STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0000	This visit was for the Investigation of Complaint IN00103221. Complaint IN00103221-Substantiated. State residential deficiencies related to the allegation are cited at R045 and R048. Unrelated deficiency cited. Survey dates: February 9 & 10, 2012 Facility number: 001140 Provider number: 001140 AIM Number: N/A Survey team: Janet Adams, RN, TC Janelyn Kulik, RN (February 9, 2012) Census bed type: Residential: 144 Total: 144 Census payor type: Medicaid: 140 Other: 4 Total: 144 Sample: 10	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	These state findings are cited in accordance with 410 IAC 16.2. Quality review 2/15/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0045	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to complete the required transfer/discharge State forms and provide a copy to each resident, resident's family or legal representative, and the ombudsman, for 7 of 10 residents reviewed for discharges in the sample of 10. (Residents #B, #C, #D, #E, #F, #G, and #H) Findings include: 1. The closed record for Resident #B was reviewed on 2/9/12 at 8:50 a.m. The resident was admitted to the facility on 9/9/11. The resident's diagnoses included, but were not limited to, schizophrenia, high blood pressure, degenerative joint disease, and compression fracture. The resident was discharged to an out of state Long Term Care facility on 1/5/12.	R0045	R045 410 IAC 16.2-5-1.2(r)(6-9) Resident B, F, E, C, D, H & G Discharge planning conference will be done with residents. Family will be invited if resident wants their attendance. Discharge conference will be done when facility is aware of discharge plans. Discharge conference will include reason for discharge, discharge date and information on contacting the state and local ombudsman. State of Indiana Notice of Transfer/Discharge will be given to resident or their family. The notice will also be sent to the local ombudsman. This is a discharge plan and no other residents are currently planning to discharge. Discharge planning will be completed as required with appropriate forms. DON responsible. Administrator to monitor by reviewing discharges as they occur, ongoing.	02/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Review of the Admission Record indicated the resident's sister was listed as an Emergency Contact. The resident's 9/9/11 Service Plan indicated the resident had temper tantrums, child like behaviors, and was verbally abusive. The 12/11 Nurses' Notes were reviewed. An entry made on 12/19/11 at 7:30 p.m. indicated the resident walked out of the building in the dark and staff were unable to find her at this time. The next entry was dated 12/19/11 at 9:00 p.m. This entry indicated the resident was in another city about 7 miles away and the police were called. The resident was returned to the facility. An entry made on 12/26/11 at 2:00 p.m. indicated staff reviewed the resident's previous walk away with her and she understood her unsafe behavior and the possible change that would have to be made if she behaved in an unsafe manner. An entry made on 12/29/11 at 3:20 p.m. indicated the resident approached the medication cart shouting and crying and the resident swung her fist at the writer. The 1/12 Nurses' Notes were reviewed. An entry made on 1/2/12 at 2:00 p.m. indicated the resident was verbally abusive. An entry made on 1/2/12 at 5:00 p.m. indicated the resident came to the medication cart and told a staff member to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	get her mail "before something bad happens to you." The next entry in the 1/12 Nurses' Notes was made on 1/5/12 at 2:30 p.m. This entry indicated the resident was discharged to (name of an out of state Nursing Home). The entry indicated all the resident's belongings were packed and the facility was here to pick up the resident. There was no documentation in the resident's record indicating the resident was informed she was being transferred on 1/5/12 prior to the discharge. There was no documentation the resident or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	been completing the forms for discharges 2. The closed record for Resident #F was reviewed on 2/9/12 at 10:40 a.m. The resident was admitted to the facility on 9/8/11. The resident had a diagnosis of schizoaffective disorder. The Admission Record indicated the resident's Emergency Contact was listed as a cousin. The resident was discharged to an out of state Long Term Care facility on 12/29/11. A Service Plan initiated on 9/8/11 indicated the resident was incontinent of bladder, combative during hygiene, and verbally abusive. A Physician's order was written on 12/29/11 for the resident to be discharged to the Nursing Home due to the increased level of care for Residential stay. The 11/11 Nurses' Notes were reviewed. An entry made on 11/23/11 (no time listed) indicated the resident refused to wear attends and her clothing was saturated with urine, and it usually took two staff members to get her to the room and showers. The 12/11 Nurses' Notes were reviewed. An entry made on 12/1/11 (no time listed) indicated staff spoke with the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	about other placement and hygiene issues. An entry made on 12/14/11 indicated the resident was verbally abusive when approached. An entry on 12/16/11 at 8:00 p.m. indicated the resident was incontinent of bowel and bladder. An entry on 12/29/11 at 2:30 p.m. indicated the resident was transferred to (name of an out of state Long Term Care Facility) and a car was here to pick her up. The resident was explained the need for higher level of care due to her inability to manage her hygiene. There was no documentation in the resident's record indicating the resident was informed she was being transferred on 12/29/11 prior to the discharge. There was no documentation the resident or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges When interviewed on 2/9/12 at 10:30 a.m., the local Ombudsman indicated he had not been informed prior to the resident's discharge. 3. The closed record for Resident #E was reviewed on 2/9/12 at 9:30 a.m. The resident was admitted to the facility 9/9/11. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, depression with psychosis, and pain. The resident was discharged to an out of state Long Term Care Facility on 12/5/11. The Admission Record indicated the resident's Emergency Contact was a Guardian. Review of the 12/11 Nurses' Notes indicated an entry was made on 12/15/11 at 2:00 p.m. The entry indicated staff spoke with the Guardian related to the resident not being appropriate for the facility due to multiple alcohol events and the resident had a hunting knife in his room. The next entry was made on 12/15/11 at 3:00 p.m. This entry indicated the resident's information was faxed to (name of an out of state Long Term Care facility). The next entry was dated 12/15/11 at 2:45 p.m. This entry			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	indicated the facility the resident was being discharged to was here to pick up the resident, and the Guardian was notified of the transfer. There was no documentation in the resident's record indicating the resident was informed he was being transferred on 12/15/11 prior to the discharge. There was no documentation the resident or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges When interviewed on 2/9/12 at 10:30 a.m., the local Ombudsman indicated he had not been informed prior to the resident's discharge.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	4. The closed record for Resident #C was reviewed on 2/9/12 at 9:05 a.m. The resident was admitted on 8/7/11. The resident's diagnoses included, but were not limited to, schizophrenia. There was a Physician's order written on 1/11/12 to discharge the resident to (name of an out of state Long Term Care facility). Review of the Admission Record indicated the resident's brother was listed as his Emergency Contact. The 1/12 Nurses' Notes were reviewed. An entry made on 1/1/12 at 2:00 p.m. indicated the resident had "alcohol issues." There was no further documentation of the above. The next entry in the Nurses' Notes was made on 1/11/12. This entry indicated the resident was moving to a nursing home per the resident's request. The resident's brother was notified and the resident left with all his belongings. There was no documentation the resident and or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges When interviewed on 2/9/12 at 10:30 a.m., the local Ombudsman indicated he had not been informed of the resident's discharge. 5. The closed record for Resident #D was reviewed on 2/9/12 at 9:20 a.m. The resident was admitted to the facility on 9/8/11. The resident's diagnoses included, but were not limited to, paranoid schizophrenia and a history of poly substance drug abuse. A Physician's order was written on 1/11/12 to discharge the resident. Review of the Admission Record indicated the resident's parents were named as Emergency Contacts for the resident. The 1/12 Nurses' Notes were reviewed. The first entries made were on 1/5/12 at 11:00 a.m. and 2:00 p.m. There was no documentation of discharge notification			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	or planning in the above entries. The next entry was made on 1/11/12 at 2:00 p.m. This entry indicated the resident was discharged to (name of an out of state Long Term Care facility) per conversation with the resident's mother and father. The resident was racist and the chance of being harmed is high. Family notified of the move today. There was no documentation the resident and/or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges When interviewed on 2/9/12 at 10:30 a.m., the local Ombudsman indicated he had not been informed of the resident's discharge.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	6. The closed record for Resident #H was reviewed on 2/9/12 at 10:50 a.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia and high blood pressure. The resident was admitted to the facility on 7/9/2008. A Physician's order was written on 1/9/12 to discharge the resident to Nursing Home due to change in level of care. Review of the "Admission Record" indicated there was no Emergency Contact listed. The 1/12 Nurses' Notes were reviewed. The only entry was made on 1/9/12 (no time indicated). The entry indicated the resident was discharged to Nursing Home and understands the need for more care. All belongings went with the resident. There was no documentation the resident was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges. When interviewed on 2/9/12 at 10:30 a.m., the local Ombudsman indicated he had not been informed of the resident's discharge. 7. The closed record for Resident #G was reviewed on 2/9/12 at 12:10 p.m. The resident was admitted to the facility on 9/21/98. The resident's diagnoses included, but were not limited to, schizophrenia, high blood pressure, and urinary incontinence. Review of the Admission Record indicated the resident's daughter was listed as an Emergency Contact. Care Plan meeting notes dated 12/16/11 indicated the facility met with the resident's mother and the resident's daughter for placement at (name of an out of state Long Term Care facility) and the family was in agreement for the change of placement. The 12/11 Nurses' Notes were reviewed. An entry made on 12/28/11 at 11:00 a.m., indicated the resident's daughter was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	notified the transfer to the other facility would be done on this date. The next entry was made on 12/28/11 at 3:00 p.m. This entry indicated the facility was here to pick up the resident and the resident was sent with all belongings. There was no documentation the resident or family was given the State of Indiana "Notice of Transfer or Discharge" required notice of the right to appeal the health facility's decision to transfer them including, the reason for discharge, the location being discharged to, the effective transfer/discharge date, and information on contacting the local and state Ombudsman. When interviewed on 2/9/12 at 11:35 a.m., the facility Director of Nursing indicated the above notices were not sent to the resident's family/legal party, the resident, or the local Ombudsman. The Director of Nursing indicated she had not been completing the forms for discharges. This state residential tag relates to Complaint IN00103221.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0048	410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident. (19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs. (20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan. (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan. (23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by: (A) the administrator or his or her designee; (B) the resident; (C) the resident ' s legal representative; and (D) an interested family member, if known; each of whom may make written comments on the report.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(24) The written report of the meeting shall be included in the resident ' s permanent record. Based on record review and interview, the facility failed to completed care planning conferences for residents to prepare them for relocation for 3 of 10 residents reviewed for discharge in the sample of 10. (Resident's #B, #D, and #E) Findings include: 1. The closed record for Resident #B was reviewed on 2/9/12 at 8:50 a.m. The resident was admitted to the facility on 9/9/11. The resident's diagnoses included, but were not limited to, schizophrenia, high blood pressure, degenerative joint disease, and compression fracture. The resident was discharged to an out of state Long Term Care facility on 1/5/12. Review of the Admission Record indicated the resident's sister was listed as an Emergency Contact. The resident's 9/9/11 Service Plan indicated the resident had temper tantrums, child like behaviors, and was verbally abusive. The 12/11 Nurses' Notes were reviewed. An entry made on 12/19/11 at 7:30 p.m. indicated the resident walked out of the building in the dark and staff were unable	R0048	R048 410 IAC 16.2-5-1.2(r) (18-24) Resident B, E and D A care planning conference will be held to prepare a resident for re-location. Conference will include reason for discharge, location being discharged to, the transfer/discharge date and information of contacting State and Local Ombudman. This is a discharge plan and no other residents are currently planning to discharge. Discharge planning will be completed as required with appropriate forms. DON responsible. Administrator to monitor by reviewing discharges as they occur, ongoing.	02/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	to find her at this time. The next entry was dated 12/19/11 at 9:00 p.m. This entry indicated the resident was in another city about 7 miles away and the police were called. The resident was returned to the facility. An entry made on 12/26/11 at 2:00 p.m. indicated staff reviewed the resident's previous walk away with her and she understood her unsafe behavior and the possible change that would have to be made if she behaved in an unsafe manner. An entry made on 12/29/11 at 3:20 p.m. indicated the resident approached the medication cart shouting and crying and the resident swung her fist at the writer. The 1/12 Nurses' Notes were reviewed. An entry made on 1/2/12 at 2:00 p.m. indicated the resident was verbally abusive. An entry made on 1/2/12 at 5:00 p.m. indicated the resident came to the medication cart and told a staff member to get her mail "before something bad happens to you." The next entry in the 1/12 Nurses' Notes was made on 1/5/12 at 2:30 p.m. This entry indicated the resident was discharged to (name of an out of state Nursing Home). The entry indicated all the resident's belongings were packed and the facility was here to pick up the resident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	There was no documentation of the resident being informed of her discharge to another facility prior to her discharge on 1/5/2012. There was no documentation the resident was involved in any care conferences related to her discharge plans. When interviewed on 2/9/12 at 11:35 a.m., the Director of Nursing indicated care conference was not held with the resident. 2. The closed record for Resident #E was reviewed on 2/9/12 at 9:30 a.m. The resident was admitted to the facility 9/9/11. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, depression with psychosis, and pain. The resident was discharged to an out of state Long Term Care Facility on 12/5/11. The Admission Record indicated the resident's Emergency Contact was a Guardian. Review of the 12/11 Nurses' Notes indicated an entry was made on 12/15/11 at 2:00 p.m. The entry indicated staff spoke with the Guardian related to the resident not being appropriate for the facility due to multiple alcohol events and the resident had a hunting knife in his room. The next entry was made on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	12/15/11 at 3:00 p.m. This entry indicated the resident's information was faxed to (name of an out of state Long Term Care facility). The next entry was dated 12/15/11 at 2:45 p.m. This entry indicated the facility was here to pick up the resident, and the Guardian was notified of the transfer. There was no documentation in the resident's record indicating the resident was informed he was being transferred on 12/15/11 prior to the discharge. There was no documentation of any care pan conference being completed prior to the resident's discharge. When interviewed on 2/9/12 at 11:35 a.m., the Director of Nursing indicated care conferences were not held with the resident. 3. The closed record for Resident #D was reviewed on 2/9/12 at 9:20 a.m. The resident was admitted to the facility on 9/8/11. The resident's diagnoses included, but were not limited to, paranoid schizophrenia and a history of poly substance drug abuse. A Physician's order was written on 1/11/12 to discharge the resident. Review of the Admission Record indicated the resident's parents were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	named as Emergency Contacts for the resident. The 1/12 Nurses' Notes were reviewed. The first entries made were on 1/5/12 at 11:00 a.m. and 2:00 p.m. There was no documentation of care conferences with the resident in the above entries. The next entry was made on 1/11/12 at 2:00 p.m. This entry indicated the resident was discharged to (name of an out of state Long Term Care facility) per conversation with the resident's mother and father. The resident was racist and the chance of being harmed is high. Family notified of the move today. There was no documentation of the resident being informed of discharge to another facility prior to his discharge on 1/11/12 There was no documentation the resident was involved in any care conferences related to his discharge plans. When interviewed on 2/9/12 at 11:35 a.m., the Director of Nursing indicated care conferences were not held with the resident. This state residential tag relates to Complaint IN00103221.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the residents' environment remained free of hazards related to light sterno devices (metal canister filled with wax that is lit) placed on the bottom of metal food storage carts used to serve meal trays to residents in the Dining Room. This deficient practice had the potential to affect 144 of 144 residents residing in the facility. Findings include: On 2/9/12 at 8:10 a.m., two dietary staff members were observed serving breakfast trays to the residents in the Dining Room. There were two tall metal food carts they were serving the meal trays from. There	R0148	R148 410 IAC 16.2-5-1.5(e)(1-4) Sternos were removed from facility on 02/10/12. An electric heated cart has been ordered and should be delivered by the 7th of March. To ensure proper food temps, food is now being served directly from steam tables until delivery of cart. Food service staff responsible. Dietary supervisor and cooks to monitor by taking food temps at 3 meals a day, ongoing. As stated previously, sternos were removed from facility on 02/10/12. Kitchen employees will check unused food carts to ensure that no sternos are present. Kitchen staff responsible. Dietary supervisor and cooks to monitor all 3 meals, ongoing.	03/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	were five lit sterno containers with flames on the bottom of one cart and three lit sterno containers on the bottom of the second cart. The staff members were pushing the carts through the Dining Room to serve residents at different tables. When interviewed on 2/9/12 at 2:30 p.m., the Director of Nursing indicated the sterno should not be used with the open flame.			