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 04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F000000		F000000		
	This visit was for the Investigation of Complaint IN00146613. Complaint IN00146613- Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F323. Survey date: April 16, 2014 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Survey team: Janet Adams, RN-TC Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 8 Medicaid: 55 Total: 63 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April 21, 2014, by Janelyn Kulik, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the Physician and the resident's family of a fall in a timely manner for 1 of 3 residents reviewed for falls in the sample of 3. (Resident #E) Findings include:	F000157	The facility will insure that notification to family member's and/or physicians when an incident or change of condition occurs with a resident. Resident E has had a complete review of the chart to verify that all notifications have occurred related to any incident or change in condition. No new issues identified. The 24-hour report has	05/12/2014

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	The closed record for Resident #E was reviewed on 4/16/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, major depression, dementia, and a history of a stroke. The resident was discharged to the hospital on 3/12/14. The 3/2014 Nurses' Notes were reviewed. The first entry was made on 3/8/14 at 4:30 p.m. This entry indicated the resident's daughter was in the facility to see the resident. The resident was yelling out loud in Greek to the staff and other residents. The resident's daughter indicated the resident was complaining of pain to her right leg, right knee, and her mid and lower back. The resident was medicated with Tylenol at this time for pain. The next entry was made on 3/8/14 at 5:00 p.m. This entry indicated the resident had no signs of pain. An entry made at 5:30 p.m. indicated the Physician was notified of the resident's pain and new orders were received for X-rays to be completed of the right and left hips, femurs, and knees. X-rays of the dorsal and lumbar spine were also ordered. The next entry was made on 3/8/14 at 8:30 p.m. This entry indicated the resident voiced no complaints of pain in English or Greek and appeared in no acute distress. No further entries were made on 3/8/14. The first entry made on 3/12/14 was at 5:00 a.m. This entry indicated the resident had no complaints or signs of pain. The next entry was made on 3/12/14 at 1:00 p.m. This entry indicated the resident complained of pain to her right leg when repositioned. The resident's right leg appeared externally		been reviewed to identify any changes in condition, x-rays or unusual occurrences to verify notification. No new issues identified. Changes in condition shall be reported on the 24-hour report and maintained by the DON/designee. The DON/designee will audit the chart of each resident that has had an incident in the facility to insure compliance with notification. All results of audits shall be reported to the QA Committee monthly for a period of 6 months or until 100% compliance has been achieved then randomly through the QA topic calendar. Request paper compliance to resolve deficiency.	

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	rotated and the resident spit out her pain medications. The Physician was notified and orders were obtained to send the resident to the hospital Emergency Room. The family was notified. When interviewed on 4/1/14 at 10:45 a.m., the DON (Director of Nursing) indicated when she came to work on Monday 3/10/14 she reviewed the 24 hour Nursing shift to shift reports. The DON indicated she noted there were Physician orders for X-rays for Resident #E related to complaints of pain. The DON indicated she spoke with Nursing staff members and they did not report any knowledge of the resident having fallen. The DON indicated she noted the results of the X-ray obtained at the facility were negative for fractures. The DON indicated on 3/12/14 a staff Nurse reported to her Resident #E had been complaining of pain and the Nurse noted external rotation of the resident's right leg. The DON indicated she also assessed the resident at this time and noted the leg rotation also. The Physician and family were notified and the resident was sent out to the hospital at that time. The DON indicated she initiated an Investigation on 3/12/14 and upon interviewing staff it was determined Resident #E had slid from the chair on 3/8/14. The DON indicated the Nurse did not notify the Physician or the resident's family of the fall on 3/8/14. The facility policy titled "Notification for Change in Condition or Status" was reviewed on 4/16/14 at 11:30 a.m. There was no date on the policy. LPN #1 provided the policy and indicated the policy was current. The policy indicated the facility or facility staff were to promptly notify the Physician, resident's Guardian or Health Care POA			

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	(Power of Attorney) of changes the resident's medical/mental condition or status. This Federal Tag relates to Complaint IN00146613. 3.1-5(a)(1)			
F000323 SS=D	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. Based on record review and interview, the facility failed to ensure staff followed fall protocol related to failure to document, report, and investigate a fall at the time of occurrence for 1 of 3 residents reviewed for falls in the sample of 3. (Resident #E) Findings include: The closed record for Resident #E was reviewed on 4/16/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, major depression, dementia, and a history of a stroke. The resident was discharged to the hospital on 3/12/14. Review of the 2/14/14 Minimum Date Set Quarterly Assessment indicated the resident was sometimes understood others and sometimes made herself understood. The assessment indicated the resident had both short term and long term memory problems. The assessment also indicated the resident required extensive assistance (resident	F000323	The facility will insure that all licensed personnel document, report, and investigate falls at the time of occurrence. Resident E has had a complete review of the chart to verify that all investigations have been completed per policy. No issues noted. The 24-hour report has been reviewed to identify any other incidents that may not have been documented, reported or investigated. No new issues identified. Nurses have been in-serviced on the fall protocol. Reported falls will be reviewed by the DON/designee to insure compliance. Chart audits will be conducted by the DON/designee to insure compliance with fall protocol. All of results of audits shall be reported to the QA Committee for a period of 6 months or until 100% compliance has been achieved then randomly through the QA topic calendar.Paper compliance	05/12/2014

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	involved in activity; staff provide weight-bearing support) of one staff person for transfers and bed mobility. The assessment also indicated the resident was totally dependent on one staff member for dressing and personal hygiene. The resident's care plans were reviewed. A care plan initiated on 8/23/13 indicated the resident was at risk for falls. The care plan was last updated on 2/22/14. Care plan interventions included for staff to assist the resident with transfers, remind the resident not to get up without assistance, and for the resident to be in a low bed. The 3/2014 Physician Order Statement indicated there were orders for bed and chair alarms to be in place due to the resident being at risk for falls. There was also an order for floor mats x 2 to be in place. Review of further Physician orders indicated there were two orders written on 3/8/14 at 4:30 p.m. The first order was for X-rays to be completed of the residents' right and left hips, femurs, knees and also the dorsal and lumbar spine areas. The second Physician order was for Tramadol (a medication for pain) 50 milligrams to be given every 6 hours for moderate pain. An order was written on 3/12/14 at 2:00 p.m. to send the resident to the hospital for an evaluation and treatment of her right hip pain. The 3/2014 Nurses' Notes were reviewed. The first entry was made on 3/8/14 at 4:30 p.m. This entry indicated the resident's daughter was in the facility to see the resident. The resident was yelling out loud in Greek to the staff and other residents. The resident's daughter indicated the resident		requested to resolve deficiency.	

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	was complaining of pain to her right leg, right knee, and her mid and lower back. The resident was medicated with Tylenol at this time for pain. The next entry was made on 3/8/14 at 5:00 p.m. This entry indicated the resident had no signs of pain. An entry made at 5:30 p.m. indicated the Physician was notified of the resident's pain and new orders were received for X-rays to be completed of the right and left hips, femurs, and knees. X-rays of the dorsal and lumbar spine were also ordered. The next entry was made on 3/8/14 at 8:30 p.m. This entry indicated the resident voiced no complaints of pain in English or Greek and appeared in no acute distress. No further entries were made on 3/8/14. The next entry in the 3/2014 Nurses' Notes was made on 3/9/14 at 12:15 a.m. This entry indicated the X-ray service arrived to take X-rays of the resident's right and left hips, femurs, and knees. X-rays of the spine were also taken at his time. The next entry was made on 3/9/14 at 6:00 a.m. This entry indicated the resident complained of pain to the right and left hips. Tylenol was given orally at this time and the resident was in no acute distress. The next entry was made on 3/9/14 at 7:00 p.m. This entry indicated the resident was in bed singing in Greek. There were no non verbal signs or symptoms of pain noted. The resident was not moaning or rubbing any extremities and had no facial grimacing. The next entry was made on 3/10/14 at 3:00 a.m. This entry indicated the resident voiced			

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	no complaints of pain or discomfort and was able to move around in bed without difficulty. An entry made at 6:00 p.m. indicated the resident complained of right hip pain when moving. No further entries were made on 3/10/14. The first entry made on 3/11/14 was at 12:30 a.m. This entry indicated the resident was in no distress and was medicated with Tramadol 50 milligrams for moderate pain in the right hip region. An entry made on 3/11/14 at 3:00 a.m. indicated the resident had no further complaints of pain. Entries made on 3/11/14 at 2:00 p.m., 3:30 p.m., and 5:30 p.m., indicated the resident had no complaints or signs of pain or discomfort. An entry made on 3/11/14 at 7:00 p.m. indicated the family was notified the results of the X-rays were negative. There were no further entries made on 3/11/14. The first entry made on 3/12/14 was at 5:00 a.m. This entry indicated the resident had no complaints of signs of pain. The next entry was made on 3/12/14 at 1:00 p.m. This entry indicated the resident complained of pain to her right leg when repositioned. The resident's right leg appeared externally rotated and the resident spit out her pain medications. The Physician was notified and orders were obtained to send the resident to the hospital Emergency Room. The family was notified. An entry made on 3/12/14 at 7:45 p.m. indicated the facility was notified the resident was admitted to the hospital with a diagnosis of a right hip fracture and her Physician was notified. The resident's X-ray result reports were reviewed. Results of the 3/8/14 right hip and femur X-ray indicated there was no evidence			

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	of fracture or dislocation. The results indicated osteoarthritis and osteoporosis were noted. The report indicated the results were faxed to the facility on 3/9/14 at 7:22 a.m. Results of X-rays completed at the hospital on 3/12/14 indicated the right hips X-ray noted the suggestion of a subcapital fracture of the femur on the right side with impaction. An Incident Report Form was completed on 3/17/14. This report indicated an initial report was filed on 3/12/14. The 3/17/14 report was identified as a Follow-up Report to the 3/12/14 initial report. The 3/17/14 Report indicated Resident #E's daughter was visiting on Saturday 3/8/14 and reported to the Nurse the resident was complaining of pain to the right hip area. The Physician was notified at that time and orders were obtained for X-rays to be completed to the hips and spine. The X-ray results were revealed no acute fractures or dislocations. On 3/12/14 the resident was complaining of pain in the right hip area and was assessed. The assessment noted the resident's right leg was externally rotated, the Physician was notified, and the resident was sent to the hospital. Hospital X-rays revealed a suspected subcapital fracture of the neck of the femur on the right side with impaction. The Incident Report Form indicated an investigation was completed and it was noted the resident had slid out of her recliner on 3/8/14 at approximately 2:30 p.m. The Nurse failed to document or report the incident to the on-coming shift or any Management staff. The resident remained hospitalized pending possible surgical intervention. Review of the facility's Investigation indicated			

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	staff interviews were obtained on 3/12/14 and the resident's record was reviewed. When interviewed on 4/1/14 at 10:45 a.m., the DON (Director of Nursing) indicated when she came to work on Monday 3/10/14 she reviewed the 24 hour Nursing shift to shift reports. The DON indicated she noted there were Physician orders for X-rays for Resident #E related to complaints of pain. The DON indicated she spoke with Nursing staff members and they did not report any knowledge of the resident having fallen. The DON indicated she noted the results of the X-ray obtained at the facility were negative for fractures. The DON indicated on 3/12/14 a staff Nurse reported to her Resident #E had been complaining of pain and the Nurse noted external rotation of the resident's right leg. The DON indicated she also assessed the resident at this time and noted the leg rotation also. The Physician and family were notified and the resident was sent out to the hospital at that time. The DON indicated she began a complete investigation on 3/12/14 and started interviewing staff. The CNA who worked on 3/8/14 was interviewed and reported she was in another room and heard Resident #E yelling and she entered her room. The CNA indicated the resident was found on the floor in her room and had slid from the chair on 3/8/14. The CNA reported the Nurse was informed at that time and the Nurse came to the room and assessed the resident. The DON indicated she then attempted to call the Nurse who had been assigned to care for Resident #E on 3/8/14 and the Nurse indicated she had been called to Resident #E's room on 3/8/14 at approximately 2:45 p.m. by the CNA . The resident was observed			

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	on her buttock on the floor. The DON indicated this Nurse did not document the fall, complete the required fall packet of paperwork, nor did she notify the resident's Physician and/or family of the fall. The fall was not recorded on the 24 hour Nursing report and the above Nurse did not notify the oncoming evening shift Nurse of the resident's fall. On 4/16/14 at 11:00 a.m., the DON provided a packet of papers identified as a packet of all forms which Nurses are to complete at the time of a fall. These papers included an Incident and Accident Report, an Initial Fall Investigation, a Pain Assessment, a Fall care plan to update, a Resident/Family Education form, and Statement forms for documenting interviews obtained by staff involved. The DON indicated these above forms were not completed at the time of the 3/8/14 fall as required. The DON did not provide a Fall Policy and indicated the papers in the Fall Packet addressed all the measures each Nurse was to complete at the time of every fall. When interviewed on 4/16/14 at 12:45 p.m., the Director of Nursing indicated she interviewed the CNA who had witnessed the resident on the floor on 3/8/14. The DON indicated the CNA was interviewed on 3/12/14 and the CNA did indicate the resident's alarm was working at the time of the fall on 3/8/14. This Federal tag relates to Complaint IN00146613. 3.1-45(a)(2)			