**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

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<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bldg. 00</td>
<td>This visit was for a Recertification and State Licensure Survey.</td>
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<td>Survey dates: April 1, 2, 3, 4, and 5, 2019.</td>
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<td>Facility number: 000369</td>
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<td>Provider number: 155530</td>
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<td>AIM number: 100275190</td>
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<td>Census Bed Type: SNF/NF: 84 Total: 84</td>
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<td></td>
<td>Census Payor Type: Medicare: 11 Medicaid: 72 Other: 1 Total: 84</td>
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<tr>
<td></td>
<td>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</td>
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<td></td>
<td>Quality review completed on 4/11/19.</td>
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<tr>
<td>F 0623</td>
<td>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</td>
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**OTHER SAFEGUARDS**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 30 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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**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

SOUTH SHORE HEALTH & REHABILITATION CENTER

353 TYLER ST

GARY, IN 46402
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

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<tr>
<th>PROVIDER/SUPPLIER/CLIA</th>
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<td>X1)</td>
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<tr>
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<td>B. WING</td>
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<td>155530</td>
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**DATE SURVEY COMPLETED**

|                        | 04/05/2019             |

**NAME OF PROVIDER OR SUPPLIER**

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<thead>
<tr>
<th>SOUTH SHORE HEALTH &amp; REHABILITATION CENTER</th>
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<tbody>
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<td>353 TYLER ST, GARY, IN 46402</td>
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<th>(X5) COMPLETION DATE</th>
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<td>PREFIX</td>
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<td>TAG</td>
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<td>TAG</td>
<td>REGULATORY OR LSC IDENTIFYING INFORMATION</td>
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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when:

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;
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SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

353 TYLER ST

GARY, IN 46402

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(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

In the case of facility closure, the individual who is the administrator of the facility must...
Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 2 of 4 residents reviewed for hospitalization. (Residents 46 and 34)

Findings include:

1. The record for Resident 46 was reviewed on 4/3/19 at 9:15 a.m. Diagnoses included, but were not limited to, chronic kidney disease stage 4, anxiety, renal dialysis, atherosclerotic heart disease without angina pectoris, anemia, dementia without behavior disturbance, major depressive disorder, heart failure and cardiomyopathy.

The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/18, indicated the resident had some moderate cognitive impairment.

Documentation in the nursing progress notes, dated 1/8/19 at 2:39 p.m., indicated the resident's Physician wanted him to be a direct admit to the hospital for dialysis. The resident refused to go, he indicated he had told the Physician that he did not want dialysis. The Physician's nurse was informed and she called the facility back indicating the Physician still wanted to see the resident and treat his kidneys at the hospital to try and improve functioning without dialysis. The resident was made aware. He indicated he would accept treatment but no dialysis. The Physician's

It is the intention of this facility to ensure residents/responsible parties are notified in writing related to a hospital transfer.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Residents 34, 69, and 46 have returned and remain in this facility. Any other residents discharged to a hospital have the potential to be affected by this alleged deficient practice.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents discharged from this facility to a hospital since 4/1/2019 have been audited to determine if any other residents/responsible parties were notified.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Social Services has been educated on the process of sending a copy of discharge papers to residents who
office was notified, transportation was set up and an attempt was made to contact the resident's Power of Attorney (POA).

At 5:29 p.m., on 1/8/19, the resident was transported to the hospital. There was no documentation to indicate if the resident or the POA had received a written copy of the transfer and discharge notice.

Interview with the Interim Director of Nursing on 4/4/19 at 10:30 a.m., indicated there was no documentation indicating the resident received a copy of the transfer/discharge notice. The record for Resident 34 was reviewed on 4/2/19 at 1:19 p.m. Diagnoses included but were not limited to, seizures, disorientation, weakness, dementia, traumatic brain injury, major depressive disorder, altered mental status, syncope, history of falling, Alzheimer's disease, high blood pressure, and anxiety disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 1/1/19, indicated the resident was not alert and oriented and needed supervision with one person physical assist for locomotion on and off the unit and walking.

Nurse's notes, dated 9/10/18 at 6:10 a.m., indicated the resident was on the floor in the bathroom and unresponsive. The resident was sent to the hospital and admitted.

Nurse's notes, dated 12/6/18 at 3:10 p.m., indicated the resident was lying on the floor snoring, unable to arouse with sternum chest rub. The resident was incontinent of bowel and bladder. 911 was called and the resident was sent to the hospital and admitted.

discharge to a hospital when they are alert and oriented and to provide a copy to responsible parties to residents who are not alert or oriented at the time of discharge. Social Services will maintain a log of all hospital discharges with who was provided copies of discharge paperwork. This log will be reviewed within 4 days post discharge in the morning clinical meeting for compliance. A summary log will be presented to the QAPI committee for compliance and further recommendations is required.

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 into place: Social Services will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATEMENT OF DEFICIENCIES**

**IDENTIFICATION NUMBER**

155530

**MULTIPLE CONSTRUCTION**

**DATE SURVEY COMPLETED**

04/05/2019

**NAME OF PROVIDER OR SUPPLIER**

SOUTH SHORE HEALTH & REHABILITATION CENTER

353 TYLER ST

GARY, IN 46402

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<tr>
<td>F 0655</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>Nurses' notes, dated 3/12/19 at 8:20 a.m., indicated the resident was observed having a seizure. 911 was called and the resident sent out to the hospital and admitted.</td>
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<td>There was no documentation in the above nurse's notes to indicate the resident's responsible party was given the state approved transfer form in writing.</td>
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<td>Interview with the Social Service Director on 4/3/19 at 2:59 p.m., indicated she had not been sending the family the State approved form in writing when a resident was discharged to the hospital.</td>
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<tr>
<td>3.1-12(a)(6)(A)(ii)</td>
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<td></td>
<td>483.21(a)(1)-(3) Baseline Care Plan</td>
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<tr>
<td>§483.21 Comprehensive Person-Centered Care Planning</td>
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<td>§483.21(a) Baseline Care Plans</td>
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<tr>
<td>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</td>
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<td>(i) Be developed within 48 hours of a resident's admission.</td>
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<td>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</td>
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<td></td>
<td>(A) Initial goals based on admission orders.</td>
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<td>(B) Physician orders.</td>
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<td>(C) Dietary orders.</td>
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<td>(D) Therapy services.</td>
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<td>(E) Social services.</td>
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</table>
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

Based on record review, and interview, the facility failed to develop an initial plan of care within 48 hours of admission related to medications for 2 of 22 residents whose care plans were reviewed.
(Residents 27 and 62)

Findings include:

1. The record for Resident 27 was reviewed on 4/3/19 at 10:55 a.m. The resident was admitted on 12/14/18. Diagnoses included, but were not limited to, hemorrhage of rectum, colon cancer, hematuria, anemia, abnormal posture, high blood pressure, colostomy, cardiac arrhythmia, diabetes, pain, urine retention, tachycardia, bone cancer,

It is the intention of this facility to develop baseline care plans within the first 48 hours after admission and to be completed including medication and appropriate diagnosis.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Residents 27 and 62 remain in the facility with current care plans reviewed and revised as needed.

How other residents having the
The Quarterly Minimum Data Set (MDS) assessment, dated 1/18/19, indicated the resident was alert and oriented. The resident weighed 125 pounds and had a significant weight loss.

The resident was discharged from the facility on 12/23/18 to the hospital with an anticipated return. He was readmitted on 1/9/19. The resident was again discharged to the hospital on 1/25/19 and returned on 1/29/19.

The 12/14/18 and 1/29/19 initial baseline care plans were not completed and were entirely blank.

Interview with the Interim Director of Nursing on 4/4/19 at 10:05 a.m., indicated the baseline care plan should have been completed within 48 hours of admission.

2. The record for Resident 69 was reviewed on 4/2/19 at 2:36 p.m. The resident was admitted to the facility on 1/14/19. Diagnoses included, but were not limited to, abscess to left foot, abnormal posture, high blood pressure, diabetes type 2, cellulitis of lower limb, history of venous embolism, major depressive disorder, pain, hyperlipidemia, peripheral neuropathy, insomnia, and osteoarthritis.

The Admission Minimum Data Set (MDS) assessment, dated 1/11/19, indicated the resident was alert and oriented. He received insulin and an antidepressant in the last 7 days.

Physician's orders, dated 1/4/19, indicated Lantus insulin 50 units at bedtime and Zolpidem (a hypnotic medication used for sleep) 10 milligrams potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any new admissions or readmission have the potential to be affected by this alleged deficient practice. New admission and readmissions from the past 15 days were audited to ensure that initial baseline care plans were created and completed within 48 hours. Licensed nurses were in-serviced on the admission process including creating and completion of the baseline care plans within 48 hours of admission.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: This concern was self-identified with audits conducted since November 2018. Additional nurse education was provided at that time. Nurses have been re-in-serviced on the baseline care plan requirements of all admissions and readmissions. IDT team will audit all new admissions and readmissions for compliance during clinical meetings held Monday through Friday. Any findings of non-compliance will be corrected and admitting nurse will be re-educated on process. A summary of audits will be presented to the QAPI committee for review and recommendations.
(mg) 1 tablet at bedtime for difficulty sleeping.

Physician's orders, dated 1/5/19, indicated Duloxetine HCL (an antidepressant medication) 30 mg 2 capsules daily.

The baseline care plan, dated 1/4/19, did not address the insulin or diabetes, nor the hypnotic and antidepressant medications.

Interview with the Interim Director of Nursing on 4/4/19 at 10:05 a.m., indicated the baseline care plan did not address the resident's psychotropic medications or the diabetes.

3.1-35(a)

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 into place: Nursing will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019

483.21(b)(1)

Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and...
psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10 (c) (6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv) In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Based on observation, record review, and interview, the facility failed to implement the care plan and Physician's orders related to the administration of enteral feeding. The facility also failed to develop a plan of care for edema for 3 of 22 residents whose care plans were reviewed. (Residents 23, 69, and 70)

Findings include:

1. On 4/2/19 at 9:30 a.m., Resident 23 was observed in bed. At that time, the resident's tube

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<tbody>
<tr>
<td>F 0656</td>
<td>It is the intention of this facility to implement care plans to follow Physicians orders related to administration of enteral feeding that are current and reflective of the Physician orders.</td>
<td>05/05/2019</td>
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Residents 23 and 70 have had their care plans revised to address their edema. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents who receive enteral feeding have had their care plans audited and were revised to reflect Physician enteral feeding orders. All residents have the potential to be affected by this alleged deficient practice. The IDT reviewed and revised all comprehensive care plans to ensure the care plans are current and reflective of the Physicians orders. 

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been in-serviced on updating a resident's plan of care with a condition change. MDS nurse will present all new orders from previous work day to IDT to ensure they are reflective of current status. Non-compliance will be addressed with individual Licensed Nurse. Reports of non-compliance will be reported each month to the QAPI committee for recommendation. How the corrective action(s) will be monitored to ensure the
Interview with the 300 unit Unit Manager on 4/4/19 at 10:15 a.m., indicated there was no stop time for the enteral feedings because they account for activities of daily living care, medication pass or any other time the peg tube would be on hold or off. The start time could be different every day, however, they were not following the Physician's orders the way it was written related to the tube feedings.

2. On 4/2/19 at 12:50 p.m. and 2:30 p.m., Resident 69 was observed in bed. At those times, the tube feeding was infusing at 60 cubic centimeters/hour (cc/hr).

The record for Resident 69 was reviewed on 4/3/19 at 11:27 a.m. The resident was admitted to the facility on 12/14/18. Diagnoses included, but were not limited to abnormal gait, weakness, cognitive communication deficit, hemiparesis, high blood pressure, angina, gastrostomy tube (a tube inserted directly into the stomach for nutrition), anxiety, cardiac arrhythmia, dementia without behaviors, muscle weakness, stroke and osteoarthritis.

The Significant Change Minimum Data Set (MDS) assessment, dated 3/6/19, indicated the resident was not alert and oriented. He was totally dependent on staff with 2 person physical assist for transfers and personal hygiene. He was totally dependent with one person physical assist for locomotion on and off the unit and eating. The resident had no oral problems and had a significant weight loss. He required a feeding tube and 51% or more of his calories came from enteral feedings.

The care plan, updated 4/1/19, indicated the resident required tube feeding due to swallowing deficient practice will not recur, i.e., what quality assurance program will be put into place: Director of Nursing/designee will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
difficulties and was at risk of complications related to its presence and function. The approaches were to see Physician's orders for current feeding orders.

The care plan, updated 4/1/19 indicated the resident had a nutritional problem or potential nutritional problem related nothing by mouth and received peg tube feeding of 2 Cal HN. The approaches were to provided tube feeding 2 Cal HN as ordered.

Physician's orders, dated 2/28/19, indicated 2 cal HN at 60 cc/hr for 18 hours. Total volume infused 1080 milliliters (ml).

The Medication Administration Record, dated 4/2019, indicated the tube feeding was to be turned on at 5:00 p.m.

Interview with the Director of Nursing on 4/4/19 at 10:25 a.m., indicated the tube feeding was not infusing according to Physician's orders.

On 4/1/19 at 9:35 a.m., Resident 70 was observed seated in a wheelchair next to his bed. His left leg and foot were extremely swollen. Interview at the time with the resident indicated he was taking a water pill to help remove the fluid.

The record for Resident 70 was reviewed on 4/3/19 at 8:58 a.m. Diagnoses included, but were not limited to, generalized edema, bilateral knee osteoarthritis, lower leg contracture, peripheral vascular disease, and lymphedema.

A Nurse Practitioner note, dated 3/28/19 at 11:45 a.m. and noted as a late entry recorded on 4/3/19 at 12:00 p.m., indicated the resident was being seen related to edema, congestive heart failure exacerbation, and hypertension. Add Zaroxolyn (a diuretic medication used to treat edema) 2.5 milligrams a day for 5 days.
The Quarterly Minimum Data Set (MDS) assessment, dated 3/6/19, indicated the resident was alert and oriented, required a 2 person physical assist with transfers, and had taken diuretics in the past 7 days.

There was no care plan related to the resident's edema or the use of diuretic medication.

Interview with the Unit Manager of 500 on 4/3/19 at 1:25 p.m., indicated there was no new and/or updated care plan related to the resident's edema and/or the use of diuretic medication.

3.1-35(a)

483.24(a)(2) ADL Care Provided for Dependent Residents
§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;

Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent on activities of daily living were provided care in a timely manner related to incontinence and oral care and getting a resident out of bed for 2 of 2 residents reviewed for activities of daily living. (Residents 4 and 69)

Findings include:

1. On 4/3/19 at 9:35 a.m., 9:42 a.m., 10:34 a.m., 10:36 a.m., 11:10 a.m., 12:08 p.m., 1:10 p.m., and 1:24 p.m., Resident 4 was observed sitting in a recliner geri chair in the 400 unit dining room in front of the television. During those times, there was no staff observed to check, change and/or provide

It is the intention of this facility to ensure residents dependent on ADL’s has ADL’s provided in a timely manner related to incontinence care, oral care and getting out of bed. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident 69 has discharged from the facility. Resident 4 remains in the facility and is being checked and changed in a timely manner. The plan of care relating to resident
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

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<th>A) BUILDING</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
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**NAME OF PROVIDER OR SUPPLIER**

SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

353 TYLER ST
GARY, IN 46402

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- **Tag**: preferences was reviewed and revised.
- **Tag**: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

  Residents who are dependent with care have the potential to be affected by this alleged deficient practice. An audit of these identified dependent resident's care plans was reviewed and revised as necessary for timely care. Nursing staff was educated on the importance of providing incontinence care, oral care and getting residents out of bed in a timely manner as related to the individual plan of care for each resident. Residents identified as being dependent in care will be observed by the charge nurse on each shift.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

- Unit managers/designee will audit dependent residents ADL documentation on Point Click Care a minimum of 3x per week for compliance. Results of these audits will be presented to the QAPI committee for further recommendation.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

  The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/18, indicated the resident was not alert and oriented. She was totally dependent with a 2 person physical assist for transfers and totally dependent with a 1 person assist for toileting. The resident was always incontinent of bowel and bladder.

  The care plan, updated 1/9/19, indicated the resident was the was incontinent and was at risk of skin breakdown and other related complications. The approaches were to observe for incontinence every two hours and as needed and provide incontinence care after every meal.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**: 155530

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED**: 04/05/2019

**NAME OF PROVIDER OR SUPPLIER**: SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 353 TYLER ST, GARY, IN 46402

### SUMMARY STATEMENT OF DEFICIENCY

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#### INCONTINENT EPISODE

A bowel and bladder assessment, dated 1/21/19, indicated the resident was a poor candidate for toilet retraining and scheduled toileting.

Interview with the Interim Director of Nursing (DON) on 4/4/19 at 10:05 a.m., indicated the resident should have been checked and changed at least every two hours.

The current and undated "Incontinence Management" policy, provided by the Interim DON on 4/5/19 at 12:08 p.m., indicated incontinent residents will be checked and changed every two hours and as needed.

2. On 4/1/19 at 9:22 a.m., Resident 69 was observed in bed. At that time, his mouth was open and a large amount of dried mucous was noted on both lips, inside his mouth and on his tongue. The mucous was dried and crusty pieces were observed on the side of his lips.

On 4/2/19 at 8:15 a.m., and 9:45 a.m., the resident was observed in bed. At those times, his mouth was open and he had a large amount of dry, crusty mucous noted on the inside on the roof of his mouth and on his tongue. His lips were also dry and flaky. CNA 1 walked into the room at 9:45 a.m., but did not provide any type of oral care. At 2:30 p.m., the resident was observed in bed. His mouth was open and his tongue has a residue of dried mucous crust and on it as well as his upper lip.

On 4/3/19 at 8:34 a.m., resident was observed in bed. At that time his mouth was clean, but the inside of his mouth including his tongue had a layer of a dried residue of mucous noted. At 12:08

**PROVIDER'S PLAN OF CORRECTION**

**EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

recur, i.e., what quality assurance program will be put into place: Nursing will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

**Date systemic changes will be completed**: 5/5/2019
p.m., the resident was still in bed and the layer of dried residue remained on his tongue.

On 4/4/19 at 8:10 a.m., the resident was observed in bed. His tongue had a dried layer of residue of mucous noted in the middle and towards the back. At 2:25 p.m., the resident had a large amount of dried mucous noted on the inside of his mouth and as well as his tongue.

The record for Resident 69 was reviewed on 4/3/19 at 11:27 a.m. The resident was admitted to the facility on 12/14/18. Diagnoses included, but were not limited to abnormal gait, weakness, cognitive communication deficit, hemiparesis, high blood pressure, angina, gastrostomy tube (a tube inserted directly into the stomach for nutrition), anxiety, cardiac arrhythmia, dementia without behaviors, muscle weakness, stroke and osteoarthritis.

The Significant Change Minimum Data Set (MDS) assessment, dated 3/6/19, indicated the resident was not alert and oriented. He was totally dependent on staff with 2 person physical assist for transfers and personal hygiene. He was totally dependent with one person physical assist for locomotion on and off the unit and eating. The resident had no oral problems and had a significant weight loss. He required a feeding tube and 51% or more of his calories came from enteral feedings.

The care plan, updated 4/1/19, indicated the resident had an activities of daily living self care deficit related to impaired mobility and muscle weakness. The approaches were to transfer the resident with a 2 person assist.

The care plan, updated 4/1/19, indicated the
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<td>F 0679</td>
<td>resident had a stroke and was at risk of functional decline. The approaches were to monitor/document the resident's abilities for activities of daily living and assist the resident as needed. There was no documentation the resident refused or resisted oral care or to get out of bed. There was no Physician's order for the resident to be on bed rest. Interview with the Interim Director of Nursing on 4/4/19 at 10:05 a.m., indicated the resident should have been provided with frequent oral care and gotten out of bed.</td>
<td>3.1-38(a)(2)(B) 3.1-38(a)(3)(C)</td>
<td>483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure activities were provided for a resident with a significant change in condition for 1 of 3 residents reviewed for activities. (Resident 54)</td>
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<tr>
<td>F 0679</td>
<td>It is the intention of this facility to provide activities or stimulation for dependent residents. What corrective action(s) will be accomplished for those residents found to have been</td>
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### Finding includes:

On 4/1/19 at 9:43 a.m., and 11:40 a.m., Resident 54 was observed in his room in bed with his eyes open, he was responsive to verbal stimuli, the television was off and there was no radio on the resident's side of the room.

On 4/2/19 at 9:18 a.m., the resident was observed in bed with his eyes open looking up toward the ceiling. At 1:55 p.m., the resident was observed in bed positioned toward the wall with his eyes opened, he was responsive to verbal stimuli, the television was off and there was no radio on the resident's side of the room.

On 4/3/19 at 8:47 a.m., the resident was observed in bed mouth-breathing, his eyes were closed at the time. At 11:52 a.m., the resident remained in bed, the television was off and there was no radio on the resident's side of the room.

The record for Resident 54 was reviewed on 4/3/19 at 11:00 a.m. Diagnoses included, but were not limited to, Parkinson's, falls, aphasia, and cerebral infarction.

The Annual Minimum Data Set (MDS) assessment, dated 2/21/19, indicated the resident was cognitively impaired and required a 2 person physical assist with transfers.

A care plan, dated 7/16/18, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs. The interventions included, but were not limited to, ensure that the activities were compatible with the resident's interests and preferences.

The Preferences for Customary Routine and affected by the alleged deficient practice: Resident 54 was a Hospice patient and has expired.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

Dependent residents who are not receiving 1 x 1 activities or provided with some type of stimulation have the potential to be affected by this alleged deficient practice. Activities staff were in-serviced on the importance of reviewing the activity or stimulation of choice for dependent residents daily to assure those services or equipment are properly working or in place.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Activities Director/activity designee will attend clinical meetings and be updated of residents who may have a change of condition and will need to be added to the 1x1 list. A scheduled morning activity person will observe 1x1, bedbound and Hospice residents daily to assure music, TV or preferred stimulation is provided and functioning for resident. Random checks during the day will be conducted to
Activities sheet, dated 2/21/19, indicated it was important to the resident to listen to music he liked.

Interview with the Activity Director on 4/3/19 at 12:08 p.m., indicated the resident was to receive 1:1 visits 3 days a week on Monday, Wednesday, and Friday. She was not aware the resident's television had not been turned on for him and she would put a radio in the resident's room per his preferences.

3.1-33(a)
3.1-33(b)

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 into place:

Activities will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
edema (swelling) was properly assessed, monitored, and documented for 1 of 1 residents reviewed for edema. (Resident 70)

Finding includes:

On 4/1/19 at 9:35 a.m., Resident 70 was observed seated in a wheelchair next to his bed. His left leg and foot were extremely swollen. Interview at the time with the resident indicated he was taking a water pill to help remove the fluid.

The record for Resident 70 was reviewed on 4/3/19 at 8:58 a.m. Diagnoses included, but were not limited to, generalized edema, bilateral knee osteoarthritis, lower leg contracture, peripheral vascular disease, and lymphedema.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/6/19, indicated the resident was alert and oriented, required a 2 person physical assist with transfers, and had taken diuretics in the past 7 days.

There was no care plan related to the resident's edema and the use of diuretic medication.

Physician's orders indicated the following: Metolazone (a diuretic medication for swelling) 2.5 milligrams and daily weights, dated 3/29/19, and diuretic monitoring, dated 3/27/19.

The March and April 2019 Medication Administration Record (MAR) indicated no documentation related to diuretic monitoring.

There were no daily weights documented.

Interview with the Unit Manager of 500 on 4/3/19 at 1:25 p.m., indicated there was no new and/or care in accordance with professional standards of practice, the comprehensive person center plan of care and the resident choices.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident 70 remains in the facility and his edema has been properly assessed, monitored and documented on the care plan. The care plan has been revised related to the edema and the use of the diuretic.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this alleged deficient practice. All resident care plans have been reviewed and revised by the IDT to ensure the residents are receiving the treatment, care and documentation. Licensed Nurses will be in-serviced on providing care and services according to Physician orders and the care plan.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The MDS nurse will bring all the prior Physician orders from the previous
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<td>3.1-37(a)</td>
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<td>updated care plan related to the Resident's edema and/or the use of diuretic medication. The nursing staff should have been monitoring the resident's edema and documenting their findings, and the daily weights were not done due to the scale was malfunctioning.</td>
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<tr>
<td>483.25(a)(1)(2)</td>
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<td>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-</td>
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<td>$\S$483.25(a) Vision and hearing</td>
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<td>$\S$483.25(a)(1) In making appointments, and</td>
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<td>$\S$483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing.</td>
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**NAME OF PROVIDER OR SUPPLIER**

SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

353 TYLER ST

GARY, IN 46402

**ID**

155530

**PREFIX**

04/05/2019

**TAG**

00

**X3) DATE SURVEY COMPLETED**

04/05/2019

**X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER**

155530

**X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**F 0685**

It is the intention of this facility to ensure vision appointments are scheduled.

**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**

Resident 60 remains in the facility. A vision appointment has been scheduled for this resident.

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**

Residents who request vision services have the potential of being affected by this alleged deficient practice. An audit was completed to identify residents who have not received vision services in the past 12 months. Those residents/responsible parties were asked if they request or need any vision services. Any residents identified will be scheduled for services requested.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

Social Services will maintain a log of residents who have requests for vision services, when services are scheduled and by which provider,

**hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.**

Based on record review and interview, the facility failed to ensure vision appointments were scheduled for 1 of 1 residents reviewed for vision. (Resident 60)

Finding includes:

During an interview with Resident 60 on 4/2/19 at 9:35 a.m., indicated he needed new glasses and was waiting for the Social Service Director to schedule an appointment for him.

The record for Resident 60 was reviewed on 4/3/19 at 2:10 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, and glaucoma.

The Annual Minimum Data Set (MDS) assessment, dated 2/25/19, indicated the resident was alert and oriented and his vision was adequate.

The 5/21/18 Optometry note indicated the resident was not seen, leave of absence.

Interview with the Social Service Director on 4/4/19 at 10:09 a.m., indicated the resident was not seen by the Optometrist in 2018, however, she would promptly schedule an appointment for him to be seen. The resident missed his last scheduled visit and she should have followed up with him and rescheduled his appointment.

3.1-39(a)(1)
### Statement of Deficiencies and Plan of Correction

**Identification Number:**
- X1) Provider/Supplier/CLIA: 155530
- X2) Multiple Construction:
  - A. Building: 00
  - B. Wing: 
- X3) Date Survey Completed: 04/05/2019

**Name of Provider or Supplier:**
- South Shore Health & Rehabilitation Center
  - Street Address, City, State, Zip Code: 353 Tyler St, Gary, In 46402

**Summary Statement of Deficiency:**
- (Each Deficiency Must Be Preceded By Full Regulatory or LSC Identifying Information)

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<td>F 0688</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and the date services were provided. These audits will be reviewed weekly by the IDT for compliance. 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 into place: Social Services will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive Social months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. Date systemic changes will be completed: 5/5/2019</td>
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assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

Based on observation, record review and interview, the facility failed to ensure a restorative nursing program was implemented for 1 of 2 residents reviewed for limited range of motion (ROM). (Resident 78)

Finding includes:

Interview with Resident 78 on 4/1/19 at 12:04 p.m., indicated that he had some stiffness to his left wrist area and nobody had been working with him to exercise his arms and legs. He indicated that he was not receiving therapy at the time and restorative nursing was not working with him either.

The record for Resident 78 was reviewed on 4/4/19 at 11:49 a.m. Diagnoses included, but were not limited to, right above the knee amputation, diabetes, muscle wasting and atrophy, muscle weakness, major depressive disorder, end stage renal disease, dependence on renal dialysis, and atherosclerotic heart disease.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/11/19, indicated the resident was cognitively intact for decision making. The resident required extensive assistance with bed mobility and transfers and had impairment on both sides of his lower extremities related to functional ROM. The resident had been receiving physical therapy during the assessment reference period.

A Physician's order, dated 3/1/19, indicated the resident was to receive skilled physical therapy three times a week for 30 days.

It is the intention of this facility that a resident with limited mobility receives appropriate services to maintain or improve mobility.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident 78 is receiving a restorative program as recommended by therapy.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The Restorative Nurse and the Therapy Lead conducted an audit on all residents to ensure they were receiving the restorative programming recommended by therapy. No other residents were identified.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Therapist recommending a restorative program will complete the restorative communication form which indicates what program they are recommending. The Therapy Lead/Designee will present the communication form.
The physical therapy discharge summary, dated 3/19/19, indicated prognosis to maintain current level of function was good with consistent staff follow through.

Discharge recommendations were made for a restorative nursing program/functional maintenance program to facilitate maintaining the resident's current level of performance in order to prevent decline. The development of and instruction in the following restorative nursing programs had been completed with the interdisciplinary team related to ambulation, transfers and bed mobility.

The resident had no current orders for a restorative nursing program

Interview with the Interim Director of Nursing on 4/5/19 at 12:20 p.m., indicated the Physical Therapy Director did not relay to restorative staff the recommendations from the discharge summary. She indicated the resident was going to be screened and picked up by either therapy or restorative.

3.1-42(a)(2)

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 into place: Restorative Nurse/designee will present a monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. Date systemic changes will be completed: 5/5/2019
tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered for 1 of 1 residents reviewed for oxygen. (Resident 1)

Finding includes:

On 4/1/19 at 9:39 a.m., Resident 1 was observed in a recliner, his oxygen was infusing at 2.5 by nasal cannula, however, the tubing was resting on the head of the bed.

On 4/2/19 at 9:01 a.m., the resident's oxygen concentrator was not on and the tubing was resting on the night stand next to his bed.

The record for Resident 1 was reviewed on 4/4/19 at 9:37 a.m. Diagnoses included, but were not limited to, hemiplegia, muscle wasting, cerebral infarction, abnormal posture, aphasia, mental and behavioral disorders, and traumatic brain injury.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/19, indicated the resident was severely cognitively impaired, he was totally dependent with a 2 person physical assist for transfers and required oxygen.

A Physician's order, dated 12/28/18, indicated oxygen at 3 liters per nasal cannula.

It is the intention of this facility to provide respiratory services consistent with professional standards of practice.

**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The facility is administering oxygen as ordered for resident #1.

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident who has an order for oxygen to be administered has the potential to be affected by this alleged deficient practice. Nursing staff were in-serviced on the importance of monitoring residents who have oxygen orders to assure oxygen is being administered as ordered. Unit nurses will observe each shift these residents are receiving oxygen as ordered.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient**
A care plan, dated 4/2/19, indicated the resident required oxygen therapy. Interventions included, but were not limited to, administer oxygen therapy as order.

Interview with the Unit Manager on 4/3/19 at 1:51 p.m., indicated the resident's oxygen should have been in place and at the correct flow rate.

3.1-47(a)(6)

practice does not recur: Unit supervisors/designee will observe residents receiving oxygen a minimum of 3x per week on alternating shifts. Supervisors will log these observations and times. Any findings of non-compliance will be addressed with the charge nurse and findings will be reported to the QAPI committee for review and recommendations.

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 into place: Nurse Supervisors will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
## Statement of Deficiencies and Plan of Correction

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<td>§483.45(d)(2) For excessive duration; or</td>
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<td>It is the intention of this facility to ensure that parameters are monitored and followed related to medication administration. <strong>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</strong> Resident #2 remains in the facility and has had no negative effects of this alleged deficient practice. <strong>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</strong> Residents who have parameters to be monitored and followed relating to medication administration have the potential to be affected by this alleged deficient practice. Licenses nurses and QMA’s were in-serviced on medication administration protocols including season.</td>
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### Summary Statement of Deficiency

**§483.45(d)(2) For excessive duration; or**

**§483.45(d)(3) Without adequate monitoring; or**

**§483.45(d)(4) Without adequate indications for its use; or**

**§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or**

**§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.**

Based on record review and interview, the facility failed to ensure heart rate parameters were monitored and followed related to the use of cardiac medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 2)

Finding includes:

The record for Resident 2 was reviewed on 4/2/19 at 2:52 p.m. Diagnoses included, but were not limited to, hypertensive heart disease without heart failure, syncope and collapse (fainting), dementia with behavior disturbance, and nontraumatic subarachnoid hemorrhage.

A Physician's order, dated 2/9/19, indicated the resident was to receive Metoprolol Tartrate (a medication used to treat high blood pressure and chest pain) 25 milligrams (mg) daily. The medication was to be held if the resident's systolic (top number) blood pressure was less than 110 and if his pulse was less than 60.

The March 2019 Medication Administration Record (MAR) indicated the following:
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- On 3/5/19 at 9:00 a.m., the resident's pulse was 57 and the Metoprolol was signed out as being given.
- On 3/30/19 at 9:00 a.m., the resident's pulse was 58 and the Metoprolol was signed out as being given.

Interview with the Interim Director of Nursing on 4/5/19 at 12:20 p.m., indicated the resident should not have received the Metoprolol based on his documented heart rate.

3.1-48(a)(3)

Checking parameters when ordered to ensure medications are not administered if not within parameter guidelines.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

- An audit of resident med passes was completed to identify any residents with parameter orders relating to medication administration. Unit supervisors will observe up to 3 resident med passes per week on various shifts for residents who have medication parameters ordered to ensure compliance. Any observations of non-compliance will be re-educated at that time and reported to the Director of Nursing. Results of these observations will be reported monthly to the QAPI committee.

**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 into place:**

Nursing will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

**Date systemic changes will be...**
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
SOUTH SHORE HEALTH & REHABILITATION CENTER
353 TYLER ST
GARY, IN 46402

ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCY
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

483.45(f)(1) Free of Medication Error Rts 5 Prct or More
§483.45(f) Medication Errors.
The facility must ensure that its-
§483.45(f)(1) Medication error rates are not 5 percent or greater;
Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Four errors were observed during 28 opportunities for errors during medication administration. This resulted in a medication error rate of 14.2%. (Residents 62 and 83)

Findings include:

1. On 4/4/19 at 8:54 a.m., RN 1 was observed preparing medications for Resident 62. The RN indicated the resident was to receive Metoprolol (a medication used to treat high blood pressure and chest pain) 50 milligrams (mg) by mouth daily. Rather than placing the tablet in the medication cup, the RN placed the punch card back into the medication cart and proceeded to give the resident the rest of his medications.

When asked why the Metoprolol was not given, the RN did not realize she put the punch card back into the medication cart without dispensing the medication.

It is the intention of this facility to ensure medication error rates are less than 5% during medication passes.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #83 and #63 have discharged from this facility.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
Residents receiving medications have the potential to be affected by this alleged deficient practice. RN #1 was re-educated by the pharmacy consultant on appropriate medication passes.

The pharmacy consultant completed a med pass observation with RN #1. Licensed Nurses and Q.M.A.’s were
2. On 4/4/19 at 9:12 a.m., RN 1 was observed preparing medications for Resident 83. The RN indicated the resident was to receive a Rivastigmine (a medication used to treat dementia) transdermal patch 4.6 mg/24 hours.

The following pills were put in the medication cup:
- Carbidopa/Levodopa (a medication to treat Parkinson's disease) 25-100 mg (1)
- Vitamin D3 1000 units (1)
- Nuplazid (an antipsychotic) 10 mg (1)
- Aspirin 81 mg (1)
- Vitamin E 100 units (1)
- Balsalazide 750 mg (3)

The RN proceeded into the resident's room. The Rivastigmine patch was removed from the resident's right shoulder and one patch was applied to the resident's left shoulder. The resident received all of his medications with water.

The record for Resident 83 was reviewed on 4/4/19 at 12:30 p.m. A Physician's order, dated 3/8/19, indicated the resident was to receive two Rivastigmine patches rather than one.

A Physician's order, dated 3/27/19, indicated the resident was to receive Zoloft (an antidepressant) 50 mg daily at 9:00 a.m. The resident did not receive Zoloft with his morning medications.

A Physician's order, dated 3/5/19, indicated the resident was to receive Amantadine HCl (a medication used to treat Parkinson's disease) 100 mg daily at 9:00 a.m. The resident did not receive Amantadine with his morning medications.

Interview with the Interim Director of Nursing on 4/5/19 at 1:30 p.m., indicated the medications in-serviced on proper medication passes and the 5 rights of medication administration.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
Medication pass observations will be completed for 4 nurses weekly on varied shifts/days by the Director of Nursing/Pharmacy consultant/Designee for accuracy. Any observations of >5% error rates will be reported to the Director of Nursing/designee. Licensed Nurses/Q.M.A. not in compliance will be re-educated and will complete a competency test. Any observations of >5% error rates will be logged with corrective action, education provided and a copy of competency test, these results will be reviewed by the Director of Nursing/Administrator for action plan. Summary of weekly observations will be presented to the QAPI Committee for review.

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 into place:
Nursing will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will
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<td>Label/Store Drugs and Biologicals</td>
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<td>§483.45(g) Labeling of Drugs and Biologicals</td>
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<td>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</td>
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<td>§483.45(h) Storage of Drugs and Biologicals</td>
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<td>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</td>
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<td>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</td>
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<td>It is the intention of this facility to ensure medications are stored properly.</td>
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medications on top of the medication cart and ensuring the emergency drug kit was secured for 1 of 4 medication carts and for 1 of 4 medication rooms. (The 200 unit medication room and medication cart)

Findings include:

1. On 4/4/19 at 9:15 a.m., RN 1 left a punch card containing Metoprolol (a cardiac medication) tablets underneath a box of gloves on top of the 200 unit medication cart while she was administering medications to a resident. The medication cart was out of the RN's view while she was administering the medications.

2. On 4/5/19 at 11:27 a.m., during an observation in the 200 unit medication room, the refrigerated emergency drug kit (EDK) which usually contained vials of insulin, insulin pens and a vial of Lorazepam (an anti-anxiety medication) was open and not secured with a red zip tie. The label on the box indicated after the box was opened, it was to be sealed with a red lock. The only item that remained in the EDK kit was the vial of Lorazepam. Documentation indicated a Lantus insulin pen had been removed on 1/8/19 and a Levemir insulin pen had been removed on 3/10/19.

Interview with LPN 2 at that time, indicated the box should have been sealed and a replacement EDK kit should have been ordered.

Interview with the Interim Director of Nursing on 4/5/19 at 1:30 p.m., indicated the medications should not have been left on top of the medication cart and the EDK should have been sealed with a red zip tie after being opened.

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<td>GARY, IN 46402</td>
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What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were identified in this alleged deficient practice.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: RN #1 was re-educated by the Director of Nursing on appropriate storage of medication cards. Licensed Nurses and QMA's were in-serviced on proper medication storage and security protocols of the emergency drug kits.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The observation of medication card storage will be monitored with med pass observations. Observations will be completed for a minimum of 4 nurses weekly on varied shifts by the Director of Nursing/Pharmacy consultant/Unit Supervisors. Unit Supervisors will monitor security of emergency drug kits 5x per week.

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 into place: Nursing will present...
The facility policy titled "Emergency Dispensing Kits-Noncontrolled Substances" was reviewed on 4/5/19 at 1:30 p.m. The policy was identified as current by the Interim Director of Nursing. The policy indicated after the kit was opened, it was supposed to be locked with a red tie.

3.1-25(m)

483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed

§483.60(c) Menus and nutritional adequacy.

Menus must-

§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
Based on observation, record review, and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect the 7 residents in the facility who received a pureed diet.

Finding includes:

On 4/4/19 at 11:10 a.m., Dietary Cook 2 was observed preparing pureed baked chicken. At that time, she donned clean gloves to both hands and removed the pan of baked chicken from the steam table. She removed the chicken from the pan with her gloved hands and placed it in the food processor. She walked over to the steam table and obtained an unmeasured amount of liquid from the chicken pan. She turned on the processor and added the liquid from the chicken pan. She stopped the processor and obtained an unmeasured amount of liquid from the pan of chicken and added it to the mixture. She turned the blender back on and proceeded to pureed the chicken. The processor was stopped and the mixture was stirred. The cook indicated at that time, she was going to have to add some hot water because it was still too thick and lumpy. She obtained and an unmeasured amount of hot water, turned the blender back on and added some of the water. She blended mixture until smooth and poured the chicken into the pan.

The processor was washed and brought back to the station. The cook proceeded to puree a mushroom casserole. She placed 7 servings of boiled potatoes with skins, peas, and onions into the processor and turned it on. She added an unknown and unmeasured amount of tomato sauce with sliced mushrooms to the potato mixture and blended it until smooth.

It is the intention of this facility to follow the recipe for a therapeutic puree diet.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents who have orders for a pureed diet have had any negative effects.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents with orders for a puree diet have been assessed to assure they have not been affected by this alleged deficient practice. The Dietary manager and the facility Registered Dietician in-serviced the dietary staff on the proper procedures of measuring ingredients as listed in the menus for proper consistency.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility purchased additional measuring devices to assure the dietary staff have the proper tools to complete the task of preparing puree diets. The Registered Dietitian/designee will observe a minimum of one puree preparation weekly for compliance in preparation process. Any findings of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

| (X1) PROVIDER/SUPPLIER/CLIA | 155530 |

**MULTIPLE CONSTRUCTION**

| A. BUILDING | 00 |
| B. WING |

**DATE SURVEY COMPLETED**

| 04/05/2019 |

**NAME OF PROVIDER OR SUPPLIER**

SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

353 TYLER ST
GARY, IN 46402

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**COMPLETION DATE**

| 5/5/2019 |

Interview with Dietary Cook 2 at that time, indicated she did not follow the recipe and did not know the new recipes from the new vendor.

The recipe for the baked pureed chicken was as follows:

8 ounces of baked chicken, 2 and 1/2 cups of hot water, 2 and 1/2 teaspoons of chicken base, and 3 tablespoons and 1/2 teaspoon of food thickener. Place the prepared chicken into the food processor and add the prepared broth (water and base) and process until smooth texture. Add thickener and process briefly until mixed. Scrape down sides with spatula and reprocess. Pour into steam table pan, cover tightly and heat in conventional oven.

The recipe for the pureed mushroom bourguignon bake was as follows:

8 - #8 scoops of the mushroom bourguignon bake, 1 and 1/2 cups of water, 1 and 1/2 teaspoon of chicken base, and 3 tablespoons of food thickener. Place the prepared mushroom bake in the processor and process until fine in consistency. Add the combined base and water and continue to process until smooth. Add the food thickener and briefly process, stir and reprocess for another 30 seconds.

Interview with the Dietary Food Manager (DFM) on 4/4/19 at 12:34 p.m., indicated the cook did not follow the recipe for the pureed chicken or the mushroom casserole.

| 3.1-20(i)(1) |

Food
Procurement,Store/Prepare/Serve-Sanitary
$483.60(i) Food safety requirements.

**non-compliance to facility policy will require addition training as needed. Any findings of non-compliance will be reported to the QAPI committee for review and recommendations.**

**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 into place:** Dietary Manager will present monthly summary of findings to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance.

**Date systemic changes will be completed:** 5/5/2019
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Based on observation, record review, and interview, the facility failed to prepare and store food under sanitary conditions related to greasy and dirty griddle, build up of ice on food packages in the freezer, the use of gloves with food, and burned food spillage in the ovens for 1 of 1 kitchens observed. (The Main Kitchen)

Findings include:

1. During the Brief Kitchen Sanitation tour on 4/1/19 at 9:01 a.m. with Dietary Cook 2, the following was observed:

   a. The convection oven doors and the stove oven doors were noted with a large amount of dried food spillage. The bottom of the both ovens also had a moderate amount of burned food noted.

It is the intention of this facility to prepare and store food under sanitary conditions.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were identified as having negative outcomes from this alleged deficient practice.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents that have their meals prepared in the facility kitchen have the potential to be affected.
b. The griddle had a large amount of dried grease and food noted on the backsplash and behind it.

c. There were boxes of frozen food with a large amount of ice build up noted in the freezer and there were icicles noted on the fan in the freezer.

Interview with Dietary Cook 2 at that time, indicated all of the above was in need of cleaning.

2. On 4/4/19 at 11:10 a.m., Dietary Cook 1 was observed to take the temperatures of the baked chicken, a mushroom casserole and noodles. She donned a pair of clean gloves to both hands and used a thermometer to obtain the temperatures. She then began to prepare the pureed baked chicken. At that time, she used the same gloved hands and removed the pan of baked chicken from the steam table. She removed the chicken from the pan using the same gloved hands and placed it in the food processor. She continued to puree the chicken with her gloved hands. The gloves were removed when she was finished.

Interview with the Dietary Food Manager (DFM) on 4/4/19 at 12:34 p.m., indicated the cook should have used utensils to put the baked chicken into the food processor.

The current and undated, "Disposable Gloves" policy, provided by the DFM on 4/4/19 at 12:34 p.m., indicated gloves will be changed when soiled, torn, or the task had changed.

3.1-21(i)

by this alleged deficient practice. The convection oven was off for repair during survey, it has been repaired and cleaned of food spillage. The oven doors and bottoms of both ovens have been cleaned. The griddle backsplash and area behind the griddle have been cleaned. Ice build up has been removed from the freezer and from the boxes of frozen food. The Dietary Manager and the facility Registered Dietitian in-serviced the dietary staff on the proper use of utensils/ or change of gloved hands when a task changes in preparing foods.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Dietary Manager/designee will inspect the kitchen equipment weekly for proper cleaning including the ovens, convection oven and the walk-in freezer. Any findings of non-compliance will be corrected and noted on the weekly audit. Dietary Manager/designee will observe dietary staff a minimum of 3x week for proper use of gloves/handwashing when switching between tasks in the kitchen. Any findings of non-compliance will be addressed with additional education and return demonstrations.

How the corrective action(s) will be monitored to ensure the
483.90(i) Safe/Functional/Sanitary/Comfortable Environment
§483.90(i) Other Environmental Conditions
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
Based on observation, and interview, the facility failed to ensure the kitchen was clean related to dirty PVC pipes and adhered food crumbs and debris along the baseboards for 1 of 1 kitchens. The facility also failed to ensure the residents' environment was clean and in good repair related to urine odors, peeling paint, peeling vinyl flooring, dirty floors, walls, furniture, light fixtures, caulk around toilets, and water faucets for 4 of 4 units. (The Main Kitchen, 200 unit, 300 unit, 400 unit, and 500 unit)

Findings include:

It is the intention of this facility to assure the kitchen is clean related to PVC pipes under equipment and baseboards in the kitchen, and the resident areas are clean and in good repair.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were identified as having negative affects by this alleged deficient practice.

deficient practice will not recur, i.e., what quality assurance program will be put into place: Dietary Manager will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

Date systemic changes will be completed: 5/5/2019
## Statement of Deficiencies and Plan of Correction

### Identification Number

**MULTIPLE CONSTRUCTION**

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### Identification Number

**155530**

### Date Survey Completed

**04/05/2019**

### Name of Provider or Supplier

**SOUTH SHORE HEALTH & REHABILITATION CENTER**

### Street Address, City, State, Zip Code

353 TYLEN ST

**GARY, IN 46402**

### Summary Statement of Deficiency

**Summary of Deficiency**

Each deficiency must be preceded by full regulatory or LSC identifying information.

### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

### Completion Date

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**

Residents who receive meals prepared in this kitchen have the potential to be affected by this alleged practice. All residents who reside in this facility have the potential to be affected by the alleged deficient practice of resident rooms in disrepair/cleanliness. The kitchen has been cleaned of any debris including pipes under sinks, baseboards, and under cooking equipment. Room 201, the heat register was repainted, bolt covers were installed on the toilet. Room 306, the bathroom door was repainted, room 310, the bathroom was deep cleaned. Room 401, room was cleaned along the baseboards and the vinyl flooring in the bathroom was repaired. Room 406, the tube feeding pole was cleaned, night stand was cleaned, and the bathroom was cleaned. Room 504, the wall was repainted, and room 508 was repainted on the wall at the head of the beds.

### What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

The areas under the kitchen sinks, pipes under cooking equipment, baseboards, and under sinks were cleaned. Room 201, the heat register was repainted, bolt covers were installed on the toilet. Room 306, the bathroom door was repainted, room 310, the bathroom was deep cleaned. Room 401, room was cleaned along the baseboards and the vinyl flooring in the bathroom was repaired. Room 406, the tube feeding pole was cleaned, night stand was cleaned, and the bathroom was cleaned. Room 504, the wall was repainted, and room 508 was repainted on the wall at the head of the beds.
3.1-19(f)

bathroom.

c. Room 314, the water faucet was dirty and the caulking around the toilet was peeling and dirty. Three residents shared the bathroom.

400 Unit

a. Room 401, there was an accumulation of adhered dirt and dust along the baseboards behind the beds. the vinyl flooring in the bathroom was lifting up behind the toiled. Two residents shared the room and 5 residents shared the bathroom.

b. Room 406, the tube feeding pole was dirty, the night stand had a dried liquid substance splattered along the top and on the drawers, and the bathroom had a strong urine odor. Three residents shared the room and 6 residents shared the bathroom.

500 Unit

a. Room 504, there was a dried liquid substance on the wall next to bed B. Two residents shared the room.

b. Room 508, the paint on the brick wall was peeling and the wood was chipped. Two residents shared the room.

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 into place: Maintenance will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.

under kitchen equipment and areas around baseboards have been added to weekly cleaning schedule. By observation the Dietary manager/designee will inspect the kitchen weekly for compliance of these issues. Any findings of non-compliance will be corrected and noted on the weekly inspection report. Resident rooms continue to be repaired and painted by a weekly/monthly maintenance schedule. Staff have been re-in serviced on the importance of completing maintenance request forms timely and where to put the completed forms. Maintenance will log the maintenance request forms and note when requested painting/repair is completed. These maintenance request logs will be presented to the QAPI committee for review and recommendation.

Maintenance will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.
Date systemic changes will be completed: 5/5/2019

Finding includes:

On 4/4/19 at 2:34 p.m., during the Resident Council meeting, the residents indicated there were mice in rooms 201, 204, 213, 308, 502, and 503. Interviews at the time indicated the mice were terrible at night, they come in to the room from the heat registers along the wall, there are so many babies you can’t even count them, they climb up the various cords onto the furniture, “they even attempt to crawl on you.”

During the Environmental Tour on 4/5/19 at 11:00 a.m., with the Administrator, Maintenance Director (MD), and the Housekeeping Supervisor (HS) mouse traps were observed in the residents' rooms. Interview at the time with the MD indicated, when residents reported complaints about mice, he had placed glue traps in the rooms and has caught many mice. He also used rodent foam spray in areas that have holes. It is an ongoing concern and being addressed.

The February and March pest control service logs indicated the last service provided for mice was on 3/15/19.

What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Rooms 201, 204, 213, 308, 502 and 503 were inspected, deep cleaned, additional glue boards set.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this alleged deficient practice. Facility continues to work with Orkin, our pest control vendor in the eradication of rodents in this facility. Vendor supplies facility with a glue board trap to place in resident rooms and common areas. Facility had advanced from the using the standard glue boards provided by the vendor to opening the boards up and baiting with peanut butter with large success. Exterior baiting continues with poison and positive results noted.
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| 3.1-19(f)(4) | **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility continues to respond to any concerns of rodents in the facility. Rooms are deep cleaned, and maintenance inspects for possible openings into that room from the exterior. Openings are closed with expandable foam when located. Facility has ordered electronic pest repellant units to be placed on each unit and main dining room. When families/residents bring personal food into the facility, facility has provided plastic storage totes to resident for storage. Facility has adopted many vacant lots in the immediate area to maintain for debris and mowing to reduce attraction of rodents into the area. Concerns will be logged for rodent/pest concerns, action taken and results. Log will be presented to the QAPI committee for further review and recommendations. **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 into place: Maintenance/designee will present monthly summary of rodent concerns and actions to Quality Assurance Committee.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 9999</td>
<td>3.1-14 Personnel (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete related to initial/annual dementia training for 5 of</td>
<td>05/05/2019</td>
<td>It is the intention of this facility to ensure personnel records are complete in relation to initial/annual dementia training. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were identified as being affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents with a dementia diagnosis have the potential to be</td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A: BUILDING 00 B: WING 00

**Date Survey Completed:** 04/05/2019

### Name of Provider or Supplier

**SOUTH SHORE HEALTH & REHABILITATION CENTER**

**Street Address, City, State, ZIP Code:**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 employee files reviewed. (Dietary Aide 1, CNA 2, LPN 1, LPN 3, and the MDS Coordinator)</td>
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Findings include:

On 4/5/19 at 9:10 a.m., the Employee files were reviewed and the following was noted:

a. Dietary Aide 1, hired on 9/22/09, completed 1 hour of annual dementia training for 2018.

b. CNA 2, hired on 1/27/05, completed no dementia training for 2018.

c. LPN 1, hired on 9/15/14, completed 1 hour of dementia training for 2018.

d. LPN 3, hired on 4/13/14, completed no dementia training for 2018.

e. MDS Coordinator, hired on 3/6/18, completed no initial 6-hour dementia training within 6 months of employment.

Interview with the Human Resource Director on 4/5/19 at 9:42 a.m., indicated the Administrator and Social Service Director were responsible for the initial and annual dementia training.

Interview with the Social Service Director on 4/5/19 at 9:57 a.m., indicated she was aware little to no dementia training took place in 2018 and she was responsible for making sure it was done.

Affected by this alleged deficient practice. An audit was conducted of all new hires in 2018 currently employed. These staff members are scheduled for completion of initial 6-hour dementia training, including Hand in Hand presentations.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

A Human Resource consultant has been hired by the Corporate who is initiating a new employee on boarding program that includes 6 hours of dementia training. All new hires will be logged into an audit tool to track date of hire and date of initial dementia training completion. Computer programs have been provided to this facility from Select Rehabilitation for a source of continued dementia training going forward.

**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 into place:**

Human Resources will present monthly summary of audits to Quality Assurance Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain
<table>
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<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>compliance. Date systemic changes will be completed: 5/5/2019</td>
<td></td>
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</tbody>
</table>

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**: 155530

**DATE SURVEY COMPLETED**: 04/05/2019

**NAME OF PROVIDER OR SUPPLIER**: SOUTH SHORE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 353 TYLER ST GARY, IN 46402

**IDENTIFICATION NUMBER**: MULTIPLE CONSTRUCTION

**A. BUILDING**: 00

**B. WING**: 00

**EVENT ID**: IKS511

**FACILITY ID**: 000369

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