

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER South Shore Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 353 Tyler St Gary, IN 46402	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure the right of a resident/Guardian to direct his or her own medical treatment, related to medication given after the legal Guardian expressed she did not want the treatment to continue, for 1 of 3 residents reviewed for resident rights. (Resident B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis.</p> <p>A court appointed guardianship, dated 9/29/22, indicated there were two Permanent Co-Guardians appointed for the resident.</p> <p>A Physician's Order, dated 3/8/24, indicated Remeron (antidepressant) 15 mg (milligrams) was to be given nightly at bedtime for major depressive disorder.</p> <p>A Psychiatric Nurse Practitioner's (NP) Progress Note, dated 3/8/24, indicated a call was received from the Director of Nursing (DON) in regards to the resident having had a significant weight loss, comments about wanting to die, and a decreased appetite. An order for Remeron 15 mg to be administered at bedtime was given and the resident's weight was to be monitored.</p> <p>A Nurse's Progress Note, dated 3/8/24 at 12:18 p.m., indicated one of the Co-Guardian's was notified of the new medication order for the Remeron and all questions and concerns were addressed.</p> <p>A Psychiatric (Psych) NP Progress Note, dated 3/12/24, indicated a decreased appetite, weight would be monitored, and the Remeron was discontinued related to family refusal of the treatment.</p> <p>There was no order in the resident's Physician Orders from 3/8/24 to 3/12/24, that indicated the Remeron had been discontinued.</p> <p>A Psych NP Progress Note, dated 3/14/24, indicated a routine follow-up visit was completed. The NP spoke with the the Resident's Co-Guardian in regards to the Remeron. The Co-Guardian indicated she had not wanted the Remeron treatment for the resident. The Co-Guardian was educated on the risks and benefits of the Remeron and the treatment was still declined.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication Administration Records, dated 3/2024 and 4/2024, indicated the Remeron was still being administered every evening from 3/8/24 to 4/28/24.</p> <p>During an interview on 4/29/24 at 3:12 p.m., the DON indicated she had spoken to the Psych NP and an order for the Remeron to be discontinued had not been written, as she had thought the nurse at the facility had already discontinued the Remeron. The DON indicated the NP's would usually put their own orders in the computer.</p> <p>This citation relates to Complaints IN00429414 and IN00429590.</p> <p>3.1-4(d)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure a resident with pain received a routine pain medication as ordered by the Physician, related to not re-ordering the pain medication from the Pharmacy in a timely manner for 1 of 1 resident reviewed for pain medications. (Resident B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis.</p> <p>An Annual Minimum Data Set assessment, dated 12/27/23, indicated a moderately intact cognitive status and pain status had not been assessed.</p> <p>A Care Plan, dated 1/27/23 and revised on 3/6/24, indicated pain was present in the resident's lower back with a medical history of osteoarthritis, and the resident's family would sometimes administer pain medications to the resident during a leave of absence from the facility. The interventions included pain medications would be administered as ordered.</p> <p>A Pain Assessment, dated 3/18/24, indicated pain was frequently present. The pain affected her sleep at night and limited her day to day activities. The pain was rated a 5 out of 10 and she had daily complaints of pain. Pain management included acetaminophen-codeine (acetaminophen #3) 300-30 mg (milligrams) and repositioning as needed.</p> <p>A Physician's Order, dated 7/14/23 and discontinued on 3/7/24, indicated acetaminophen #3 was to be administered every eight hours related to pain. The medication was scheduled for 12 a.m., 8 a.m., and 4 p.m.</p> <p>The Physician's Order for the acetaminophen #3 was revised on 3/7/24, and the scheduled times for the administration were changed to 4 a.m., 12 p.m., and 8 p.m.</p> <p>The Medication Administration Record (MAR), dated 3/2024, indicated the acetaminophen #3 had not been given on 3/7/24 at 12 a.m. and 3/8/24 at 4 a.m. and 8 p.m.</p> <p>The MAR, dated 3/2024, indicated the acetaminophen #3 had been given on 3/6/24 at 8 a.m. and 4 p.m. and 3/7/24 at 8 a.m. and 12 p.m.</p> <p>The Controlled Drug Records, dated 2/2/24 and 3/8/24, indicated the last dose of acetaminophen #3 had been administered on 3/6/24 at 12 a.m. The acetaminophen #3 had not been administered again until 3/9/24 at 12 a.m., after the delivery of the medication.</p> <p>The Administration Progress Notes, dated 3/7/24 at 12:39 a.m., 3/8/24 at 4:06 a.m., and 3/8/24 at 6:47 p.m., indicated the acetaminophen #3 had not been available for administration.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation in the Nurses' Progress Notes, that indicated the family had administered pain medication to the resident from 3/6/24 at 12 a.m. through 3/9/24 at 12 a.m.</p> <p>During an interview on 4/29/24 at 4:49 p.m., the Director of Nursing (DON), indicated the acetaminophen #3 had not be given on 3/6/24 at 8 a.m. and 4 p.m., 3/7/24 at at 8 a.m. and 12 p.m. and this had been an error in documentation. She indicated the resident had gone two days without the acetaminophen #3 and controlled substances required a prescription to be refilled.</p> <p>During an interview on 4/30/24 at 9:33 a.m., the DON indicated the acetaminophen #3 had not been re-ordered until 3/7/24. The Pharmacy had to obtain a prescription, which was received on 3/8/24, and the medication was delivered early morning on 3/9/24. The acetaminophen #3 should have been re-ordered when the medication was getting low.</p> <p>This citation relates to Complaints IN00429414 and IN00429590.</p> <p>3.1-37(a)</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>20580</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information was up-to-date and current, related to Nurse Staffing Information not posted daily and a lack of of actual hours worked documented on the postings. This had the potential to affect all of the residents who resided in the facility in February, March, and April, 2024.</p> <p>Finding includes:</p> <p>During an observation on 4/28/24 at 8:15 a.m., the Nurse Staffing Information was located in a locked glass frame on the wall across from the Main Entrance. The date on the Nurse Staffing Information was 4/19/24.</p> <p>During an interview on 4/28/24 at 11:10 a.m., the Administrator indicated the staff member who completed the form was on vacation and no one else had the key to the locked frame.</p> <p>During an interview on 4/29/24 at 10 a.m., the Director of Nursing (DON), indicated she had found the past postings in the box for papers to be shredded. The the Scheduler had not known she was supposed to keep the postings.</p> <p>Nursing schedules and posting information, dated February 20, 2024 to March 20, 2024 and April 15 - 30, 2024 were reviewed on 4/29/24 at 5 p.m. The postings for March 1 & 2, 2024 were not available to be reviewed.</p> <p>The Nurse Staffing Information included how many RN's, LPN's, non-licensed staff were scheduled each day on each shift. The actual hours worked were not included on the postings.</p> <p>During an interview on 4/30/24 at 9 a.m., the Regional Nurse Consultant indicated the actual hours worked were not on the postings.</p> <p>This citation relates to Complaints IN00429414 and IN00429590.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>20580</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to medications administered when the blood pressure was out of prescribed parameters and multiple pain patches applied to a resident, for 2 of 2 residents reviewed for unnecessary medications. (Residents B and F)</p> <p>Findings include:</p> <p>1. During an observation on 4/28/24 at 9:26 a.m., Agency LPN 1 was administering Resident B's morning medications, which included a Lidocaine patch 4% (pain patch). The resident was observed to have undated patches on her right upper arm, right hip, right thigh, right outer buttock, and her right upper buttock. Agency LPN 1 indicated there were no dates on the patches and that the resident had a lot of pain. She then placed the dated lidocaine patch on the resident's lower back.</p> <p>Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis.</p> <p>An Annual Minimum Data Set assessment, dated 12/27/23, indicated a moderately intact cognitive status and pain status had not been assessed.</p> <p>A Care Plan, dated 1/27/23, indicated the resident's Guardian would place pain patches on the resident. The interventions were to check the resident for additional patches on the body and educate the Guardian of the negative outcomes.</p> <p>A Care Plan, dated 1/27/23 and revised on 3/6/24, indicated pain was present in the resident's lower back with a medical history of osteoarthritis, and the resident's family would sometimes administer pain medications to the resident during a leave of absence from the facility. The interventions included pain medications would be administered as ordered.</p> <p>A Pain Assessment, dated 3/18/24, indicated pain was frequently present. The pain affected her sleep at night and limited her day to day activities. The pain was rated a 5 out of 10 and she had daily complaints of pain. Pain management included acetaminophen-codeine (acetaminophen #3) 300-30 mg (milligrams) and repositioning as needed.</p> <p>A Physician's Order, dated 8/12/23, indicated a Lidocaine Patch 4% was to be applied to the lower back daily for back pain.</p> <p>The Manufacturer's Instructions, located on the back of the Lidocaine Patch packet, indicated to not use more than one patch at a time.</p> <p>During an interview on 4/30/24 at 9:28 a.m., the Assistant Director of Nursing indicated the family would put extra patches on her when they took her out of the facility for a visit and the staff were to remove the extra patches when she returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident F's record was reviewed on 4/30/24 at 9:30 a.m. The diagnoses included, but were not limited to stroke and dementia.</p> <p>A Physician's Order, dated 4/20/23, indicated Midodrine HCl (used for hypotension), 5 milligrams daily was to be given. The medication was to be held if the systolic blood pressure was greater than 120 and diastolic blood pressure was greater than 80.</p> <p>The Medication Administration Record, dated 4/2024, indicated the Midodrine was administered on April 6, 2024 with a blood pressure of 127/69, April 12, 2024 with a blood pressure of 142/70, April 15, 2024 with blood pressure of 139/70, and April 20, 2024 with a blood pressure 151/66.</p> <p>During an interview on 4/30/24 at 9:49 a.m., the Director of Nursing indicated the medication was given outside of the Physician's ordered parameters.</p> <p>This citation relates to Complaints IN00429414 and IN00429590.</p> <p>3.1-48(a)(1)</p> <p>3.1-48(a)(6)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580</p> <p>Based on observation, interview and record review, the facility failed to ensure the residents' environment was clean and in good repair, related to dirt and debris in the corners and around the base board in resident rooms and bathrooms, unlabeled/uncovered personal care items stored in the bathroom, dried liquid feeding on pump poles and floors, stains on the floor, dirty and stained privacy curtains, cobwebs, trash on the floor, trash and equipment stored behind closets and in unused bathtubs, dirty unused bathtubs, dim bathroom lights, loose baseboard, missing bathroom tile, holes in the tile floor in the bathroom, and a full water pitcher liner used for urine elimination for 14 of 15 rooms and /or bathrooms observed randomly on 4 of 4 halls. (Rooms 214, 213, 206, 204, 205, 311, 310, 308, 306, 408, 410, 402, 404, and 510.)</p> <p>Findings include:</p> <p>Random observations of resident rooms and bathrooms indicated the following:</p> <p>1. 200 Hall</p> <p>a. On 4/28/24 at 8:43 a.m., the floor behind the door in room [ROOM NUMBER] (two residents) was stained and dirty. There was dirt and debris along baseboards and corners of the room. There were cobwebs in the corner by the window. The bathroom, which was shared with room [ROOM NUMBER] (one resident), was dirty with debris. There was a green plastic container on the floor between the toilet and the wall.</p> <p>b. On 4/28/24 at 9:30 a.m., there was dirt and debris on the floor and along the baseboards of room [ROOM NUMBER]. There was a stain and dirt behind the door to the room. there was dried liquid feeding on the base of the feeding pump pole and on the equipment stored on the bedside dresser.</p> <p>c. On 4/29/24 at 10:17 a.m., there was dried feeding on the base of the feeding tube pole and on the bedside dresser in room [ROOM NUMBER] (one resident).</p> <p>d. On 4/29/24 at 10:35 a.m., there was dirt and debris in the corners of the room and along the baseboards in room [ROOM NUMBER] (one resident). The bathroom, which is shared with room [ROOM NUMBER] (one resident), there two washbasins stored on the floor, uncovered, and unlabeled. There were two bottles without resident names of cleanser in one of the basins. There was an uncovered/unmarked bedpan, wipes, and a graduated container stored on the floor of the bathroom.</p> <p>2. 300 Hall</p> <p>a. On 4/29/24 at 10:52 a.m., there was dirt and stains on the privacy curtain of the bed by the door in room [ROOM NUMBER] (two residents). Dirt and debris was under the bed and an opened small packet of potato chips was on the floor of the bed by the door. There was dirt and debris under the bed by the window.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. On 4/29/24 at 10:55 a.m., the bathroom shared by rooms 310 (two residents/three bed room) had a hole in the floor behind the bathroom door of 310. The bathtub and splatters of a rust colored substance and the shower curtain was dirty. The floor between the bed by the door and the middle bed there was dirty with dried food and what appeared to be spit on the floor by the wastebasket. There was dirt under the cabinets and dried liquid feeding on the floor. There was debris/dirt under the bed by the window and along the base board. There was trash, equipment, and furnishings stored behind the closet.</p> <p>c. On 4/29/24 at 11:06 a.m., there was a wet floor sign in the doorway of room [ROOM NUMBER] (two residents/three bed room). The privacy curtain for the bed by the door was dirty and stained. There was dirt and debris behind the closet for the second bed. In the bathroom, which was shared by room [ROOM NUMBER] (two residents/three bed room), the light was very dim and the room was dark when the door was closed. There was a missing tile, two bottles of unmarked bathing cleanser on the sink, and the baseboard by the toilet was loose. There were toilet safety rails, a pillow, and a rag stored in the bathtub.</p> <p>3. 400 Hall</p> <p>a. On 4/29/24 at 11:18 a.m., room [ROOM NUMBER] (two residents/three bed room) had dirt and debris on the floor and at the baseboards. The privacy curtain between the door and middle bed was stained and dirty. The closet doors would not stay closed. There was a water pitcher liner sitting on the bedside dresser of the middle bed and was full (1000 milliliters) of straw colored fluid with an odor of urine. The resident was in the room and indicated it was urine and he had a urinal but someone took it. In the bathroom, which was shared with room [ROOM NUMBER], there was dirt and debris in the corners and behind the door of 408.</p> <p>b. On 4/29/24 at 11:28 a.m., room [ROOM NUMBER] (three residents), identified by Housekeeper 1 as just being cleaned, had a dried substance by the dresser on the floor of the bed by the door. There was dirt, debris and cob webs in the corner and on the floor under the closet door. The privacy curtain between the door and middle bed was stained and dirty. The bathroom, which was shared with room [ROOM NUMBER] (two residents) was dirty, there were two bath basins unmarked and uncovered stored behind the toilet and there was bathing cleanser without a name on the sink.</p> <p>4. 500 Hall</p> <p>a. On 4/29/24 at 1:58 p.m., in room [ROOM NUMBER] (two residents), there was dried liquid feeding on the feeding pump pole.</p> <p>An Environmental Tour was completed with the Administrator on 4/30/24 from 10:04 a.m. through 10:40 a.m. The Administrator acknowledged the above findings.</p> <p>A facility policy for routine cleaning of rooms, received from the Administrator as current and dated 2/9/23, indicated, routine cleaning and disinfection of frequently touched or visibly soiled surfaces would be performed in resident rooms and included feeding pump poles. The privacy curtains in the resident rooms were to be changed when visibly dirty.</p> <p>During an interview on 4/30/24 at 11:42 a.m., the Administrator indicated there was no policy for deep cleaning the rooms and he was unsure how often it was to be done.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580</p> <p>Based on observation, and interview, and record review, the facility failed to maintain an effective pest control program related to dead bugs/water bugs and mice droppings in the resident rooms and bathrooms for 4 of 15 rooms randomly observed. (Rooms 310, 408, 402, and 213)</p> <p>Findings include:</p> <p>During random observations, the following was observed:</p> <p>a. On 4/29/24 at 10:55 a.m., there were dead bugs on the floor in the corner under the cabinets in room [ROOM NUMBER]. There were 2 mouse traps under the heater located under the window and there were mice droppings seen by the trap in the corner of the room by the window.</p> <p>b. On 4/29/24 at 11:18 a.m., there were mouse droppings in the corner behind the bed by the window in room [ROOM NUMBER].</p> <p>c. On 4/29/24 at 11:28 a.m., there were mouse droppings behind the bathroom door next to the bathtub in room [ROOM NUMBER] and a dead bug in the bathtub.</p> <p>d. During an observation on 4/30/24 from 10:04 a.m. to 10:40 a.m., with the Administrator present. room [ROOM NUMBER] had glue trap for bugs on the floor by the window. there were multiple bugs in the trap. The Administrator indicated they were, water bugs. There were mouse traps located under the heater in the room. The Administrator indicated he was not sure who checked the mice and bug traps and they should be checked when the room was cleaned.</p> <p>An undated facility pest control policy, received as current from the Administrator on 4/30/24 at 10:20 a.m., indicated a qualified pest control service would be contracted and the facility would maintain a report system of issues that may arise between scheduled visits of the contracted company.</p> <p>This citation relates to Complaints IN00429414 and IN00429590.</p> <p>3.1-19(f)(4)</p>