot on					
	the assessment and	it was the left toe he had					
	injured.						
	During an interview	v on 9/28/23 at 9:17 a.m., RN 2					
	indicated the injury	was on the left foot not the					
	right. The toenail w	as blue and painful. She					
	_	ht the x-ray was taken of the					
	left foot.	Ž					
	The initial X-ray wa	as done on the incorrect foot					
	_	e injured left foot was not					
		ays due to the error in					
	identification.	-					
	This Federal tag rela	ates to Complaint IN00415780.					
		•					
	3.1-37						

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