STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415264, IN00415780, IN00417740 and IN00417823. Complaint IN00415264 - No deficiencies related to the allegations are cited. Complaint IN00415780 - Federal/State deficiency related to the allegations are cited at F684. Complaint IN00417740 - No deficiencies related to the allegations are cited. Complaint IN00417823 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: September 27 & 28, 2023 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 9 Medicaid: 73 Other: 4 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Philip Marc Birn	Administrator	10/17/2023

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.

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	Quality review completed on 10/2/23.			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to ensure a resident was free from misappropriation of resident property, related to missing narcotics/controlled medication, for 1 of 2 residents reviewed for misappropriation of property. (Resident E) The deficient practice was corrected by 8/18/23, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the missing narcotic medication, as well as notified the police. A report was initiated by the police department. LPN 4 is no longer employed by the facility. Nurses and QMA's were educated on the policy for receiving controlled substances and shift to shift counting. Staff with access to the missing narcotics were interviewed. Audits were completed on all medications carts and for residents who had narcotics in the past 30 days. Unit Managers are to monitor their Units for policy compliance. Finding includes: An incident reported to the Indiana Department of Health (IDOH), dated 8/14/23, indicated a medication card of hydrocodone-acetaminophen	F 0602	The deficient practice was corrected by 8/18/23, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the missing narcotic medication, as well as notified the police. A report was initiated by the police department. LPN 4 is no longer employed by the facility. Nurses and QMA's were educated on the policy for receiving controlled substances and shift to shift counting. Staff with access to the missing narcotics were interviewed. Audits were completed on all medications carts and for residents who had narcotics in the past 30 days. Unit Managers are to monitor their Units for policy compliance.	10/23/2023

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	(narcotic pain medication), 5-325 mg (milligrams), that belonged to Resident E, was missing from the locked narcotic drawer located on the medication cart. The investigation of the missing medication card, ending on 8/18/23, indicated before and after each shift, the narcotic drawer medications were counted by the oncoming and off going staff. The staff counted the number of cards in the drawer, then counted each medication and compared the count with the narcotic sign out record. They initialed the Shift Change Accountability Record for Controlled Substances if all of the medication counts were correct. On 8/9/23, a Hospice Nurse for Resident E and LPN 3 counted all the narcotics for Resident E. He had two cards of hydrocodone-acetaminophen 5-325 mg. One card had seven tablets and one card had 22 tablets. On 8/11/23 at 3:45 p.m., LPN 3 indicated the hydrocodone-acetaminophen card with 22 tablets was missing from the medication cart. A signed statement from LPN 4 indicated three or maybe four cards of scheduled medications (countable medications) were delivered from the Pharmacy. He could not remember exactly, but was sure there were at least three cards delivered. The Pharmacy had been notified for the verification of when and the amount of the medications delivered, as well as which nurse had signed for the medications. All carts were checked and the 22 count card of hydrocodone-acetaminophen was not found.			

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	All count forms were audited and staff were interviewed. The count sheet for the 22 hydrocodone-acetaminophen was also missing. Resident E's record was reviewed on 9/28/23 at 8 a.m. The diagnoses included, but were not limited to Parkinson's disease and dementia. A Quarterly Minimum Data Set assessment, dated 7/17/23, indicated a severely impaired cognitive status and no pain was present. A Physician's Order, dated 4/17/23, indicated hydrocodone-acetaminophen, 5-325 mg every six hours as needed for pain. The Medication Administration Record, dated 8/2023, indicated the as needed hydrocodone-acetaminophen had not been administered. The Nurses' Progress Notes, dated 8/1/23 to 8/14/23, indicated the resident had not had any signs and symptoms of pain. During an interview with the Corporate Regional Nurse on 9/28/23 at 8:25 a.m., she indicated the Hospice Nurse and LPN 3 had checked the resident's medication cards and both had seen the cards for the hydrocodone-acetaminophen. The night before the medication card was missing, four countable medications were delivered to the facility. LPN 4 placed the four medication cards in the narcotic drawer, though only logged in three cards. When the narcotics were counted, the total number of cards were correct in the cart due to LPN 4 not recording the fourth card of the narcotics that was delivered. The count form for			

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	the hydrocodone was also missing and that is why the missing medication card had not been found. LPN 3 had counted the cards and documented the count was correct then realized the 22 tablets of hydrocodone-acetaminophen card was missing from the narcotic drawer later on in the shift. Every medication cart had been searched and the Police were notified. LPN 4 was placed on suspension and is no longer employed at the facility. A narcotic policy, dated 5/25/22 and received from the Administrator as current, indicated when a controlled substance arrived at the facility it was to be immediately locked in the narcotic medication drawer and the sign out sheet was to be placed in the binder. Two nurses must count narcotics at the beginning and end of each shift. Each nurse must sign the narcotic count record log. The two nurses should be the incoming and outgoing nurses. The narcotic count record log signatures reflect that the count for number of items counted and individual count for each resident is correct for the oncoming/outgoing shifts. If there was a discrepancy in the narcotic count, the Director of Nursing was to be notified immediately. 3.1-28(a)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	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/toe 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 osteomyelitis 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 femur 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.	F 0684	**F684 G Quality of Care** **1 What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?** This resident no longer resides in the facility. **2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a wound have the potential to be affected by the alleged deficient practice. A skin sweep to identify all wounds / injuries will be completed. An audit of all residents with wounds / injuries to ensure each resident had a thorough and accurate assessment of the area will be completed. An audit of all residents with wounds / injuries to ensure each resident had physician orders for treatment of wound / injury in place and on MAR will be completed. **3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Nursing staff will be re-educated on the policy and	10/24/2023

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	The Physician's Order, was dated 8/2/23 for an x-ray of the right foot and toes. A Physician's Order, dated 8/3/23, indicated the right foot was to be monitored and skin prep with a dry dressing was to be applied every shift. A x-ray of two views of the right foot was obtained on 8/3/23. The results indicated soft tissue swelling of the anterior foot. The order for the right foot to be monitored and the treatment for the skin prep and dry dressing was missing and lacked initials that indicated the treatment had been completed as ordered on the Medication and Treatment Administration Records (MAR/TAR), dated 8/2023. The Nurses' Progress Notes, dated 8/3/23 at 10:11 p.m., 8/4/23 at 3:13 p.m., 8/5/23 at 2:45 a.m. indicated the skin prep and dry dressing treatment continued to the right toes. There were no assessments of the injury from 8/1/23 to 8/5/23 and no documentation the treatment had been applied every shift as ordered. A Nurse's Progress Note, dated 8/5/23 at 10:54 p.m., indicated the right toe still looked swollen and there were no complaints from the resident. A Skin Assessment Form, dated 8/5/23, indicated the skin was intact, the right great toe was swollen, the treatments to all affected areas continued, and there were no new open areas. A Nurse's Progress Note, dated 8/6/23 at 1:41 a.m., indicated a new order for a dry dressing with skin prep to the right toes every shift and to monitor the area was obtained.		procedure of identifying and assessing wounds / injuries. Nursing staff will be re-educated in the process of entering physician orders / treatments in the MAR and ensuring that they are completed and signed in the MAR as ordered. Nursing leadership will be re-educated on IDT procedures post resident wound / injury being identified. Nursing leadership will be re-educated on IDT procedure of new order verification to ensure order is correctly placed on MAR. Nursing leadership will be re-educated on IDT / UM procedure of daily verification of completion of treatment orders in the MAR. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** DON / designee will complete audits to ensure that nursing staff have followed policy and procedure for identifying and assessing wounds / injuries. DON / designee will complete audits to ensure that nursing staff have entered all physician orders / treatments correctly in the MAR and all treatments are being signed correctly in the MAR.	

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	A Nurse's Progress Note, dated 8/6/23 at 2:19 p.m., indicated skin prep and a dressing was applied to the right great toe, the foot remained swollen, bruised, and was reddened at the nail bed. There were no further assessments of the foot nor documentation the treatment had been completed until 8/10/23. A Wound Nurse Progress Note, dated 8/10/23 at 11:37 a.m., indicated a ruptured blister to the left great toe. The area measured at 2.4 centimeters (cm) by 2.8 cm x 0.1 cm depth. There was moderate sero-purulent (serum and pus) drainage with a faint odor. The Physician was notified and an order for a culture and sensitivity of the left great toe was received. During an interview with the Wound Nurse on 9/27/23 at 11:41 a.m., she indicated the injury was on the left foot and had taken a picture of the left foot. She was informed by the Nurse there was a blister and when she assessed the area it was an opened blister. There were no other assessments after the assessment on 8/1/23 and then on 8/5/23 it was assessed to still be swollen. The documented assessments had indicated it was the right foot that was assessed not the left. She indicated she should have been notified when the blister was first found. The Physician's Order for the treatment of the skin prep and the dry dressing had not been transcribed correctly, so it had not been placed on the 8/2023 MAR/TAR. There was no documentation the treatment had been completed. The Left Great Toe Assessment picture was of the left foot and toe and indicated there was		Regional Nurse Consultant / designee will complete audits to ensure that nursing leadership is following IDT policy and procedures of new order verification, wound / injury post identification and daily verification of completion of treatment orders in the MAR. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **5 By what date will the systemic changes for each deficiency be completed?** October 24, 2023	

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	suspected infection of the area. A Physician's Order was received on 8/10/23 to cleanse the left great toe with normal saline, pat dry, and then calcium alginate (wound treatment) was to be applied and covered with a dry dressing three times a week. A Nurse's Progress Note, dated 8/10/23 at 12:45 p.m., indicated the Wound Nurse completed a culture and sensitivity of the right great toe. A Nurse's Progress Note, dated 8/12/23 at 9:46 a.m. indicated the resident had called EMS (Emergency Medical Services) due to pain in his foot. An ambulance arrived at the facility and transferred the resident to the hospital. A Nurse's Progress Note, dated 8/12/23 at 9:05 p.m., indicated he was admitted to the hospital for treatment to the foot. The TAR, dated 8/2023, indicated the treatment to the left great toe was completed on 8/11/23 and 8/14/23 (resident was admitted into the Hospital on 8/12/23) The Emergency Room Physician Progress Note, dated 8/12/23 at 10:26 a.m., indicated left foot great toe pain. The resident indicated his toe had been run over by a wheelchair at the long term care facility. He indicated there had been drainage and an odor was present. A wound culture had been completed on 8/10/23. The left great toe was assessed and it was malodorous (bad smelling) and had redness of the toe and foot. An x-ray of the left foot indicated first digit soft tissue swelling, negative for a fracture. The wound culture from 8/10/23 had indicated MRSA (methicillin resistant staphylococcus aureus) of			

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	the left great toe. The resident would be admitted into the facility for treatment. The diagnoses included, but were not limited to, infection of the toe and cellulitis of the foot. A MRI of the left foot, dated 8/13/23, indicated, "...suspicious for developing acute osteomyelitis.." A Hospital Wound Nurse assessment, dated 8/13/23, indicated the left hallux was pink and looked like a blister was present that sloughed off. The picture taken was of the left foot. During an interview on 9/27/23 at 3:58 p.m., LPN 1 indicated she had documented the wrong foot on the assessment and it was the left toe he had injured. During an interview on 9/28/23 at 9:17 a.m., RN 2 indicated the injury was on the left foot not the right. The toenail was blue and painful. She indicated the thought the x-ray was taken of the left foot. The initial X-ray was done on the incorrect foot and treatment to the injured left foot was not completed for 10 days due to the error in identification. This Federal tag relates to Complaint IN00415780. 3.1-37			