

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 11/25/2014
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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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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: November 24 &amp; 25, 2014.</p> <p>Facility number: 001140 Provider number: 001140 AIM number: N/A</p> <p>Survey team: Cynthia Stramel, RN-TC Yolanda Love, RN</p> <p>Census bed type: Residential: 126 Total: 126</p> <p>Census payer type: Other: 126 Total: 126</p> <p>Sample size: 9</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on December 1, 2014, by Janelyn Kulik, RN.</p>	R000000		

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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R000123	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure personnel records were complete and accurate related to an employee record not being available for review for 1 of 5 employee records reviewed. (Employee #1)</p> <p>Findings include:</p> <p>The employee roster was provided by the Business Manager on 11/24/14. The roster indicated Employee #1 was a CNA that was hired on 8/7/14, and was currently employed at the facility.</p>	R000123	Employee files have been compared to payroll records and no other lost files were discovered. The lost file has been found. New employee files will be scanned and saved in a secure computer as well as kept in paper form to prevent file from being lost. Business office personnel responsible for completing files and scanning. Business office manager to monitor against payroll sheets every two weeks for the first 60 days, then monthly, ongoing.	12/16/2014			

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R000144	<p>On 11/24/14 at 12:30 a.m., the Business Manager indicated she was unable to locate the file for Employee #1. She indicated she would check with another staff member and would continue to look for the employee's file.</p> <p>On 11/25/14 at 9:00 a.m., the Administrator indicated they were still looking for Employee #1's file. At 12:30 p.m., the Administrator indicated they were not able to locate the employee's file. She indicated it should be available for review.</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 marred walls, marred doors, stained and torn carpet, torn wall paper, missing mosaic square tiles, chipped paint, brown substance on brick walls, and dusty walls, ceilings and vents. This had the potential to affect 126 of the 126 residents who resided in the facility. (The 100 hall, the 300 hall, the Great room, the center stairwell, the east center stairwell, and the west center stairwell)</p>	R000144	<p>Room doors for 306, 309, 315, 315, 318, 323, 105, 108, 110 and 112 have been repainted. Doors were checked throughout building and doors that were marred have been repainted. Housekeepers will be responsible to clean doors daily. Any doors that need repainting will be reported to maintenance supervisor to be put on painting list. Large stain on carpet between room 320 and 322 has been cleaned. Carpet in other hallways was checked and no other stains were observed. When carpets are observed to be stained/worn/torn, staff members are responsible to report it</p>	01/01/2015

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	<p>Findings include:</p> <p>During the Environmental tour with the Maintenance Supervisor on 11/25/14 at 12:30 p.m., the following was observed:</p> <ol style="list-style-type: none"> <li>1. Room 306, the door was marred. Two residents resided in the room.</li> <li>2. Room 309, the door was marred. One resident resided in the room.</li> <li>3. Room 315, the door was marred. Two residents resided in the room.</li> <li>4. Room 316, the door was marred. One resident resided in the room.</li> <li>5. Room 318, the door was marred. One resident resided in the room.</li> <li>6. Room 323, the door was marred. Two residents resided in the room.</li> <li>7. Room 105, the door was marred. No residents resided in the room.</li> <li>8. Room 108, the door was marred. Two residents resided in the room.</li> <li>9. Room 110, the door was marred. Two residents resided in the room.</li> <li>10. Room 112, the door was marred.</li> </ol>		<p>to maintenance to be cleaned/repaired/replaced as needed. Walls in nurses station waiting room have been painted. Lobby will be painted. The call light cover has been replaced. No other call light covers are missing. Carpet in upstairs stairwell has been removed and replaced with tile. Building was checked and no other carpet was noted to be worn or torn. When carpets are observed to be stained/worn/torn, staff members are responsible to report it to maintenance to be cleaned/repaired/replaced as needed. Brown substance in west center stairwell has been cleaned. Building was checked and no other stairwells had a brown substance on the brick. Carpet in 100 hallway has been cleaned. When carpets are observed to be stained/worn/torn, staff members are responsible to report it to maintenance to be cleaned/repaired/replaced as needed. Wall paper across from DON's office has been replaced. Missing mosaic tiles were replaced. Stairwells were checked and any missing tiles were replaced. Painter/maintenance persons responsible. Maintenance supervisor to monitor visually, 5 times weekly, during daily rounds, ongoing.</p>		

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	<p>Two residents resided in the room.</p> <p>11. There was a large water stain on the carpet between room 320 and 322.</p> <p>12. The walls in the nursing station waiting area were marred.</p> <p>13. There was chipped paint near the elevator button on the first floor.</p> <p>14. Room 360, there was no call light cover above the door.</p> <p>15. The carpet in the upstairs 300 hallway by the east center stairwell was stained, worn and torn.</p> <p>16. There was a brown substance on the brick walls in the west center stairwell.</p> <p>17. The carpet in the downstairs 100 hallway was soiled.</p> <p>18. The wallpaper across from the DON's office was torn.</p> <p>19. There were missing mosaic square tiles on two stairs in the center stairwell.</p> <p>20. There were missing mosaic square tiles on one stair in the west center stairwell.</p>			

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R000154	<p>Interview with the Maintenance Supervisor at the time indicated, the above items were in need of cleaning and/or repair.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen equipment was maintained in good repair related to the walk in freezer and reach in refrigerator temperatures above acceptable temperatures. This had the potential to effect all 126 residents that resided in the facility.</p> <p>Findings include:</p> <p>1. On 11/24/14 at 9:55 a.m., the kitchen was observed with the Dietary Manager. There was a reach in refrigerator, the outside thermometer indicated 45 degrees. The Dietary Manager indicated the temperature was not correct because</p>	R000154	<p>The repairman was in by noon and the refrigerator and freezer are at correct temperatures. A temperature log has been developed and temperatures will be taken twice daily. Cook responsible for logging temperatures. Dietary supervisor to monitor daily by checking temperature logs, 5 times weekly, ongoing.</p>	12/03/2014			

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R000326	<p>the refrigerator was cycling. At 10:10 the refrigerator was checked again. The thermometer outside indicated 45 degrees. An inside thermometer indicated 50 degrees. He indicated the temperature of the refrigerator should be 41 degrees or below, and the current temperature was too warm. He further indicated they did not keep temperature logs for the refrigerator or freezers.</p> <p>2. The walk in freezer had an outside thermometer that the Dietary Manager indicated did not work. The inside thermometer indicated it was 36 degrees. The ham, lunch meat and peas were soft when pressed, they were not frozen solid. Interview with the Dietary Manager at that time, indicated the freezer should be at 0 degrees and was in need of servicing.</p> <p>410 IAC 16.2-5-7.1(a) Activities Programs - Deficiency (a) The facility shall provide activities programs appropriate to the abilities and interests of the residents being served. Based on observation, record review and interview, the facility failed to provide an ongoing activity program for the residents. This had the potential to affect all 126 residents residing at the facility.</p> <p>Findings include:</p>	R000326	<p>Facility has been advertising for an Activity Director for the previous nine months with no acceptable candidates applying. Facility will now advertise for an activity aide. An activity aide will be hired and will pass a state approved course within one year of hire. The activity aide will complete an activity calendar and</p>	12/15/2014			

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	<p>During initial tour of the facility on 11/24/14 at 9:00 a.m., there were no activity calendars observed in common areas or in resident rooms.</p> <p>Interview with Resident #4 on 11/24/14 at 8:44 a.m., indicated there were no activities offered at the facility. Continued interview of the resident indicated he stayed in bed all day because there was nothing to do.</p> <p>Interview with Resident #6 on 11/24/14 at 10:20 a.m., indicated the facility no longer offered daily activities since there was no longer an Activity Director.</p> <p>An interview with Resident #7 on 11/24/14 at 10:45 a.m., indicated there were no activities at the facility. He indicated they received snacks three times a day and that was it.</p> <p>Interview with the Administrator on 11/24/14 at 1:20 p.m., indicated they had not had an Activity Director since November 2013 and they were currently looking for one. The Receptionist was currently in charge of activities.</p> <p>Interview with the Receptionist on 11/24/14 at 1:30 p.m., indicated staff would do crafts sometimes, they gave the Veterans baseball hats, they had puzzle</p>		will interview/assess residents. Administrator responsible to hire.				

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	<p>sheets the resident's could do. She provided a large desk top calendar she used for activities, it was kept next to a file cabinet, not in view of residents. She indicated she would make announcements on the overhead intercom when activities were going to be held, they did not provide calendars of the scheduled activities. September 2014 events on the calendar were: 9/19 birthday cake; 9/24 Chinese buffet; 9/26 Baptist church visit and movie day. October 2014 events were: 10/7, 10/14, 10/21 and 10/28 puzzle club; 10/24 Baptist church; 10/31 Halloween party and movie. November 2014 events were: 11/1 Goodwill/ Salvation Army coats; 11/7 popcorn Friday; 11/14 birthday cake; 11/17 took Veterans to eat at restaurant; 11/21 Baptist church and movie. The remainder of the calendar dates were blank.</p> <p>The admission agreement was received from the Business Manager on 11/24/14. Page 2 of the packet indicated residents were encouraged to participated in activities. "An activity calendar will be provided to you each month, and the activity director will visit you in a few days to determine how to meet your activity needs".</p>			

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R000328	<p>410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.</p> <p>Based on interview, the facility did not ensure an Activities Director was designated to oversee the activity program. This had the potential to effect all 126 of the residents that resided in the facility.</p> <p>Findings include:</p> <p>Interview with the Administrator on 11/24/14 at 1:20 p.m., indicated they did not have an Activity Director since November 2013 and they were currently looking for one. The Receptionist was currently in charge of activities.</p> <p>Interview with the Receptionist on 11/24/14 at 1:30 p.m., she indicated she was not a therapist or therapy assistant and had not taken any courses related to activity programming.</p> <p>The admission agreement was received from the Business Manager on 11/24/14. Page 2 of the packet indicated residents</p>	R000328	<p>Facility has been advertising for an Activity Director for the previous nine months with no acceptable candidates applying. Facility will now advertise for an activity aide. An activity aide will be hired and will pass a state approved course within one year of hire. The activity aide will complete an activity calendar and will interview/assess residents. Administrator responsible to hire.</p>	12/15/2014			

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R000349	<p>were encouraged to participate in activities. "An activity calendar will be provided to you each month, and the activity director will visit you in a few days to determine how to meet your activity needs".</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain complete and accurate clinical records related to the lack of a readmission assessment and/or semi-annual evaluation, readmission and/or semi-annual weight, and an annual Tuberculin (TB) skin test for 1 of 7 residents reviewed in a sample of 7. (Resident #4)</p> <p>Findings include:  The record for Resident #4 was reviewed on 11/24/14 at 10:30 a.m. The resident was admitted to the facility on 7/6/10 and readmitted to the facility on 6/14/14. The</p>	R000349	An in-service was held with nursing on timely bi-annual assessments with documentation, including weights. A review of the bi-annual schedule was completed. The TB skin tests are done with the yearly history and physical. The history and physical schedule was reviewed to ensure timely compliance. There were no other untimely bi-annual or history and physicals found. Charge nurse responsible to complete bi-annual and TB skin tests and weights, timely. DON to monitor history and physicals and bi-annuals weekly, by reviewing schedule history and physicals and bi-annuals. Ongoing.	12/12/2014			

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R000354	<p>resident's diagnoses included, but were not limited to, major depression, hypertension, and right arm amputation.</p> <p>There was no evidence of documentation indicating a readmission assessment and/or semi-annual evaluation was completed.</p> <p>There was no evidence of documentation indicating a readmission or semi-annual weight was completed.</p> <p>There was no evidence of documentation indicating a TB skin test was completed.</p> <p>Interview with the Charge Nurse and the Director of Nursing on 11/25/14 at 9:45 a.m., indicated the resident should have been weighed and had a readmission assessment completed on 6/14/14. Continued interview at the time indicated the resident had not received his annual TB skin test.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution.</p>						

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	<p>(3) Name of the receiving institution and date of transfer.</p> <p>(4) Resident ' s personal property when transferred to an acute care facility.</p> <p>(5) Nurses ' notes relating to the resident ' s:</p> <p>(A) functional abilities and physical limitations;</p> <p>(B) nursing care;</p> <p>(C) medications;</p> <p>(D) treatment; and</p> <p>(E) current diet and condition on transfer.</p> <p>(6) Diagnosis.</p> <p>(7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to provide transfer sheets for two residents upon discharge from the facility for 2 out of 2 closed records reviewed. (Resident #8 and #9)</p> <p>Findings include:</p> <p>1. On 11/25/14 at 9:30 a.m., the closed records for Resident #8 was reviewed. Resident #8 was admitted to the facility on 8/1/14 with the diagnoses of bi-polar disorder and general weakness.</p> <p>A Nursing note dated 8/21/14 indicated the resident was discharged to a Nursing home per his request. There was no transfer sheet in the resident's record.</p> <p>2. The record for Resident #9 was reviewed on 11/25/14 at 9:35 a.m. Resident #9 was admitted to the facility</p>	R000354	In-service was held on transfer forms to all licensed personnel. Training was also done with medical assistant on discharged records/closed charts. No further discharge charts were noted to be affected. LPN charge nurses responsible for completing transfer forms and putting copy in chart. Medical records responsible for completion of closed charts. DON to monitor all discharges weekly, ongoing, using monitoring tool. DON will sign tool at end of monitoring to show chart is complete.	12/15/2014			

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R000406	<p>on 9/10/14 with the diagnoses of major depression.</p> <p>A Nursing noted dated 9/25/14 indicated the resident was discharged to home. There was no transfer form in the resident's record.</p> <p>The Resident Rights policy included in the admission packet was received from the Business Manager on 11/25/14, indicated when relocation was necessary, "provision for continuity of care shall be provided by the facility".</p> <p>Interview with the Director of Nursing (DON) on 11/25/14 at 11:40 a.m., indicated when a resident left the facility the transfer sheet was to be sent with them. The transfer sheet included the current medications, treatments and most recent assessment. The DON indicated if the transfer sheets were not in the record, they were not completed.</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>						

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 11/25/2014	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
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	<p>Based on observation and interview, the facility failed to ensure infection control was maintained related to mouse droppings in the kitchen. This had the potential to effect all 126 residents that received meals prepared in the kitchen.</p> <p>Findings include:</p> <p>On 11/24/14 at 9:55 a.m., the kitchen was observed with the Dietary Manager. There were two stacks of bread on pallets on wheeled carts. The Dietary Manager pulled the carts away from the wall. There was mouse bait under the carts and mouse droppings on the floor. The Dietary Manager indicated he had not seen evidence of mice in the kitchen recently, but indicated he also saw the mouse droppings on the floor.</p>	R000406	<p>Mouse droppings have been swept up. Mouse bait has been moved from under the bread. Per the cleaning schedule, the kitchen maintenance person will continue to check for mouse droppings under kitchen equipment, three times per day. Dietary maintenance person responsible. Dietary supervisor to monitor three times daily, five times per week, visually, ongoing.</p>	12/03/2014			