

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER BEACH TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00209427 and IN00209668.</p> <p>Complaint IN00209427- Substantiated. State Residential deficiencies related to the allegations are cited at R052, R0090, R0149, and R0349</p> <p>Complaint IN00209668 - Substantiated. State Residential deficiencies related to the allegations are cited at R052, R0090, R0149, and R0349</p> <p>Survey dates: September 9 &amp; 10, 2016</p> <p>Facility number: 001140 Provider number: 001140 AIM Number: N/A</p> <p>Census bed type: Residential: 122 Total: 122</p> <p>Residential Sample: 18</p> <p>These State residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 32883 on 9/12/16.</p>	R 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

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R 0052 Bldg. 00	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure residents remained free of physical abuse related to resident to resident altercations resulting in injury for 2 of 3 residents reviewed for physical altercations in a sample of 18. The facility also failed to ensure the resident to resident altercations were reported to Administration and the Indiana State Department of Health. (Residents #C and #D)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 9/9/16 at 1:50 p.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, major depression, and chronic obstructive pulmonary disease.</p>	R 0052	<p>A. Mandatory training will be held with staff on de-escalating aggressive/agitated behavior. Residents identified as having difficulty standing in line/easily agitated will be brought up for medication when there is no line. Residents will continue to be referred to psychiatrist when behaviors are noted by nursing staff or reported by other staff. Residents who continue to show signs of unmanageable behavior will be considered to be above the level of care for Miller Beach Terrace and alternate placement will be found. B. Nursing staff were in-serviced on Miller Beach Terrace's policy for mandatory reporting to ISDH. A new reporting form was developed which indicates who it was reported to and when so appropriate report can be submitted. Nursing staff who fail to report appropriately can be</p>	10/01/2016

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	<p>Review of the 6/23/16 Admission assessment indicated the resident was alert and his mood appeared "sad." A Psychiatric Evaluation completed on 7/7/16 indicated the resident had short term memory impairment and was easily distracted.</p> <p>The 9/2016 Charting Notes were reviewed. An entry made on 9/1/16 at 8:26 p.m. indicated Resident #C was involved in a physical altercation with another male resident. The incident occurred in the doorway of the Nursing Station. The resident sustained a head injury and an ambulance was called for a bleeding cut to the forehead and also a blow to the head. The name of the resident was not listed. No incident report had been made out.</p> <p>The next entry was made on 9/2/16 at 1:43 p.m. The entry indicated the resident returned from the hospital via an ambulance. The resident had (4) sutures noted the left forehead and two noted to the left cheek.</p> <p>The next entry was made on 9/2/16 at 9:04 p.m. This entry indicated a staff member and another resident reported to the LPN that Resident #C had a physical altercation with another resident identified as Resident #D. The altercation</p>		<p>terminated. Nursing staff identified residents who chronically require some degree of redirection. They also identified 3 specific areas in the building where certain residents need verbal cueing or some degree of redirection: the TV room next to the nurses station during med pass, the dining room during meal service and the outside sitting area. Security will now be present in the dining room during meals, the TV room during med pass and they will make rounds hourly outside or more often if required. Residents that were involved in events were referred to therapy. Review of charts and interview with residents and staff found no other residents affected. A new form was developed to use when reporting that indicates that the Administrator, DON and UO reporter (person who submits the report to the ISDH) were notified that includes time, date, how (ie. telephone, in person, etc.) and signature of person reporting. Nurses were in-serviced on reporting and consequences of failure to report appropriately. Nursing responsible to do incident report and report to the Administrator, DON and UO reporter. DON to monitor all reports daily, 5 days per week, weekly.</p>				

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	<p>occurred "out back" during the 3:30 p.m. Medication Pass. Resident #D struck Resident #C when he attempted to sit on a bench next to him.</p> <p>Review of the 9/2/16 Hospital Discharge Summary indicated Resident #C was admitted to the Emergency Room on 9/1/16 and discharged back to the facility on 9/2/16. The resident was diagnosed with Post Concussion Syndrome and facial laceration.</p> <p>The record for Resident #D was reviewed on 9/9/16 at 2:44 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, anemia, and high blood pressure. The 9/2016 Charting Notes were reviewed. An entry made on 9/2/16 at 9:23 p.m. indicated it was reported the the resident was in a physical altercation with Resident #C during the 3:30 p.m. medication pass. The resident had superficial scratches to both sides of his face and first aid was rendered. Both residents were separated and encouraged to stay away from each other. An entry made on 9/4/16 at 10:27 a.m. indicated the resident was noted with purple bruising under his right eye and per charting suspected cause of said bruising to be from the 9/2/16 altercation.</p> <p>When interviewed on 9/9/16 at 3:20 p.m.,</p>			

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	<p>LPN #1 indicated she had been aware of two resident to resident altercations involving Resident #C. The LPN indicated it was reported to her that Resident #C had an altercation with another resident. The LPN indicated Resident #C came back from the hospital with sutures. That same day there was another altercation involving between Resident #C and Resident #D.</p> <p>When interviewed on 9/9/16 at 2:45 p.m., the Director of Nursing indicated she had not been aware of the above altercations. The Director of Nursing indicated the Administrator did not inform her that she was aware of the incidents either. The Director of Nursing indicated the above incidents should have been reported to the Administrator and then to the State Department of Health.</p> <p>The facility policy "Reportable Unusual Occurrences" was reviewed on 9/9/16 at 4:05 p.m. The policy had a "revised" date of 10/23/13. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated reportable occurrences in the facility were to be recorded and monitored. The policy indicated "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse " were to be reported immediately to the</p>						

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R 0090	<p>Administrator of the facility and other officials in accordance with State law. The policy also defined abuse as willful infliction of injury of injury , unreasonable confinement, intimidation or punishment with resulting physical or pain. Physical abuse included, but was not limited to, hitting, slapping, pinching, or corporal punishment. Physical abuse included resident to resident abuse with or without injury.</p> <p>The facility "Abuse Policy" was reviewed on 9/9/16 at 4:15 p.m. The policy had a reviewed date of 10/28/15. The Director of Nursing provided the policy and indicated the policy was current. The policy defined abuse as willful infliction of injury of injury, unreasonable confinement, intimidation or punishment with resulting physical or pain. The policy indicated the staff members were to report Abuse allegations immediately to the Administrator/DON of the facility and an "Unusual Occurrence Report" was to be completed.</p> <p>This Residential tag relates to Complaints IN00209427 and IN00209668.</p>			
	410 IAC 16.2-5-1.3(g)(1-6)			

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Bldg. 00	<p>Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the Administrator informed the required state division of resident to resident physical altercations which resulted in injury for 2 of 3 residents reviewed for Unusual Occurrences. (Residents #C and #D)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 9/9/16 at 1:50 p.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, major depression, and chronic obstructive pulmonary disease.</p> <p>The 9/2016 Charting Notes were reviewed. An entry made on 9/1/16 at 8:26 p.m. indicated Resident #C was involved in a physical altercation with another male resident. The incident occurred in the doorway of the Nursing Station. The resident sustained a head injury and an ambulance was called for a bleeding cut to the forehead and also a blow to the head. The name of the</p>	R 0090	Nursing staff was in-serviced on Miller Beach Terrace's policy of reporting incidents. Employees were given the new form that includes the incident and that the Administrator, DON and UO reporting person have been notified, date and time of that notification as well as type (ie. in person, telephone, etc). Nursing understands that they can be terminated for not reporting correctly. Incident policy was reviewed and dated on 09/16/2016. Residents that were involved in incidents have been seen by the therapists and psychiatrist. No other residents were identified to be affected by same practice. Charge nurse responsible for reporting incidents. DON to monitor by reviewing internal nursing shift logs daily, 5 days per week, ongoing. DON and UO person will be called in on any incident that occurs during the weekend.	10/01/2016			

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	<p>resident was not listed. No incident report had been made out.</p> <p>The next entry was made on 9/2/16 at 1:43 p.m. The entry indicated the resident returned from the hospital via an ambulance. The resident had (4) sutures noted the left forehead and two noted to the left cheek.</p> <p>The next entry was made on 9/2/16 at 9:04 p.m. This entry indicated a staff member and another resident reported to the LPN that Resident #C had a physical altercation with another resident identified as Resident #D. The altercation occurred "out back" during the 3:30 p.m. Medication Pass. Resident #D struck Resident #C when he attempted to sit on a bench next to him.</p> <p>Review of the 9/2/16 Hospital Discharge Summary indicated Resident #C was admitted to the Emergency Room on 9/1/16 and discharged back to the facility on 9/2/16. The resident was diagnosed with Post Concussion Syndrome and facial laceration.</p> <p>The record for Resident #D was reviewed on 9/9/16 at 2:44 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, anemia, and high blood pressure. The 9/2016 Charting Notes</p>			

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	<p>were reviewed. An entry made on 9/2/16 at 9:23 p.m. indicated it was reported the the resident was in a physical altercation with Resident #C during the 3:30 p.m. medication pass. The resident had superficial scratches to both sides of his face and first aid was rendered. Both residents were separated and encouraged to stay away from each other. An entry made on 9/4/16 at 10:27 a.m. indicated the resident was noted with purple bruising under his right eye and per charting suspected cause of said bruising to be from the 9/2/16 altercation.</p> <p>When interviewed on 9/9/16 at 3:20 p.m., LPN #1 indicated she had been aware of two resident to resident altercations involving Resident #C. The LPN indicated it was reported to her that Resident #C had an altercation with another resident. The LPN indicated Resident #C came back from the hospital with sutures. That same day there was another altercation involving between Resident #C and Resident #D.</p> <p>When interviewed on 9/9/16 at 2:45 p.m., the Director of Nursing indicated she had not been aware of the above altercations. The Director of Nursing indicated the Administrator did not inform her that she was aware of the incident either. The Director of Nursing indicated the above</p>			

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	<p>incidents should have been reported to the Administrator and then to the State Department of Health.</p> <p>The facility policy "Reportable Unusual Occurrences" was reviewed on 9/9/16 at 4:05 p.m. The policy had a "revised" date of 10/23/13. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated reportable occurrences in the facility were to be recorded and monitored. The policy indicated "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse " were to be reported immediately to the Administrator of the facility and other officials in accordance with State law. The policy also defined abuse as willful infliction of injury of injury , unreasonable confinement, intimidation or punishment with resulting physical or pain. Physical abuse included but was not limited to, hitting, slapping, pinching, or corporal punishment. Physical abuse included resident to resident abuse with or without injury.</p> <p>This Residential tag relates to Complaints IN00209427 and IN00209668.</p>			

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R 0149  Bldg. 00	<p>410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to maintain an effective Pest Control program related to the repeat occurrences of bed bugs in resident rooms.</p> <p>Finding includes:</p> <ol style="list-style-type: none"> <li>During the Environmental Tour with the Maintenance Supervisor on 9/9/16 at 12:30 p.m., the following was observed on the 300 hall: <ul style="list-style-type: none"> <li>There was a dead bed bug on the mattress of the the resident in room 333 Bed A.</li> </ul> </li> <li>During the Environmental Tour with the Maintenance Supervisor on 9/9/16 at 1:00 p.m., the following was observed on the 200 hall: <ul style="list-style-type: none"> <li>There was on dead bed bug and one alive bed bug crawling on bed of the resident in room 212 Bed B.</li> </ul> </li> </ol> <p>When interviewed at the time of the Environmental Tour, the Maintenance</p>	R 0149	<p>The beds have been checked and no further signs of bed bugs were found. The facility has ordered bed bug proof zippered cases for mattresses. In 30 days the facility will order bed bug proof zippered cases for box springs. On "sheet day" maintenance department will check beds on hallway to ensure no further signs of bed bugs and spray as needed. In addition, maintenance will continue to spray common areas and halls weekly as well as completing weekly hall checks. Assistant Administrator will perform random checks of mattresses and box springs to make sure that there are no rips or tears in zippered cases and that mattresses and box springs are covered. Housekeepers responsible for reporting any intermittent signs of bugs. Maintenance supervisor to monitor pest log and keep internal pest log, 5 times per week, ongoing.</p>	10/24/2016			

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R 0349  Bldg. 00	<p>Supervisor indicated there had been concern with bed bugs in some rooms. The Maintenance Supervisor indicated rooms 210 and 332 had recently been treated. The Maintenance Supervisor identified the bugs in the above room as appearing to be bed bugs. The Supervisor indicated the facility was completing weekly full checks of all the sheets rotating on different halls.</p> <p>When interviewed on 9/10/16 at 2:45 p.m., Resident #N indicated bed bugs were present in the current room Resident #N resides in. The resident still wears long pants to bed because of the bugs and having been bitten before.</p> <p>This Residential tag relates to Complaints IN00209427 and IN00209668.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.</p>						

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	<p>(4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately maintained related to lack of nursing assessment after a change in condition for 1 of 3 residents reviewed for change in condition in a sample of 18. (Resident #H)</p> <p>Finding includes:</p> <p>The record for Resident #H was reviewed on 9/9/16 at 3:40 p.m. The resident's diagnoses included, but were not limited to, alcohol abuse, major depression, chronic pain, and osteoarthritis.</p> <p>Review of the 8/12/16 Psychiatric Evaluation indicated the resident had a history of major depressive disorder and alcohol abuse. The resident had been hospitalized many times. The last hospitalization was for (2) weeks secondary to alcohol abuse.</p> <p>The 8/2016 Charting Notes were reviewed. An entry made on 8/23/16 at 10:46 p.m. indicated the resident was in bed and there was an alcohol smell in the room. The resident refused his medications and dinner. The resident refused to go to the hospital. No further</p>	R 0349	<p>Nurses have been in-serviced on their charting responsibilities including charting when a resident goes to the hospital and when they return. The resident indicated was sent out to hospital at the end of the 3 - 11 pm shift. That person is no longer an employee of Miller Beach Terrace. No other residents were identified as affected by the same practice. Charge nurse responsible to document appropriately on residents condition upon transfer. If an incident has occurred, they are responsible for reporting to the appropriate supervisors. They have been in-serviced on reporting incidents to the correct staff. DON to monitor all incident reports and internal nurse logs, daily, 5 times per week, ongoing.</p>	10/01/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER BEACH TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403
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	<p>entries were documented in August 2016.</p> <p>The next entry in the Charting Notes was made on 9/8/16 at 2:33 p.m. This entry indicated the resident returned from the hospital. The resident was alert and had a dried scabbed area above his left eyebrow.</p> <p>When interviewed on 9/9/16 at 3:50 p.m., LPN #1 indicated the resident was sent out to the hospital because he "hit his head and was drunk." The LPN indicated she was unsure when he fell or when he was sent out to the hospital.</p> <p>When interviewed on 9/9/16 at 4:00 p.m., the Director of Nursing indicated the resident had been sent to the hospital for a fall during the midnight shift. The Director of Nursing indicated she believed the resident went out to the hospital on the 11:00 p.m. to 7:00 a.m. shift on 8/25/16. The Director of Nursing indicated there are no Nurses in the facility on the night shift and the CNAs do not have access to chart. The Director of Nursing indicated Nursing staff coming in on the Day shift could have charted the event.</p> <p>This Residential tag relates to Complaints IN00209427 and IN00209668.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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