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	09/22/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician was notified timely of residents not receiving medications as ordered for 2 of 6 residents reviewed for unnecessary medications. (Residents C and B)Findings include:1. The closed record for Resident C was reviewed on 9/17/25 at 10:55 a.m. Diagnoses included, but were not limited to, left below the knee amputation (BKA), diabetes, hypertension, pressure ulcers of the hip and buttock, and heart failure.The 7/29/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and was dependent for activities of daily living (ADLs) and transfers.The resident was admitted to the facility on [DATE] following a hospitalization related to the left BKA surgery. At that time, the resident had a unstageable pressure ulcers to the right thigh and buttock as well as a dehisced (reopened surgical incision) wound to the left leg stump. An 8/5/25 Skin/Wound Note indicated the wound to the right thigh was odorous and had purulent (pus) drainage. An 8/8/25 Progress Note indicated the wound doctor assessed the resident's pressure ulcers and ordered Flagyl (an antibiotic) 500 mg intravenously (IV) every 8 hours for 7 days for the wound infection.An 8/9/25 Nurse's Note indicated the Flagyl was not available, and they were awaiting its delivery from the pharmacy.The August 2025 Medication Administration Record (MAR) indicated the resident did not receive any doses of the Flagyl. The record lacked documentation that the physician was notified that the resident did not receive the Flagyl as ordered.During an interview on 9/18/25 at 10:25 a.m., the Infection Preventionist indicated if an antibiotic was not started as ordered, the nurse should have notified the physician and documented it, but she did not see that had been done.During an interview on 9/19/25 at 10:40 a.m., the wound doctor indicated he would expect the IV antibiotic to be started the day it was ordered, and that he was not informed that the resident did not receive the Flagyl until after 8/14/25.During an interview on 9/19/25 at 2:30 p.m., the DON and Corporate Nurse 1 were informed of the findings. Both indicated they did not know why the Flagyl was not administered to the resident. No further information was received. 2. The record for Resident B was reviewed on 9/19/25 at 9:04 a.m. Diagnoses included, but were not limited to, Alzheimer's, diabetes, and COVID-19.The 8/8/25 Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance with Activities of Daily Living (ADLs), and was independent with transfers.The Physician's Order Summary indicated a Covid test and stat chest x-ray were ordered on 8/6/25 at 10:30 a.m. for shortness of breath. On 8/6/25 at 12:40 p.m., the resident tested positive for Covid.A Nurse's Note, dated 8/7/25 at 2:12 p.m., indicated the resident had wheezing and shortness of breath on exertion. New orders were received including Paxlovid (an oral antiviral medication for treating Covid-19 in patients who are at high risk of the disease progressing to a more severe illness) twice a day for 5 days.The August Medication Administration Record (MAR) indicated the resident only received 3 of the 10 scheduled doses of Paxlovid. A Nurse's Note, dated 8/10/25 at 6:43 p.m., indicated the Paxlovid had not yet arrived, and the nurse manager was made aware. The record lacked documentation that the physician was notified that the resident did not receive the Paxlovid as ordered.During an interview on 9/19/25 at 2:30 p.m., the DON and Corporate Nurse 1 indicated the nurse should have notified the physician that the resident did not receive the medication as prescribed and documented the notification in the resident's record.A policy titled, Notification of Changes, received as current from the DON on 8/19/25 at 2:58 p.m. indicated, . The facility must . consult the resident's physician . when there is a change requiring such notification . Circumstances requiring notification include: . a need to alter a treatment.3.1-5(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure blood pressure medications were administered and/or held per parameters as ordered. The facility also failed to ensure medications were administered as ordered and laboratory tests were obtained for 3 of 7 residents reviewed for unnecessary medications. (Residents F, E, and D)Findings include: 1. The record for Resident F was reviewed on 9/18/25 at 11:42 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypotension (low blood pressure), and hypertension. The 8/27/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and he was receiving dialysis while a resident of the facility. A Care Plan, reviewed on 8/22/25, indicated the resident had hypotension with episodes of syncope (fainting) related to dialysis. Interventions included, but were not limited to, administer medications per physician's order. A Physician's Order, dated 8/21/25, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 5 milligrams three times a day. The medication was to be held for systolic blood pressure (top number) less/greater than 110 or heart rate less than 60. The August 2025 Medication Administration Record (MAR), indicated the resident received the Midodrine on the following dates and times: 8/23/25 at 9:00 a.m. blood pressure 136/92 8/23/25 at 2:00 p.m. blood pressure 117/78 8/27/25 at 2:00 p.m. blood pressure 127/76 8/21/25 at 9:00 p.m. blood pressure 122/68 8/24/25 at 9:00 p.m. blood pressure 132/68 8/25/25 at 9:00 p.m. blood pressure 115/68 8/26/25 at 9:00 p.m. blood pressure 132/68 8/31/25 at 9:00 p.m. blood pressure 141/71 The September 2025 MAR, indicated the resident received the Midodrine on the following dates and times: 9/12/25 at 9:00 a.m. blood pressure 117/68 9/18/25 at 9:00 a.m. blood pressure 92/62 (the medication was held) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/4/25 at 2:00 p.m. blood pressure 139/93 9/4/25 at 9:00 p.m. blood pressure 131/79 9/6/25 at 9:00 p.m. blood pressure 135/78 9/9/25 at 9:00 p.m. blood pressure 121/72 9/10/25 at 9:00 p.m. blood pressure 148/80 9/14/25 at 9:00 p.m. blood pressure 119/76 9/16/25 at 9:00 p.m. blood pressure 119/70 9/17/25 at 9:00 p.m. blood pressure 115/65 9/18/25 at 9:00 p.m. blood pressure 121/71 During an interview on 9/19/25 at 2:40 p.m., the Director of Nursing indicated the medication order needed to be clarified. 2. The record for Resident E was reviewed on 9/17/25 at 9:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertensive heart disease, and hypotension (low blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 7/31/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. A Physician's Order, dated 6/7/24 and listed as current on the September 2025 Physician's Order Summary (POS), indicated the resident was to receive Lisinopril (a blood pressure medication) 10 milligrams (mg) one time daily. The medication was to be held if the resident's blood pressure was less than 100/60. The July 2025 Medication Administration Record (MAR) indicated the resident received the Lisinopril on the following dates and time when her blood pressure was less than 100/60: 7/5/25 at 9:00 a.m. blood pressure 110/59 7/7/25 at 9:00 a.m., blood pressure 110/56 7/10/25 at 9:00 a.m. blood pressure 100/56 7/11/25 at 9:00 a.m. blood pressure 100/56 7/14/25 at 9:00 a.m. blood pressure 108/56 The August 2025 MAR indicated the resident received the Lisinopril on the following dates and time when her blood pressure was less than 100/60: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/11/25 at 9:00 a.m. blood pressure 89/46 The September 2025 MAR indicated the resident received the Lisinopril on the following dates and time when her blood pressure was less than 100/60: 9/10/25 at 9:00 a.m. blood pressure 103/58 9/12/25 at 9:00 a.m. blood pressure 107/54 A Physician's Order, dated 8/5/24 and listed as current on the September 2025 POS, indicated the resident was to receive Midodrine HCl (a medication for low blood pressure) 10 milligrams (mg) every 8 hours as needed (PRN) for hypotension. Give when systolic blood pressure (top number) was less than 90. The July, August, and September 2025 Medication Administration Records (MARs) indicated the resident's blood pressure was monitored once a day rather than every 8 hours. The July 2025 MAR indicated on 7/30/25 at 9:00 a.m., the resident's blood pressure was 79/55. The resident did not receive the PRN Midodrine. The August 2025 MAR indicated on 8/20/25 at 9:00 a.m., the resident's blood pressure was 83/60. The resident did not receive the PRN Midodrine. During an interview on 9/19/25 at 2:40 p.m., the Director of Nursing indicated the resident should have received the Midodrine as ordered and a clarification order for the Lisinopril should have been obtained. 3. Resident D's record was reviewed on 9/18/25 at 3:07 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction, diabetes mellitus, and atrial fibrillation. The Quarterly MDS, dated [DATE], indicated the resident had moderate cognitive impairment and was dependent for toileting and transfers. A complete blood count (CBC) and comprehensive metabolic panel (CMP) lab tests were completed on 4/28/25. There were handwritten orders at the bottom of the lab results that indicated to repeat the labs in one week and to give potassium 40 milliequivalents x 1. There were no orders for the repeat lab or the potassium entered into the electronic record. There was no indication the repeat lab had been completed in one week or the potassium had been given as ordered. During an interview on 9/22/25 at 1:59 p.m., the Director of Nursing indicated the repeat lab had not been done and the potassium had not been given. This citation relates to Intake 2597285. 3.1-37(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were free of significant medication errors related to medications not administered as ordered for infections for 2 of 6 residents reviewed for unnecessary medications. (Residents C and B)Findings include: 1. The closed record for Resident C was reviewed on [DATE] at 10:55 a.m. Diagnoses included, but were not limited to, left below the knee amputation (BKA), diabetes, hypertension, pressure ulcers of the hip and buttock, and heart failure.The [DATE] Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and was dependent for activities of daily living (ADLs) and transfers.The resident was admitted to the facility on [DATE] following a hospitalization related to the left BKA surgery. At that time, the resident had a unstageable pressure ulcers to the right thigh and buttock as well as a dehisced (reopened surgical incision) wound to the left leg stump. A Physician's Order, dated [DATE], indicated Tigecycline (an intravenous antibiotic) 100 milligrams two times a day, related to infection of the skin and subcutaneous tissue, for 28 days.A Skin/Wound Note, dated [DATE], indicated the wound to the right thigh was odorous and had purulent (pus) drainage. On [DATE], a culture was sent of the right thigh wound.A Progress Note, dated [DATE], indicated the wound doctor assessed the resident's pressure ulcers and ordered Flagyl (an antibiotic) 500 mg intravenously (IV) every 8 hours for 7 days for the wound infection.A Nurse's Note, dated [DATE], indicated the Flagyl was not available, and they were awaiting its delivery from the pharmacy.The [DATE] Medication Administration Record (MAR) indicated the resident did not receive any doses of the Flagyl. A Skin/Wound Nurse's Note, dated [DATE] at 11:54 a.m., indicated the wound doctor was informed of the wound culture results. New orders were received to discontinue the Flagyl and start Levaquin (an antibiotic) for pseudomonas (a bacteria that can be resistant to many antibiotics). An Acute Care Note, dated [DATE] at 1:20 p.m., indicated the resident was found altered mentally and verbally unresponsive and was being sent to the hospital emergency department (ED) for evaluation. An ED physician's note, dated [DATE], indicated, Pt [patient] in septic shock; source of infection is not known.During an interview on [DATE] at 10:25 a.m., the Infection Preventionist indicated the right hip wound was infected, the wound doctor ordered Flagyl and wanted it started right away. It happened over the weekend, and when she came back Monday, she saw the Flagyl had not been started. At that time, she received the culture results and the antibiotic order was changed. She indicated if an antibiotic was not started as ordered, the nurse should have notified the physician and documented it.During an interview on [DATE] at 10:40 a.m., the wound doctor indicated the right hip wound was the only infected wound he observed, and the resident had no other infectious process he was aware of. He would expect the IV antibiotic to be started the day it was ordered, and that he was not informed that the resident did not receive the Flagyl until after she expired in the hospital on [DATE]. He indicated he could not determine if the resident's outcome would have been different if she had received the Flagyl as prescribed. During an interview on [DATE] at 2:30 p.m., the DON and Corporate Nurse 1 were informed of the findings. Both indicated they did not know why the Flagyl was not administered to the resident. No further information was received. 2. The record for Resident B was reviewed on [DATE] at 9:04 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, diabetes, and COVID-19.The [DATE] Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance with Activities of Daily Living (ADLs), and was independent with transfers.The current Physician's Order Summary indicated a Covid test and stat chest x-ray were ordered on [DATE] at 10:30 a.m. for shortness of breath. On [DATE] at 12:40 p.m., the resident tested positive for Covid.A Nurse's Note, dated [DATE] at 2:12 p.m., indicated the resident had wheezing and shortness of breath on exertion. New orders were received including Paxlovid (an oral antiviral medication for treating Covid-19 in patients who are at high risk of the disease progressing to a more severe illness) twice a day for 5 days.A Nurse's Note, dated [DATE] at 6:43 p.m., indicated the Paxlovid had not yet arrived and the nurse manager was made aware. The [DATE] Medication Administration Record (MAR) indicated the resident only received 3 of the 10 scheduled doses of Paxlovid. The record lacked documentation as to why the resident did not receive the medication as ordered. During an interview on [DATE] at 2:30 p.m., the DON and Corporate Nurse 1 indicated the medication came as one unit from the pharmacy, and should have been available for the resident to receive as ordered. They did not know why the resident did not receive the medication as it was prescribed. The manufacturer prescriber administration instructions for Paxlovid indicated to alert the patient