

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 02/10/2016
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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 a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00192349.</p> <p>Complaint IN00192349-Substantiated. State deficiencies related to the allegations are cited at R90.</p> <p>Survey date: February 9 &amp; 10, 2016.</p> <p>Facility number: 001140 Provider number: 001140 Aim number: N/A</p> <p>Residential census: 123</p> <p>Residential sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 26143, on February 17, 2016.</p>	R 0000		
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;</p>			

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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	<p>(5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from physical abuse related to an employee throwing a telephone at a resident and then slapped the resident's face for 1 of 1 residents reviewed for abuse in the sample of 10. (Resident #1)</p> <p>Finding includes:</p> <p>The record for Resident #1 was reviewed on 2/9/16 at 11:00 a.m. The resident's diagnoses included, but not limited to, seizure disorder and schizophrenia.</p> <p>Nursing Progress Notes dated 12/29/15 at 10:46 a.m., indicated "Called to lobby for altercation involving resident and front desk receptionist (name). CNA witnessed resident spit on (employee name) and throw cup of ice on her. (Employee name) responded by throwing phone receiver at resident hitting her in left temple. (Employee name) then went around the desk and smacked resident on the left side of face. Resident has small 1 centimeter (cm) bump with less than 0.1 cm laceration in center of bump near hairline left temple area. Not actively bleeding. Resident assessed for signs and symptoms of head injury. Denies pain. MD (Medical Doctor) notified." (sic)</p>	R 0052	<p>Employee was immediately terminated. No other incidents were reported. Facility will continue to follow the DATED (10/28/15) abuse policy. A copy of the DATED (10/28/15) abuse policy is given and discussed with new employees upon hire. Facility will increase abuse in-service from 3 times per year to quarterly. The abuse policy is also discussed in the resident rights in-service, dementia in-service and in the in-service for non-violent crisis intervention. In-service will be held on March 29, 2016, and semi-annually, with residents in regards to reporting if they do not feel safe. First quarterly in-service was given on January 06, 2016. Upon admission, residents are orientated to their rights and given a copy of the grievance policy. Dementia trainer responsible for scheduling and giving abuse in-service. Administrator to monitor by reviewing abuse in-service sign-in sheets quarterly, ongoing. Due to the fact that this is the only abuse complaint by a resident in 24 years, and nursing personnel see residents daily and have been instructed to report any concerns to Administrator, monitoring will not include weekly interviews unless deemed necessary.</p>	03/29/2016			

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	<p>The Incident report dated 12/29/15, provided by the Business Office Manager on 2/9/16 at 10:30 a.m., indicated on 12/29/15 Resident #1 was having a verbal altercation with the receptionist. The resident spit on her and threw a cup of ice water on her. The receptionist was on the phone and responded by throwing the phone receiver at the resident, hitting her in the left temple. The receptionist then came from behind the desk and slapped the resident across the face. The employee was terminated and the police were notified.</p> <p>A witness statement was reviewed from the incident report. The statement indicated "(Resident name) spit then through water on (name of receptionist) through the phone then walked around the desk and slapped (Resident name)." (sic)</p> <p>The police report dated 12/29/15 indicated the police were dispatched to the facility for a battery incident. The report indicated "(Employee name) and Resident #1 were involved in a physical altercation at the front desk around 9:00 a.m. Resident #1 was walking past (Employee name) with a cup of water to get ice when (Employee name) told the resident to walk no further towards the</p>			

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R 0090  Bldg. 00	<p>kitchen area because staff was mopping. Resident #1 became angry and threw the cup of water at (Employee name) and then spit at (Employee name). (Employee name) then became angry and threw a plastic corded phone at the resident. (Employee name) then walked around the front desk to the resident and slapped the resident with an open fist to her face."</p> <p>The current and undated Abuse Policy provided by the Business Office Manager on 2/9/16 at 2:30 p.m., indicated "Abuse is willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or anguish.... Physical abuse includes, but not limited to, hitting, slapping, pinching, and corporal punishment."</p> <p>Interview with the Business Office Manager on 2/9/16 at 11:00 a.m., indicated the receptionist was terminated the day of the incident. She further indicated she had an all staff inservice on abuse on 1/6/16.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p>				

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	<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 available for examination in the facility in a place readily accessible to residents and a</p>			

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	<p>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 promptly arrange for and help with providing transportation to and from Physician appointments for 1 of 3 residents reviewed for transportation needs in the sample of 10. (Resident #B)</p> <p>Finding includes:</p> <p>The record for Resident #B was reviewed on 2/9/16 at 1:00 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder, diabetes, and schizophrenia.</p> <p>The Physician appointment log dated 1/21/16 provided by the Director of Nursing was reviewed. The log indicated the name of the resident, the time of the appointment, the Physician's name and the resident's Medicaid number. There was no documentation of when the resident was picked up or dropped off by the transportation company. There was also no documentation as to what transportation company was used to take residents back and forth to their appointments.</p>	R 0090	Resident B was picked up from Doctor's office. No other transportation issues were reported. Nursing will be notified immediately if there is a transportation problem. As stated in our policy, nursing will be responsible for contacting Cab Company. Nursing staff in-serviced regarding new policy. Staff has been instructed to contact nursing if there is a transportation issue. If transportation company cannot pick up resident, for whatever reason, an agreement has been reached with QuickCab for immediate (within the hour) pick-up. Hours for Quick-Cab is 24 hours per day, 7 days as week. Scheduler responsible. Facility has and internal log of appointment in/out and Quick-cab use. DON to monitor log, 5 times weekly, ongoing.	03/01/2016			

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	<p>Resident #B's name was listed on the appointment log. The date of the appointment was 1/21/16 at 2:00 p.m. The name of the Physician was documented by the resident's name. There was no documentation of when the resident was picked up or dropped back off at the facility.</p> <p>A list of events dated 1/21/16 provided by the Physician's office (where the resident's appointment was) indicated at approximately 4:45 p.m., Resident #B was dropped off for an appointment that was scheduled for 2:00 p.m. The resident indicated he did not know who dropped him off. The Physician's office called the facility at 4:47 p.m., to inform them the resident needed to be picked up due to arriving over 2 hours late and their office was closed. At 4:52 p.m., an employee from the facility called the Physician's office back and wanted to know how the resident got to their office. At 5:01 p.m., the employee informed the Physician's office they were trying to contact their normal transportation companies to come pick up Resident #B, however, they were not successful. The employee informed the Physician's office she had tried to call the charge nurse and had not been successful at contacting her either. At 5:07 p.m., the Physician's office called the facility back and had given the</p>			

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	<p>employee numbers of transportation services to come pick up the resident. At 5:27 p.m., the Physician's office called the facility again wanting to know who was picking up the resident. At that time, the facility informed them they might have to send an employee over to get him when they went on their break. The facility had asked the Physician's office if they could possibly meet them half way. At 5:38 p.m., the facility indicated the scheduler from the facility would be coming to pick him up. At 6:00 p.m., the resident was picked up from the Physician's office and taken back to the facility.</p> <p>Interview with the facility's Scheduler on 2/9/16 at 10:00 a.m., indicated on 1/20/16 their normal transportation company had quit in the middle of the day. She indicated she had to scramble to find transportation for the residents who had appointments on 1/21/16 and future appointments. She indicated she was able to get all the other residents rescheduled except Resident #B. She indicated she could not remember what the transportation company's name was that picked the resident up for his appointment. She further indicated she was called by the facility at her house to go and pick him up because whoever she had scheduled to pick him up, did not</p>			

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	<p>show up to bring him back to the facility. The Scheduler indicated the facility had a company car, however, the Administrator drove it back and forth and when she was not at the facility the car was not there. She indicated they could not have used the car anyway, because the Administrator goes home around 3:00 p.m., and the resident would have needed to be picked up after that time. The Scheduler indicated the car was currently not at the facility at the present time, due to the Administrator was not coming in today.</p> <p>Interview with the Director of Nursing on 2/10/16 at 9:00 a.m., indicated the facility's car was parked at the facility 5 days a week. She further indicated she had no insured employee but maybe 1, that could drive the car and take residents to and from their appointments.</p> <p>Interview with the Scheduler on 2/10/16 at 9:15 a.m., indicated she was able to find the name of the transportation service used to take Resident #B on 1/21/16 to his appointment as she researched the Internet and the name "rang a bell." She also called the number and recognized the woman's voice on the phone.</p> <p>This Residential tag relates to Complaint</p>			

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R 0095  Bldg. 00	IN00192349.  410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure three (3) hours of annual dementia training was completed for 6 of 44 employees	R 0095	The training has a pre and post test to ensure understanding of material presented. The 3 hour dementia training will be given on March 24, 2016 for missing	03/24/2016			

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	<p>reviewed for dementia training.</p> <p>Finding includes:</p> <p>The Dementia Training Logs for the year of 2015 were reviewed on 2/9/16 at 2:00 p.m., and indicated the following:</p> <p>a. The Administrator, who had been working at the facility since 7/13/92 did not receive the three hours of annual dementia training for the year of 2015.</p> <p>b. The Director of Nursing, who had been working at the facility since 7/27/92, did not receive the three hours of annual dementia training for the year of 2015.</p> <p>c. QMA #1, who had been working at the facility since 12/17/09, did not receive the three hours of annual dementia training for the year of 2015.</p> <p>d. LPN #1, who had been working at the facility since 10/30/14, did not receive the three hours of annual dementia training for the year of 2015.</p> <p>e. LPN #2, who had been working at the facility since 4/22/11, did not receive the three hours of annual dementia training for the year of 2015.</p>		<p>employees. Employees who do not attend dementia training will be suspended until the class is taken on their own time and their own expense. Dementia trainer responsible for scheduling dementia training and doing training. Administrator to monitor by reviewing dementia sign-in sheets against payroll forms as training is completed, ongoing.</p>				

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R 0117 Bldg. 00	<p>f. LPN #3, who had been working at the facility since 11/10/08, did not receive the three hours of annual dementia training for the year of 2015.</p> <p>Interview with the Business Office Manager on 2/10/16 at 10:00 a.m., indicated all of the above employees had not received their three hours of annual dementia training.</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p>						

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	<p>Based on record review and interview, the facility failed to ensure there was at least one awake staff person with current CPR (Cardiopulmonary Resuscitation) and First Aid certificates on site at all times for 1 of 3 shifts. (The midnight shift)</p> <p>Finding includes:</p> <p>The Nursing Schedule dated February 3-9, 2016 was reviewed on 2/10/16 at 9:00 a.m. On 2/3/16 for the 11-7 shift, CNA #2 and Activity Employee #1 were scheduled to work. Neither one of the employees were CPR or First Aid certified.</p> <p>CNA #1 and CNA #2 were scheduled to work the 11-7 shift 2/4-2/6 and 2/8-2/9/16. CNA #1 was CPR certified but not First Aid certified. CNA #2 was not CPR or First Aid certified.</p> <p>Activity Employee #1 and CNA #1 were scheduled to work the 11-7 shift on 2/7/16. CNA #1 was CPR certified but not First Aid certified. Activity Employee #1 was not CPR or First Aid certified.</p> <p>Interview with the Business Office Manager on 2/10/16 at 10:00 a.m., indicated the midnight shift was lacking a</p>	R 0117	<p>CNA #1 has been first aid certified. CNA #2 has been CPR/first aid certified. Activity employee has been CPR/first aid certified. New midnight employees will be required to obtain their CPR/first aid certification within one week of start. Personnel department responsible for overseeing CPR/first aid testing. Business office manager to monitor as employees are hired, ongoing.</p>	02/22/2016			

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R 0144  Bldg. 00	<p>CPR and First Aid trained staff member for the week of 2/3-2/9/16.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to maintain an environment that was clean and in a state of good repair related to dented rusted floor vents, discolored and torn dining chairs, holes in ceiling tiles, discolored ceiling tiles, dusty and dirty overhead vents, a dirty and discolored microwave, burn holes and cigarette ashes on a bingo table, vomit observed on a table, and loose stair treads for 2 of 2 floors. (The first and second floors)</p> <p>Findings include:</p> <p>1. During the Environmental tour with the Maintenance man on 2/10/15 at 8:40 a.m., the following was observed on the first floor:</p> <p>A. Eight (8) dented rusted floor vents in the Dining Room.</p> <p>B. Fifty one (51) discolored and torn dining chairs located in the Dining</p>	R 0144	<p>1A,C. Vents throughout building have been checked and changed/cleaned as necessary. Specific maintenance person has been made responsible for checking vents weekly for cleaning/changing. B. Chairs throughout building have been inspected and replaced/repared as needed. Chairs will be inspected monthly by maintenance staff and replaced/repared as needed. Maintenance staff responsible. D. The microwave was cleaned. Kitchen employee has been assigned to clean the microwave daily. Kitchen employees responsible. Dietary Supervisor to monitor 5 times weekly, visually, ongoing. E. Treads have been re-attached. Maintenance department responsible to check stair treads and re-attach as needed. A, B, C and E: Maintenance supervisor to monitor visually, during rounds, 5 times weekly, ongoing. 2 A &amp; B. Ceiling tiles throughout building have been inspected and replaced as necessary. Specific maintenance person responsible</p>	03/01/2016			

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	<p>Room, second floor lobby, nurses station, and recreation room.</p> <p>C. The overhead vent located over the ice machine in the Dining Room was dusty and dirty.</p> <p>D. The microwave in the Dining Room was discolored and dirty.</p> <p>E. The two (2) backstairs in the Dining Room had loose black treads.</p> <p>2. During the Environmental tour with the Maintenance man on 2/10/15 at 8:40 a.m., the following was observed on the second floor:</p> <p>A. Seven (7) holes in ceiling tiles located in the second floor nurses station.</p> <p>B. Five (5) discolored ceiling tiles located in the second floor nurses station.</p> <p>C. The Bingo table had burn holes, and cigarette ashes on it.</p> <p>D. The Checker table had vomit on it.</p> <p>Interview with the Maintenance man at that time indicated, the above items were in need of cleaning and/or repair.</p>		<p>for checking ceiling tiles and replacing as needed. Maintenance supervisor to monitor, visually, during rounds, 5 times weekly. C &amp; D. Housekeeper responsible to clean tables in great room daily. Housekeeping supervisor to monitor, daily, visually, during rounds, 5 times weekly, ongoing.</p>				

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R 0214  Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency</p> <p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure an evaluation of each resident's needs was initiated prior to admission for 1 of 10 records reviewed for Service Plans. (Resident #5)</p> <p>Finding includes:</p> <p>The closed record for Resident #5 was reviewed on 2/9/16 at 10:30 a.m. The resident's diagnoses included, but were not limited to, bipolar disease.</p> <p>The record indicated no evidence of documentation a Service Plan had been completed.</p> <p>Interview with the Director of Nursing on 2/10/16 at 10:15 p.m., indicated the closed record did not include a Service Plan for the resident and a Service Plan should have been initiated prior to admission.</p>	R 0214	Care plans have been checked and no other care plans were in need of signing. Care plans have been added to the closed records monitoring form. An in-service was held on care plans. Charge nurses responsible for care plans. DON to monitor care plans on charts bi-monthly for 3 months, then monthly, ongoing.	03/29/2016
R 0217	410 IAC 16.2-5-2(e)(1-5)			

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Bldg. 00	<p><b>Evaluation - Deficiency</b></p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident for 2 of 10 sampled residents. (Residents #7 and #8)</p> <p>Findings include:</p> <p>1. The record for Resident #7 was</p>	R 0217	Care plans have been checked and no other care plans were in need of signing. Care plans have been added to the closed records monitoring form. If resident refuses to sign care plan, it will be noted and witnessed on care plan signature form. An in-service was held on care plans. Charge nurses responsible for care plans. DON to monitor for signature	03/29/2016			

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R 0273 Bldg. 00	<p>reviewed on 2/9/16 at 10:40 a.m. The resident was readmitted to the facility on 6/22/15. The resident's Service Plan was dated 6/22/15. The Service Plan was not signed by the resident.</p> <p>Interview with the Director of Nursing on 2/11/16 at 11:00 a.m., indicated some residents refuse to sign their Service Plan, however, it wasn't documented the resident refused.</p> <p>2. The record for Resident #8 was reviewed on 2/9/16 at 11:55 a.m. The resident's Service Plan was dated 10/2/15. The Service Plan was not signed by the resident.</p> <p>Interview with the Director of Nursing on 2/11/16 at 11:00 a.m., indicated some residents refuse to sign their Service Plan, however, it wasn't documented the resident refused.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure staff did not touch food that was being served from the steam table for 1 of 1 meals observed in</p>	R 0273	<p>on care plans bi-monthly for 3 months, then monthly, ongoing.</p> <p>In-service was given on February 15, 2016 regarding proper procedures and purpose of glove use. New employees will be trained in proper procedures and</p>	02/15/2016			

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R 0300	<p>the Main Kitchen. (The Main Kitchen)</p> <p>Finding includes:</p> <p>On 2/10/16 at 11:30 a.m., Dietary Employee #1 was observed serving food from the steam table in the kitchen. The Dietary Employee was wearing a pair of disposable gloves. As she was serving, she would touch the edge of the plates and serving utensil handles. The Dietary Employee was not observed to change her gloves. At 11:35 a.m., the Dietary Employee was observed to touch pieces of sliced bread with her gloved hand and place them on the plates. She continued to do this for the first portion of the tray line.</p> <p>Interview with the Dietary Food Manager on 2/10/16 at 11:15 a.m., indicated the server should not have touched the bread with her gloves after touching everything else.</p>		<p>purpose of glove use by cooks. Cooks responsible for training and enforcing glove compliance. Dietary supervisor to monitor 2 times daily, five times per week, visually, ongoing. When dietary supervisor is not available, the cook is to monitor with the same parameters as the supervisor.</p>				
	410 IAC 16.2-5-6(c)(4)						

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Bldg. 00	<p>Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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.</p> <p>Based on observation, record review and interview, the facility failed to ensure multi-dose medications of eye drops, nasal sprays, and inhalers were labeled when opened in 1 of 2 medication carts throughout the facility. (Cart #1)</p> <p>Finding includes:</p> <ol style="list-style-type: none"> <li>1. On 2/9/16 at 12:21 p.m., during an observation with LPN #1 the following multi-dose medications were observed in Medication Cart #1: <ol style="list-style-type: none"> <li>a. In drawer #2 there were 5 inhalers, 5 eye drops, and 1 nasal spray with no open dates.</li> <li>b. In drawer #3 there were 5 inhalers, 5 eye drops, and 2 nasal sprays with no open dates.</li> <li>c. In drawer #4 there were 2 inhalers, 9 eye drops, and 2 nasal sprays with no open dates.</li> <li>d. In drawer #5 there was 1 inhaler with</li> </ol> </li> </ol>	R 0300	<p>The 6 eye drops, the open date was put on as date received, and the medication was used up. Medications were audited and no further undated medications were found.</p> <p>An in-service was held on dating multi-dose medications when opened. Charge nurse responsible for dating all multi-dose medications when they are opened. DON to monitor medication carts daily, 5 days for 4 weeks, then weekly, ongoing.</p>	03/29/2016			

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R 0406 Bldg. 00	<p>no open date.</p> <p>e. In drawer #6 there was 1 eye drop with no open date.</p> <p>f. In drawer #7 there were 2 inhalers with no open dates.</p> <p>g. In drawer #8 there was 1 eye drop and 1 inhaler with no open dates.</p> <p>Interview with the Director of Nursing on 2/10/16 at 9:00 a.m., indicated the medications were to be labeled with an open date after opening.</p> <p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, record review, and interview, the facility failed to prevent the widespread of infection related to live rodents in the facility and failure to disinfect shared glucometers after use for 1 of 1 accucheck observed during medication pass. (Resident #9)</p> <p>Findings includes:</p> <p>1. On 2/9/16 at 8:50 a.m., three mice</p>	R 0406	<p>Exterminator from Monroe treated the building on 02/10/2016. Miller Beach Terrace has a contract with Monroe Pest Services and the pre-arranged contract is for treatment 2 times per month (every other Wednesday). Exterminator, when he comes in, first checks the extermination book and treats those areas first. Then the building is treated to prevent other problems. Housekeepers have been in-serviced on the importance of</p>	03/29/2016			

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	<p>were observed running up and down the counters and on the floor in a room located just behind the receptionist's desk. The room housed food that staff would sell to the residents who resided in the facility.</p> <p>At that time, there were 2 large plastic bags of individual bags of chips and cheetos. There was one container of licorice and 18 Styrofoam containers of instant soup mix. There was 1 box of cookies and numerous jars of peanut butter and jarred pickles and about 20 cases of soda pop.</p> <p>On 2/9/16 at 1:28 p.m., Room 305 was observed. Inside the resident's room was a stand alone wardrobe closet. Inside the closet were large amounts of rodent feces observed on the bottom shelf. At that time, both residents were in the room and indicated they have seen many mice in the last three weeks running around in their room.</p> <p>Interview with the Director of Nursing on 2/9/16 at 2:00 p.m., indicated the facility had not had a rodent problem in a long time and it wasn't until about 3 weeks ago did she start to get complaints from residents about mice in their rooms.</p> <p>Interview with the Maintenance</p>		<p>making sure there is no open food or sugar packets in resident rooms, cleaning of mice feces and using the exterminator book. The "store" has purchased large plastic bins to store foods. More sticky traps have been purchased for resident rooms and traps are checked daily by maintenance department. Employees are responsible for reporting mice activity in the exterminator book. Maintenance supervisor to monitor reports of mice, daily, ongoing. An in-service was held on proper use of glucometer. New policy on glucometer was reviewed with nursing staff. Charge nurses responsible for educating residents on glucometer use and supervising residents testing themselves. Charge nurses responsible for sanitizing glucometer before and after each test with bleach sanitizing wipes on all shifts. Charge nurses responsible for dating test strips when opened. DON to monitor glucometer use daily for 5 days, alternating shifts, for 4 weeks and then 2 times weekly, alternating shifts, ongoing.</p>				

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	<p>Supervisor on 2/10/16 at 9:00 a.m., indicated the last time the Pest Control company had been out to the facility to treat rodent infestation was on 12/8/15. He indicated the rodent problem was getting worse about the end of December 2015 right after Christmas. He further indicated he had bought the sticky mouse traps at the store and set them up in resident rooms. He indicated the traps were effective, but did not fully get rid of the rodent problem.</p> <p>Confidential interview with another resident on 2/10/16 at 9:30 a.m., indicated there were mice observed in the room where the resident resided. The resident indicated the problem had been going on for about a month.</p> <p>2. On 2/9/16 at 11:50 a.m., LPN #1 was observed performing blood glucose monitoring for Resident #9. She cleansed the resident's finger with an alcohol sanitation wipe, pricked his finger with a lancet (a blade with a sharp point) then collected a small sample of blood on to the blood monitoring strip. Upon finishing the blood sample collection she wiped the glucometer with an alcohol sanitation wipe and placed it back into the fabric casing and closed the medication drawer. Interview at the time</p>			

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	<p>with LPN #1 indicated she had 2 glucometers in her medication cart and the residents shared the meters. Continued interview indicated she cleansed the meter with an alcohol sanitation wipe and there were no bleach sanitation wipes in the nursing station. She was not aware the shared meters should have been cleansed with sanitation wipes containing bleach.</p> <p>Review of the Insulin Diabetics List provided by the facility during the entrance conference indicated there were 16 residents who resided in the facility that required blood glucose monitoring.</p> <p>Interview with the Director of Nursing (DoN) on 2/10/16 at 9:00 a.m., indicated the facility had approximately 17 residents who were diabetic and required blood glucose monitoring. She further indicated all residents should have their own meters. She was not aware that shared meters should be sanitized with wipes containing bleach. She further indicated she had no policy for cleaning and disinfecting the glucose meters.</p> <p>Interview with LPN #2 on 2/10/16 at 10:35 a.m., indicated the nursing staff only monitored 4 of the 16 resident's blood glucose levels, and of the 4 residents 3 of the residents had their own</p>			

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R 0407 Bldg. 00	<p>meters. Continued interview with the LPN indicated there were no resident identifiers on the meters and she differentiated the meters between the residents by their brand.</p> <p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review and interviews, the facility failed to ensure there was an infection control program that monitored, tracked and trended, all infections.</p> <p>Finding includes:</p> <p>The infection control logs were reviewed on 2/10/16 at 9:45 a.m. The logs were provided by the Director of Nursing</p>	R 0407	<p>Policy was written for infection control trending and tracking. In-service was held on infection control monthly reporting. A form was developed for tracking patterns and trends. Charge nurse responsible for infection control report and tracking and trending report. DON to monitor infection control reports weekly, ongoing.</p>	03/29/2016

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	<p>(DoN) who had been monitoring the infections for the last three months.</p> <p>The facility infection control monthly report sheet for the months of December 2015, and January &amp; February 2016 were reviewed. The infections (urinary tract infection, respiratory, dental, and gastro-intestinal) were charted on the spreadsheet.</p> <p>Continued review of the facility report sheet indicated the infection control rate was not completed, nor had there been any tracking for patterns and trends for each month to determine if the facility needed a plan of action due to increased or patterned infections. The report sheet identified the resident, name of medication, illness, initiated date, and resolution date.</p> <p>Interview with the DoN on 2/10/16 at 10:00 a.m., indicated she had never done trending, and she did not know she was supposed to track and trend the infections of the residents.</p> <p>Interview with the Business Office Manager on 2/10/16 at 10:20 a.m., indicated the facility did not have a policy regarding an infection control program with monitoring, tracking and trending.</p>						

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R 0410 Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure a two-step Tuberculin (TB) skin test was completed within 3 weeks after admission for 1 of 10 residents reviewed for TB skin testing. (Resident #5)</p> <p>Finding includes:</p> <p>The closed record for Resident #5 was reviewed on 2/9/16 at 10:30 a.m. The resident's diagnoses included, but were</p>	R 0410	<p>In-service was held for nursing on Tuberculin skin test requirements for residents. Charts were audited and no other residents were noted to be missing 1st or 2nd step Mantoux skin test.</p> <p>Charge nurses responsible for Mantoux skin test. 2nd step administration to be completed within 3 weeks after admission. DON to monitor by reviewing new admissions for tuberculin skin test compliance daily, 5 days weekly, ongoing.</p>	03/29/2016
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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 02/10/2016	
NAME OF PROVIDER OR SUPPLIER  MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>not limited to, bipolar disease.</p> <p>The record indicated the resident received her first TB skin test on 1/11/15. There was no evidence of documentation a two-step TB skin test had been completed.</p> <p>Interview with the Director of Nursing on 2/10/16 at 10:15 a.m., indicated the facility had not completed a two-step TB skin test for the resident and the skin test should have been completed within 3 weeks after the first test.</p>						