STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD GARY, IN46403

(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 IN00099085. Compliant IN00099085 - Substantiated. State deficiencies related to the allegations are cited at R 0090, R 0091, and R 0116. Survey date: November 4, 2011 Facility number: 001140 Provider number: 001140 AIM number: N/A Survey team: Janelyn Kulik Census bed type: Residential: 151 Total: 151 Census payor type: Other: 151 Total: 151 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2. Quality review completed 11/9/11 by Jennie Bartelt, RN.	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.

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

FORM APPROVED
OMB NO. 0938-0391

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 11/04/2011

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R0090	(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: (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: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (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. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (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			

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	notice posted of their availability. (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 Based on observation, record review and interview the facility failed to ensure allegations of physical abuse were reported to the Administrator and to the Indiana State Department of Health for 3 of 3 residents reviewed for allegations of abuse in a sample of 7. (Resident #C, Resident #D, and Resident #G) Findings include: 1. The record for Resident #C was reviewed on 11/4/11 at 11:10 a.m. The resident's diagnoses included, but were not limited to, major depression and chronic obstructive pulmonary disease. A nursing note dated 10/21/11, indicated the resident's television was up too loud. He was encouraged to turn it down. The resident complied and was verbally abusive. The resident went to bed. There was no other documentation in the nursing notes. The Abuse Policy was provided on 11/4/11 at 12:30 p.m. by the Administrator. "Abuse is willful	R0090	We have updated reporting procedures and developed a new form to facilitate the process of reporting allegations of abuse. We have in-serviced staff on indentifying and reporting allegations of physical and mental abuse. 1/2 of the staff was inserviced on November 15th and the other 1/2 of the staff will be in-serviced on November 23, 2011. Staff have been instructed to report allegations of abuse to their supervisor. Employee #3 was suspended for 3 days for failure to report allegation of resident-to-resident abuse. Supervisors were instructed as to their responsibility as to the use of the newly updated complaint form. DON will be notified if the administrator cannot be contacted. Administrator will review complaint forms as they are submitted, on-going. The alleged abuse to resident #C was investigated and proven to be untrue as evidenced by the written statement from resident #C and DON. Report was given to surveyor by a vindictive employee. The results of the investigation of this rumor was submitted to your office by fax. Interview with resident revealed resident had never said that DON	11/23/2011

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	infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychological well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." Physical abuse includes, but not limited to, hitting, slapping, pinching and corporal punishment. Resident to resident abuse with or without injury; staff to resident abuse with or without injury; other (visitor, relative) to resident abuse with or without injury. Reporting/Investigation/Identification: If abuse, molestation, or misconduct are suspected or discovered, the following steps will be taken. All steps will be documented. Staff member must report immediately by phone or in person to the Administrator/DoN any suspected abusive activity, misconduct or relationship of another employee in violation of this policy. Occurrences to be reported: Facilities are are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Division. Interview with the Director of Nursing on		had touched him. Per our company policy, failure to report any allegations of abuse can result in termination. DON will be notified if the administrator cannot be contacted. Administrator will review complaint forms as they are submitted, on-going. Resident and staff were interviewed and no other unusual occurrences were reported. Resident D & G are now seeing therapist for anger management.	

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	11/4/11, at 1:45 p.m., indicated she had been informed by another resident that someone's music was too loud. When she went down the hall the music was coming from Resident #C's room. She knocked and identified herself, entered the room and told the resident to turn off his music. The resident turned off the music and as she was leaving the room stated that he did not have to turn off his music until 10:00 p.m. She informed him that he could listen to his music at a low level. He then stated he was going to break all of the windows. She indicated she told him to go to bed. She further indicated he was drunk at this time. A confidential interview with Employee # 1 on 11/4/11, indicated he/she had been informed by Resident #C that Employee #2/Director of Nursing and Resident #C had words over how loud his music was playing. Resident #C had slapped Employee #2 and Employee #2 had then slapped Resident #C. Employee #1 indicated he/she did not tell the Administrator about the incident because nothing would be done about the incident. Employee #1 further indicated he/she had been told about the incident and had not witnessed the incident. Interview with the Administrator on 11/4/11 at 2:30 p.m., indicated she was			

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not aware of the incident between Resident #C and Employee #2.

2. Resident # D was observed on 11/4/11 at 10:30 a.m. in her room. The resident had a small reddish purple mark under her right eye.

The record for Resident #D was reviewed on 11/4/11 at 10:00 a.m. Her diagnoses included, but were not limited to, depression and arthritis.

The nursing notes indicated the last entry was on 8/10/11 at 1:13 p.m.

A letter from the Gary Police Department was provided on 11/4/11 at 10:17 a.m. by Resident #D. Review of the letter indicated it was dated 10/24/11. It was written to Resident #D and indicated, "I have received your Offense Report. Your report has been assigned the following number (number was indicated)." The letter was signed by Detective (detective's name).

Interview with Resident #D on 11/4/11 at 10:17 a.m., indicated she had an altercation with with Resident #G. She indicated the altercation took place on a Sunday 10/23/11. She was getting off of the elevator and dropped something. She was having trouble picking it up, and she

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	and another resident started laughing. Resident #G started calling her names. She indicated she kicked at him. He moved away and continued to call her names. She then indicated she told him to come on. She thought he went outside. As she was going down to the dining room, she felt something on her wheelchair and hair. She turned around and Resident #G had his hand on her wheelchair. She reached back at him, and she thought she may have hit his glasses. He then punched her in the right eye. She indicated Employee #3 was aware of the situation and told her that she instigated the incident. The resident indicated she called the police and they came to the facility that night. She further indicated she does not know why the police form was dated 10/24/11. The incident happened on 10/23/11, because Employee #3 only works on the weekend. Interview with the Administrator and the Director of Nursing on 11/4/11 at 10:25 a.m., indicated they knew nothing about the altercation or that the police had been to the facility on 10/23/11. Interview with the Director of Nursing on 11/4/11 at 11:00 a.m., indicated Employee #3 should have informed her or the Administrator of the incident between Resident #D and Resident #G.			

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	This state residential finding relates to Complaint IN00099085.			
R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on observation, record review and interview, the facility failed to ensure the Abuse Policy was followed for 3 of 3 residents reviewed for allegations of abuse in a sample of 7 related to reporting allegations of abuse to the Administrator or Director of Nursing and reporting the incidents to the Indiana State Department of Health, and for 4 of 5 Employees	R0091	We have updated reporting procedures and developed a new form to facilitate the process of reporting allegations of abuse. We have in-serviced staff on identifying and reporting allegations of physical and mental abuse. 1/2 of the staff was in-serviced on November 15, and the other 1/2 will be in-serviced on November 23, 2011. Staff	11/23/2011

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	reviewed for reference checks related to not obtaining reference checks prior to employment. (Resident #C, Resident #D, Resident #G, CNA #1, Maintenance #1, Maintenance #2, and Dietary #1) Findings include: 1. The Abuse Policy was provided on 11/4/11 at 12:30 p.m. by the Administrator. Review of the policy indicated, "Abuse is willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychological well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." "Physical abuse includes, but is not limited to, hitting, slapping, pinching and corporal punishment. Resident to resident abuse with or without injury; staff to resident abuse with or without injury; other (visitor, relative) to resident abuse with or without injury. Reporting/Investigation/Identification: If abuse, molestation, or misconduct are suspected or discovered, the following steps will be taken. All steps will be		have been instructed to report allegations of abuse to their supervisor. Employee #3 was suspended for 3 days for failure to report allegation of resident-to-resident abuse. Supervisors were instructed as to their responsibility as to the use of the newly updated complaint form. DON will be notified if the Administrator cannot be contacted. Administrator will review complaint forms as they are submitted, on-going. The alleged abuse of resident #C was investigated and proven to be untrue as evidenced by the written statement from resident #C and DON. Report was given to surveyor by a vindictive employee. The results of the investigation of this rumor was submitted to your office by fax. Interview with resident revealed resident has never said that DON had touched him. Per our company policy, failure to report any allegations of abuse can result in termination. Don will be notified if the Administratote cannot be contacted. Administrator will review complaint forms as they are submitted, on-going. No resident was affected by references not being checked on a timely basis. References were checked on CNA # 1, Maint. # 1 & 2, and dietary #1. Procedure has been changed, supervisors are now responsible for calling and making notes on reference	

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	documented. Staff member must report immediately by phone or in person to the Administrator/DoN any suspected abusive activity, misconduct or relationship of another employee in violation of this policy. Occurrences to be reported: Facilities are are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Division." "Screening/Protection: Hiring and screening procedures included, but were not limited to, previous employment check." 2. The record for Resident #C was reviewed on 11/4/11 at 11:10 a.m. The resident's diagnoses included, but were not limited to, major depression and chronic obstructive pulmonary disease. A nursing note dated 10/21/11, indicated the resident's television was up too loud. He was encouraged to turn it down. The resident complied and was verbally abusive. The resident went to bed. There was no other related documentation in the nursing notes. Interview with the Director of Nursing on 11/4/11 at 1:45 p.m., indicated she had been informed by another resident that someone's music was too loud. When she		checks before start date.	

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	went down the hall the music was coming from Resident #C's room. She knocked and identified herself, entered the room and told the resident to turn off his music. The resident turned off the music and as she was leaving the room, the resident stated that he did not have to turn off his music until 10:00 p.m. She informed him that he could listen to his music at a low level. He then stated he was going to break all of the windows. She indicated she told him to go to bed. She further indicated he was drunk at this time. A confidential interview with Employee #1 on 11/4/11, indicated he/she had been informed by Resident #C that Employee #2/Director of Nursing and Resident #C had words over how loud his music was playing. Resident #C had slapped Employee #2 and Employee #2 had then slapped Resident #C. Employee #1 indicated he/she did not tell the Administrator about the incident because nothing would be done about the incident. Employee #1 further indicated he/she had not witnessed Employee #2 slap Resident #C. Interview with the Administrator on 11/4/11 at 2:30 p.m., indicated she was not aware of the incident between Resident #C and Employee #2.			

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	3. Resident # D was observed on 11/4/11 at 10:30 a.m. in her room. The resident had a small reddish purple mark under her right eye. The record for Resident #D was reviewed on 11/4/11 at 10:00 a.m. Her diagnoses included, but were not limited to, depression and arthritis. Review of the nursing notes indicated the last entry was on 8/10/11 at 1:13 p.m. A letter from the Gary Police Department was provided on 11/4/11 at 10:17 a.m. by Resident #D. Review of the letter indicated it was dated 10/24/11. It was written to Resident #D and indicated, "I have received your Offense Report. Your report has been assigned the following number (number was indicated)." The letter was signed by Detective (detective's name). Interview with Resident #D on 11/4/11 at 10:17 a.m., indicated she had an altercation with with Resident #G. She indicated the altercation took place on a Sunday 10/23/11. She was getting off of the elevator and dropped something. She was having trouble picking it up and she and another resident started laughing. Resident #G started calling her names. She indicated she kicked at him. He			

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	moved away and continued to call her names. She then indicate she told him to come on. She thought he went outside. As she was going down to the dining room she felt something on her wheelchair and hair. She turned around and Resident #G had his hand on her wheelchair. She reached back at him and she thought she may have hit his glasses. He then punched her in the right eye. She indicated Employee #3 was aware of the situation and told her that she instigated the incident. The resident indicated she called the police and they came to the facility that night. She further indicated she does not know why the police form was dated 10/24/11. The incident happened on 10/23/11, because Employee #3 only works on the weekend. Interview with the Administrator and the Director of Nursing on 11/4/11 at 10:25 a.m., indicated they knew nothing about the altercation or that the police had been to the facility on 10/23/11. Interview with the Director of Nursing on 11/4/11 at 11:00 a.m., indicated Employee #3 should have informed her or the Administrator of the incident between Resident #D and Resident #G. 4. Review of the employee records on 11/4/11 at 1:00 p.m., indicated no			

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	previous employment checks were completed for CNA #1 hired on 9/27/11, Maintenance #1 hired on 9/13/11, Maintenance #2 hired on 9/15/11, and Dietary #1 hired on 9/9/11. Interview with the Administrator on 11/4/11 at 2:30 p.m. indicated she was unable to locate the information on the previous employment checks. She believes the forms were mailed to the previous employers and copies of the envelopes are kept but she was unable to locate the copies. This state residential finding relates to Complaint IN00099085.			

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R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.			
	Based on record review and interview, the facility failed to ensure the Abuse Policy was followed for 4 of 5 employees reviewed for reference checks related to not obtaining reference checks prior to employment. (CNA #1, Maintenance #1, Maintenance #2, and Dietary #1) Findings include: Review of the employee records on 11/4/11 at 1:00 p.m., indicated no previous employment checks were completed for CNA #1 hired on 9/27/11, Maintenance #1 hired on 9/13/11, Maintenance #2 hired on 9/15/11, and Dietary #1 hired on 9/9/11. The Abuse Policy was provided on 11/4/11 at 12:30 p.m. by the Administrator. Review of the policy indicated: Screening/Protection: Hiring and screening procedures included, but were not limited to, previous employment check. Interview with the Administrator on 11/4/11 at 2:30 p.m., indicated she was	R0116	Employee files have been checked and are in compliance. A new procdure has been developed for checking references. Supervisors will be responsible for checking references on employees hired in their department. Reference must be made or requested prior to first day worked. Supervisors have been in-serviced to the change in procedure. Supervisors responsible. Office Manager will monitor by reviewing new employee files as submitted, on-going.	11/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	unable to locate the information on the previous employment checks. She believes the forms were mailed to the previous employers and copies of the envelopes are kept but she was unable to locate the copies. This state residential finding relates to Complaint IN00099085.			