STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Health & Rehabilitation Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure dignity was maintained related to knocking before entering a resident's room for 1 of 3 residents reviewed for dignity. (Resident E)Finding includes:On 8/4/25 at 5:55 a.m., Resident E was observed during incontinence care with LPN 1. LPN 1 did not knock on the door before entering the resident's room and did not announce herself when she entered. There were 2 residents residing in the room.During an interview at the time, LPN 1 indicated oops, I forgot to knock.Resident E's record was reviewed on 8/4/25 at 3:47 p.m. The diagnoses included, but were not limited to, Parkinson's, dementia, pressure ulcer sacral stage 4, heart disease, dysfunction of bladder, hypertension (high blood pressure), gastrostomy status, and psychotic disorder.The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/25, indicated the resident was cognitively impaired for daily decision making and was dependent with all Activities of Daily Living and transfers.A policy, titled, Dignity and received as current from Nurse Consultant 1 on 8/6/25, indicated, .7. Staff are expected to knock and request permission before entering residents' rooms.This citation relates to complaint 1540563.3.1-3(t)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure equipment was properly functioning and ensure fall precautions were in place to prevent injury from a fall for 1 of 3 residents reviewed for accidents. (Resident J)Finding includes: On 8/5/25 at 10:22 a.m. and 10:50 a.m., the resident was observed sitting up in bed asleep. There was no bolster on the bed, there were two pads sitting on the floor in front of the residents' bed.Resident J's record was reviewed on 8/5/25 at 3:21 p.m. The diagnoses included, but were not limited to, heart disease, hypertension (high blood pressure), congestive heart failure, psychotic disorder, depression, and anemia (low iron).The Significant Change in Status Minimum Data Set (MDS) assessment, dated 7/11/25, indicated the resident was moderately cognitively impaired. The resident required dependent assistance with all Activities of Daily Living (adls). The resident was dependent with tub and shower transfers.A Care Plan, dated 7/14/25, indicated the resident was at risk for falls related to impaired ability to stand, transfer, and walk. Interventions included, but were not limited to, placing fall mat next to bed, placing a bolster to the right side of the bed and monitor placement every shift and keep call light within reach.A Physician's Order, dated 7/21/25, indicated to send the Resident to the hospital to evaluate and treat for status post fall.A Incident Note, dated 7/21/25 at 10:02 a.m., indicated the resident experienced a fall during a shower. Nursing staff rendered first aid at the time of the fall and neuro checks were initiated. The resident was awake and verbally responsive, able to follow commands and move all extremities without difficulty.A Post Fall Evaluation, dated 7/21/25 at 11:17 a.m. indicated Resident J had a witnessed fall in the shower room and an injury was obtained. Bleeding was noted to the frontal lobe (forehead) and resident was sent to the hospital for evaluation. Contributing factors indicated the shower bed was broken.The Treatment Administration Record (TAR) indicated the bed bolster was signed out in July but was not listed on the TAR for August. There was no monitoring documented from 8/1/25- 8/5/25.During an interview on 8/6/25 at 8:36 a.m., the Director of Nursing indicated she understood the concern about the broken shower bed and resident J's fall. The staff had been in-serviced about broken equipment and requested if they see something, say something. New shower beds and chairs had been ordered.During an interview on 8/6/25 at 9:20 a.m., CNA 1 indicated she had transferred Resident J to the shower bed with CNA 2. She then pushed the resident to the shower room and pushed the shower bed against the shower wall. She then locked the shower bed. She had washed and dried Resident J's front and had turned the resident on her side to wash/dry her back. That was when the shower bed moved off the wall towards CNA 1. The resident had fallen off the bed where the bed had scooted from the wall. CNA 1 indicated the shower bed was broken; it should never have moved. She screamed for help and stayed with the resident.A policy, titled, Accidents and Supervision and received as current from Nurse Consultant 1 on 8/6/25, indicated, .Identification of Hazards and Risks, the process through which the facility becomes aware of potential hazards in the resident environment and the risk of having an avoidable accident.The facility should make reasonable effort to identify the hazards and risk factors for each resident.This citation relates to Complaint 2580575.3.1-45(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure residents' pain medications were administered as ordered and in a timely manner for 1 of 3 residents reviewed for pain. (Resident B)Finding includes:During an interview on 8/4/25 at 8:28 a.m., Resident B's daughter indicated the resident did not receive her pain medication on time on 7/28/25 and 7/29/25.The record for Resident B was reviewed on 8/4/25 at 9:30 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's, hypertension (high blood pressure), depression, anxiety, COPD, and adult failure to thrive.The 5/16/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired for daily decision making and received scheduled pain medication.A Care Plan, dated 4/23/25, indicated the resident had pain in her lower back. The approaches were to administer pain medications as ordered by the physician and monitor/record and report signs and symptoms of nonverbal pain.Physician's Orders, dated 7/21/25, indicated to administer Acetaminophen-Codeine 300-30 milligrams (mg) by mouth three times a day for pain. The 7/2025 Medication Administration Record (MAR) indicated the Tylenol 3 was given incorrectly on the following dates:7/28/25 - medication was administered at 12:18 p.m. and was due at 8:00 a.m.7/28/25 - medication was administered at 6:45 p.m. and was due at 4:00 p.m.7/29/25 - medication was administered at 11:18 a.m. and was due at 8:00 a.m.During an interview on 8/6/25 at 4:40 p.m., Nurse Consultant 1 indicated she understood the pain medication should have been administered on time.This citation relates to complaint 1540563 and1540684 .3.1-37(a)