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 10/03/2013

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 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
R000000	This visit was for a State Licensure Survey. This visit also included the Investigation of Complaints IN00124248, IN00125465, IN00126667, IN00130454, IN00131905, and IN00134192. Complaint IN00124248-Substantiated. State deficiencies related to the allegations are cited at R053 and R241. Complaint IN00125465-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00126667-Substantiated. State deficiencies related to the allegations are cited at R053. Complaint IN00130454-Substantiated. State deficiencies related to the allegations are cited at R053. Complaint IN00131905-Substantiated. State deficiencies related to the allegations are cited at R090, R147, and R349. Complaint	R000000		

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.

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	IN00134192-Substantiated. State deficiencies related to the allegations are cited at R036. Survey Dates: October 2 and 3, 2013 Facility Number: 001140 Provider Number: 001140 Aim Number: N/A Survey Team: Heather Tuttle, RN. TC. Caitlyn Doyle, RN. Yolanda Love, RN Heather Hite, RN. Census Bed Type: Residential: 137 Total: 137 Census Payor Type: Other: 137 Total: 137 Sample: 18 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on October 10, 2013, by Janelyn Kulik, RN.			

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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's Physician and/or family member was promptly notified of a change in the resident's condition for 2 of 3 residents reviewed for notification of change in the sample of 18. (Residents #B & #J) Findings include: 1. The record for Resident #B was reviewed on 10/3/13 at 10:50 a.m. The resident was admitted to the facility on 6/14/13. The resident's diagnoses included, but were not limited to Schizophrenia. Review of Nursing Progress Notes dated 8/3/13 at 6:35 p.m., indicated the resident was transferred to the hospital on the 11-7 shift 8/2/13-8/3/13 for complaints of chest pain and headache. Returned at 5:30	R000036	It is the policy of this facility to notify a resident's physician and family of the need to hospitalize the resident. All residents may be affected by this alleged deficient practice. The nursing staff will be re-inserviced on the facility policy to notify a resident's physician and family of any condition change, including the potential that the resident requires hospitalization. On 11/04/13 in case of emergency persons were advised of hospitalization of residents #B and #J. Charts were reviewed and no other residents were found to be affected by practice. The Director of Nurses or her designee will for the next three months conduct a weekly audit of clinical records of those residents who were hospitalized to ensure that the nursing staff follows facility notification policy. After this three month period of time the DON or her designee will conduct a monthly audit. After this three month period of time the DON or her	11/15/2013

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	a.m., new orders for Tylenol 500 milligrams two tabs every six hours as needed and Prilosec 20 milligrams take two capsules daily. The next documented entry was on 8/7/13 (four days later) and there was no documentation the resident's Physician and/or family was notified the resident was in the hospital. Further record review indicated there was no transfer sheet completed with notification of the resident's Physician and/or family. Interview with the Director of Nursing on 10/3/13 at 1:30 p.m., indicated there was no documentation the resident's Physician and/or family was notified of the resident's trip to the hospital. 2. The record for Resident #J was reviewed on 10/2/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dementia, major depression, and congestive heart failure (CHF). Review of the Resident Transfer Form on 10/3/13 at 10:39 a.m., indicated the resident was transferred to the hospital with a complaint of right sided weakness. The form also indicated the resident's sister was contacted and a voice message was		designee will conduct a quarterly audit. Any deviation from the facility notification protocol will be addressed one-on-one with the nursing staff in question. A second violation of this protocol will result in disciplinary action.	

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	left. Review of the Miller Beach Terrace Admission Record, indicated the resident's emergency contact was his sister. On 10/3/13 at 9:55 a.m., an attempt was made to contact the resident's sister to verify notification was made related to the resident's transfer from the facility. The telephone number listed on the transfer form indicated a telephone number that was no longer in service. A second attempt was made to contact a relative of the resident for verification. At that time the resident's brother was called and he indicated that he was not aware of his brother's transfer from the facility. Interview with the DoN and the Charge Nurse on 10/3/13 at 10:05 a.m., indicated the contact number for the resident's sister was no longer in service and no attempt was made to contact the resident's brother. This State Residential Tag relates to Complaint IN00134192.			

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R000052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure each resident was free from physical abuse related to confidential interviews regarding pulling resident's hair and grabbing their faces. Findings include: 1. Confidential Interview #1 indicated the Director of Nursing (DoN) was observed to pull a resident's hair and throw the resident down to the ground and give the resident an injection. Further interview indicated the DoN was also witnessed to grab resident's faces and pinch their cheeks and squeeze their jaws. The interview further indicated the person did not tell the Administrator because "they were all in it together and what good would it do." 2. Confidential Interview #2 indicated the Director of Nursing (DoN) was observed to slap residents in the face.	R000052	This plan of correction is submitted in accordance with the requirement of Indiana law. Submission of the plan of correction is not an admission to or agreement with the allegations cited in this survey; rather, this plan of correction is submitted because it is required. It is the policy of this facility to prevent abuse, neglect and mistreatment of residents, and to investigate timely allegations of abuse, neglect and mistreatment. Outside agency was engaged to conduct investigation into alleged abuse. All residents and all employees of Miller Beach Terrace were interviewed. Preliminary report has been received and the findings of the independent review did not substantiate the allegations in the Indiana Department of Health's report dated 10/02/13. The nurse who is alleged to have mistreated residents was suspended, in accordance with facility policy, during this investigation. All staff will be re-inserviced on the facility's policy and procedure preventing abuse, neglect and	11/15/2013

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	Further interview indicated the person had told the Administrator and was told "that she would take care of it." Review of the current and undated Abuse Policy provided by the DoN indicated "It is the expressed policy of Miller Beach Terrace that staff shall not engage in sexually oriented activity with residents. It is also the policy of this facility that staff shall not physically or emotionally abuse any resident for any reason. If abuse, molestation, or misconduct are suspected or discovered, the following steps will be taken. All steps will be documented. Staff members 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." Interview with the Administrator on 10/3/13 at 9:00 a.m., indicated "Abuse will not be tolerated in this facility."		mistreatment and on the facility's reporting and investigation protocols for allegations of abuse, neglect and mistreatment. The Administrator will weekly for the next three months check the complaint/grievance log to ensure that investigations are conducted timely an in accordance with the facility's policy. After this three month period, the Administrator will check the complaint/grievance log monthly for the next three months, and after that three month period of time the Administrator will check the complaint/grievance log quarterly. Any deviation from facility policy and procedure will result in the suspension of the facility employee who is alleged to have abused, neglected or mistreated any resident pending the outcome of an investigation that will be immediately undertaken by the Director of Nurses or the Administrator. Once an investigation is completed the employee will be allowed to return to work only after it is determined that he or she did not violate facility policy and procedure. Any violation discovered during the investigation will result in termination.	

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R000053	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to ensure each resident was free from verbal abuse related to screaming in resident's faces, name calling and using profanity towards the residents. Findings include: 1. Confidential Interview #1, indicated if a resident smells bad, staff will tell them to take a shower, but they will not say it in a nice way. Further interview indicated staff will tell the resident they "stink" and to take a shower, has witnessed staff be more verbal and not in a nice way towards residents when the resident did not do what the staff wants them to do. 2. Confidential Interview 2, indicated the Director of Nursing (DoN) was verbally abusive towards residents all the time. Further interview indicated this has been witnessed by staff and other residents and the DoN gets away with it because no one questions her behavior. Further interview indicated the DoN was observed screaming at residents and	R000053	This plan of correction is submitted in accordance with the requirement of Indiana law. Submission of the plan of correction is not an admission to or agreement with the allegations cited in this survey; rather, this plan of correction is submitted because it is required. It is the policy of this facility to prevent abuse, neglect and mistreatment of residents, and to investigate timely allegations of abuse, neglect and mistreatment. Outside agency was engaged to conduct investigation into alleged abuse. All residents and all employees of Miller Beach Terrace were interviewed. Preliminary report has been received and the findings of the independent review did not substantiate the allegations in the Indiana Department of Health's report dated 10/02/13. The nurse who is alleged to have mistreated residents was suspended, in accordance with facility policy, during this investigation. All staff will be re-inserviced on the facility's policy and procedure preventing abuse, neglect and mistreatment and on the facility's reporting and investigation protocols for allegations of abuse, neglect and mistreatment. The Administrator	11/15/2013

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	threatening them all the time. 3. Confidential Interview #3, indicated the Director of Nursing was observed to verbally abuse the residents all the time. Further interview indicated the DoN calls the residents names like B#*#*. Confidential interview stated "What goes on here is really bad" Review of the current and undated Abuse Policy provided by the DoN indicated "It is the expressed policy of Miller Beach Terrace that staff shall not engage in sexually oriented activity with residents. It is also the policy of this facility that staff shall not physically or emotionally abuse any resident for any reason. If abuse, molestation, or misconduct are suspected or discovered, the following steps will be taken. All steps will be documented. Staff members 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." Interview with the Administrator on 10/3/13 at 9:00 a.m., indicated "Abuse will not be tolerated in this facility."		will weekly for the next three months check the complaint/grievance log to ensure that investigations are conducted timely an in accordance with the facility's policy. After this three month period, the Administrator will check the complaint/grievance log monthly for the next three months, and after that three month period of time the Administrator will check the complaint/grievance log quarterly. Any deviation from facility policy and procedure will result in the suspension of the facility employee who is alleged to have abused, neglected or mistreated any resident pending the outcome of an investigation that will be immediately undertaken by the Director of Nurses or the Administrator. Once an investigation is completed the employee will be allowed to return to work only after it is determined that he or she did not violate facility policy and procedure. Any violation discovered during the investigation will result in termination.	

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	4. Confidential Interview #4, indicated the DoN has been overheard being verbally abusive to residents in the facility. Confidential Interview #5, indicated there has been witnessed verbal abuse by staff to residents in the facility. Interview with the DoN on 10/3/13 on 9:15 a.m., indicated she was stern when communicating with some residents, however, denied being verbally abusive to residents. This State Residential Tag relates to Complaint IN00124248, IN00130454 and IN00126667.			

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R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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			

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	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a 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 record review and interview, the facility failed to promptly notify the State Agency of a resident to resident altercation that resulted in injury for 2 of 18 sampled residents. (Residents #B & #H) Findings include: 1. The record for Resident #H was reviewed on 10/2/13 at 12:37 a.m. The resident's diagnoses included, but were not limited to, Paranoid Schizophrenia. Review of Nursing Progress Notes dated 6/25/13 at 10:55 p.m., indicated the resident was transferred to the hospital by the way of the police department after he assaulted Resident #B with an extension cord from the air conditioner. Resident #H made delusional statements regarding roommate, inappropriately making sexual comments towards him. The Physician and the Director of Nursing were both notified.	R000090	It is the policy of this facility that the Administrator/designee inform the State Department of Health of all unusual occurrences as required by State law, including resident-to-resident abuse. Charts were audited and no other residents were found to be affected by practice. Nurses have be re-inserviced on reporting procedures for any unusual occurrences as required by state law. The Administrator will daily for the next three month review the complaint/grievance log to ensure that all unusual occurrences, as defined by State law, were timely reported to the ISDH. After this three month period of time, the Administrator will review the complaint/grievance log weekly to ensure the timely reporting to the ISDH of all unusual occurrences, After this three month period of time, the Administrator will review the complaint/grievance log monthly to ensure timely reporting to the ISDH of all unusual occurrences. Any deviation from facility policy will be reported immediately to the facility owner who will take steps to ensure the	11/15/2013

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	Review of the incident log indicated there was no evidence of an incident report that Resident #H assaulted Resident #B. The record for Resident #B was reviewed on 10/3/13 at 10:50 a.m. Nursing Progress Notes dated 6/26/13 at 8:35 p.m., indicated the resident had returned from the hospital on the day shift and had two staples to the middle of his forehead. Review of the current and undated Abuse Policy provided by the Director of Nursing (DoN) indicated resident to resident abuse with or without injury must be immediately reported by phone or in person to the Administrator/DON. Interview with the Director of Nursing on 10/2/13 at 2:00 p.m., indicated she was unaware Resident #H had assaulted Resident #B. She indicated she would have reported the incident if she would have known. Interview with the Administrator on 10/3/13 at 9:00 a.m., indicated she had just found out about the incident on 10/2/13 This State Residential Tag relates to		Administrator complies with facility policy and procedure, including disciplinary action.	

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	Complaint IN00131905			

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R000117	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. Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary resuscitation) certificate scheduled for the night shift for 5 of 7 days of the past two weeks of schedules reviewed. Findings include: Review of the Nursing , Dietary,	R000117	It is the policy of the facility to ensure that there is at least on staff member with current CPR and first aid certification on duty on each shift. All staff's CPR and first aid certification will be updated, and where necessary additional training will be obtained to ensure that staff's CPR and first aid certification is current. Any additional training will be accomplished by November 15, 2013. The facility's supervisors will ensure that at least one staff	11/15/2013

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MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

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	Housekeeping, and Maintenance staff schedules, dated 9/25/13 through 10/1/13, received as current by the Office Manager, indicated there were no employees scheduled for duty on night shift, who had both a CPR and a first aid certificate for September 25, 26, 29, 30 2013 and October 1 2013. Interview with the Office Manager at 1:00 p.m. on 10/3/13, indicated there was no staff who were first aid and CPR certified scheduled on the night shift for the above dates. She indicated one CNA's CPR and first aid certification had expired and one CNA could not find her current CPR and first aid certification card.		member with current CPR and first aid certification are on duty for all three shifts, seven days a week. The Administrator will weekly review the staff schedule to ensure that there is a least one staff member with current CPR and first aid certification on duty each shift.	

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R000144	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. Based on observation and interview, the facility failed to maintain an environment that was clean and in a state of good repair, related to missing light shields, discolored shower caulking, broken floor tiles, patched chair cushions, non functioning bathroom emergency call light, water damaged walls, loose and broken wall tiles, missing base board, missing ceiling tiles, soiled overhead light shields, uncovered wall outlets, full lint traps, and an unlocked boiler room door for 3 of 3 units throughout the facility as well as the Great Room, TV Room, Resident Laundry Room, and the Dining Room. This deficient practice had the potential to affect 137 of 137 residents residing in the facility. (Dining Room, TV Room, Great Room, 100 Unit, 200 Unit, and 300 Unit) Findings include: 1. During the environmental tour on 10/3/13 at 12:00 p.m., with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed:	R000144	a. In room 309 wall light was securely attached to the wall. Wall lamps were checked throughout the facility to ensure no other lamps were loose. b,c,d,e,f,i,&n. Loose tiles behind toilet were reattached. Cracked tiles were replaced. Missing tiles were replaced. Tiles were checked throughout the facility and were replaced, repaired, reattached as necessary. Caulking in showers was replaced. Showers were checked throughout the facility and caulk was replaced as necessary. The ceiling light cover for room 357 was tightened. Call light covers were checked throughout the facility and tightened as necessary. Paper in room 350 was taken down from vent. Resident has been encouraged not to reattach. Housekeeper has been instructed to remove it as necessary. g. Door to boiler room was locked as evidenced by the fact the maintenance supervisor had to use his key to unlock the door to admit surveyor, and will continue to be locked. h. Ceiling tiles were replaced and light shield was cleaned. j/l. Overhead light shields were cleaned. Overhead tracks were checked for burned	11/15/2013

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	A. In Room 309, the wall mounted lamp above the bed was loose and not secured to the wall. One resident resided in the room. B. In Room 319, there was tape around the air conditioning unit. The caulking in the shower was black and in need of cleaning. Tiles on the wall behind the toilet were loose. There were several pieces of floor tile missing by the shower. One resident resided in the room. C. In Room 330, tiles on the wall behind the toilet were loose. One resident resided in the room. D. Outside Room 357, the call light cover above the room door was loose and not covering the light bulb. Two residents resided in the room. E. In Room 350, there were 3 loose tiles near the bathroom door taped together. There was a piece of notebook paper taped over the wall vent in the bathroom. One resident resided in the room. F. In Room 332, the wall near the air conditioner was chipped and crumbling. The caulking in the shower was black and in need of		out bulbs and replaced as necessary. The housekeeper assigned to the 100 hall has been instructed to check and clean dryer vent daily. Housekeeper responsible. Housekeeper supervisor to monitor visually, daily during rounds, ongoing. k. Residents were moved out of room 116 and unit will be reconditioned. m. No chair cushions are torn or taped as they were all reupholstered in Nov 2012 and still in good condition. However, the chair backs are scheduled to be reupholstered in Nov. The start date will be November 15th and will be completed before December 01, 2013. Housekeeping responsible for filling out internal housekeeping reporting forms to be turned in weekly to office manager to be given to maintenance supervisor. Maintenance supervisor responsible to assign repairs. Maintenance staff responsible. Maintenance supervisor to monitor visually, daily, during rounds, ongoing.	

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	cleaning. A piece of baseboard was missing on the bathroom wall near the shower. There were cracks in the bathroom floor tile near the bathroom entrance and near the toilet. There was water damage along the bathroom wall behind the bathroom door. One resident resided in the room. G. Near the Great Room, the boiler room door was found unlocked. A housekeeping cart containing chemicals was stored in the boiler room. H. In the TV Room, there were 2 missing ceiling tiles near the fireplace. One overhead light shield was soiled. I. In Room 201, there was tape around the air conditioning unit. The toilet lid cover was chipped and missing a piece. Tile behind the bathroom sink was missing. A strip of floor tile in the bathroom entrance was missing. Two residents resided in the room. J. In the Resident Laundry Room 2 of 2 dryer lint traps were full. One of 2 overhead light shields was missing. K. In Room 116, the bathroom emergency call light was not			

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	functioning. The light shield for the light inside the shower stall was missing. There were 2 sockets on the wall behind the bed without covers. One resident resided in the room. L. In the hallway along the outside of the dining room there was one track of overhead lights burnt out. M. In the Dining Room, 10 of 14 chair booths had torn areas on the chair cushions. The areas were patched with tape. The chair booths were in need of replacement. N. In the hallway between the front desk and the Dining Room, tile underneath the railing was cracked. The tile was patched with tape. Interview with the Maintenance Supervisor and the Housekeeping Supervisor at the time of the environmental tour, indicated all of the above areas were in need of cleaning and/or repair.			

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R000147	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on observation, record review, and interview, the facility failed to follow the Smoking Policy related to smoking in the designated areas. Findings include: 1. On 10/2/13 at 9:09 a.m., there were three residents observed sitting on a bench by the sidewalk path. At that time, all three of the residents were smoking cigarettes. There were two residents observed smoking cigarettes and standing right by the entrance doors to the facility. There was one resident observed smoking a cigarette and sitting in a white resin chair by the entrance doors to the facility. On 10/2/13 at 11:33 a.m., there was one resident sitting right outside the entrance door smoking a cigarette. There were four residents seated on the bench by the sidewalk, all four of the residents were smoking cigarettes. On 10/2/13 at 3:09 p.m., there were	R000147	1. Smoking policy has been revised and dated to include smoking area as back yard. An 8 foot area has been marked off outside the entrance. Residents have been inserviced on the "no smoking zone" to comply with Indiana state law IC 7.1-5-12. 2&3. Residents have been in-serviced, again, on the law that states there is no smoking allowed in the building. Employees responsible for reporting smoky, hazy rooms to their supervisor. Supervisors to report to nursing staff who will counsel residents verbally not to smoke in their rooms. Ongoing	11/15/2013

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	four residents standing on the sidewalk path that leads to the parking lot smoking cigarettes. There were two residents standing by the entrance doors smoking cigarettes. On 10/3/13 at 8:29 a.m., There was one resident sitting in the white resin chair by the entrance doors smoking a cigarette. There were two residents standing by the entrance doors smoking a cigarette. There were three residents sitting on the bench by the sidewalk smoking cigarettes. On 10/3/13 at 9:27 a.m., there were three residents standing by the entrance door smoking cigarettes. On 10/3/13 at 9:00 a.m., the Administrator was observed sitting in her office. At that time, there was a strong cigarette smoke smell coming from her office. The room was observed to be smoke filled. Review of the current and undated Smoking Policy provided by the Director of Nursing indicated "Smoking was prohibited throughout the facility except in designated smoking areas. The designated smoking area for resident and visitors was the back of the dining room and patio."			

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	Interview with the Administrator on 10/3/13 at 9:00 a.m., indicated the designated smoking area for the residents was outside. The Administrator indicated the patio was located away from the sidewalk by the dumpster area and other picnic tables. The Administrator was unaware and not familiar with the facility's smoking policy. She was unaware the residents were to only smoke in the patio area. She was also unaware residents were smoking by the entrance door to the facility. 2. During the environmental tour on 10/3/13 at 12:00 p.m., upon entrance to Room 319, the room was noted to be very smoky and hazy. There was a strong smoke odor present in the room. 3. During the environmental tour on 10/3/13 at 12:00 p.m., upon entrance to Room 216, the room was noted to be very smoky and hazy. There was a strong smoke odor present in the room. One of the three residents present in the room was witnessed exhaling a puff of smoke into the air. This State Residential tag relates to Complaint IN00131905			

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R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (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. Based on record review and interview the facility failed to ensure there was a completed and updated service plan that reflected the resident's current status for 2 of 13 service plans reviewed. (Residents #2 and #F) Findings include: 1. The record for Resident #F was reviewed on 10/2/13 at 1:44 p.m. The resident's diagnoses included, but were not limited to, Schizophrenia. Review of the Service Plan signed and dated by the resident on 9/9/11 indicated the concerns of Schizophrenia, high blood pressure, and Chronic Obstructive Pulmonary Disease (COPD). There were no further concerns or updates noted on the Service Plan. Review of Nursing Progress Notes dated May 23, 2013 indicated the resident was noted with delusional	R000214	Resident service plans have been reviewed, audited and updated as required, and reflect the residents current status. An evaluation of the individual needs of each resident upon admission and any change of condition will be completed by licensed nursing staff. Nursing staff will be inserviced on service plans requirements and the Internal Change of Condition Form. DON to monitor by reviewing Internal Change of Condition Form and service plans daily, 5 days a week for 90 days, then ongoing, 10% of charts weekly. Charge nurse is responsible to update service plans and Internal Change of Condition Form. Resident F chart has been updated to show disorganized behavior/delusional conversation. Resident #2 was a discharged chart, no correction could be completed.	11/15/2013

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	conversations all the time. Another Nursing Progress Note dated September 12, 2013, indicated the resident has delusional conversations at all times and has periods of agitation. Interview with the Director of Nursing on 10/2/13 at 2:30 p.m., indicated the resident's Service Plan was not updated and reflective of the resident's current status. 2. The closed record for Resident #2 was reviewed on 10/2/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, major depression, gout, and hypertension. Further review of the clinical record indicated there was no evidence of documentation for a Service Plan. Interview with LPN #1 on 10/2/13 at 1:37 p.m., indicated Service Plans were completed during each new resident admission by the DoN. She also indicated there was no evidence of documentation of a Service Plan for the resident.			

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to follow Physician's Orders related to the administration of pain medication for 1 of 3 residents reviewed for pain in a sample of 18. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 10/2/2013 at 1:00 p.m. Diagnoses included but were not limited to: bipolar disorder, seizures, Crohn's disease, chronic obstructive pulmonary disease. Review of Physician's Orders for January 2013 indicated an order for "Percocet (pain medication) 10-325 tablet. Take 1 tablet by mouth as needed every six hours. Start date of 9/1/2012." A Physician's Order dated 1/11/2013 indicated "Percocet 10/325 [one] tab 8am, 12pm, 4pm & 8pm daily."	R000241	MAR's for resident #D has been printed and placed in residents chart. MAR's that had not been printed by previous computer company and have been printed and placed in residents charts. Nursing staff will be inserviced on documenting change of medication and sending prescriptions to pharmacy. DON to monitor daily all new order faxs, 5 days per week, ongoing. Charge nurse responsible to fax presriptions to pharmacy and check order after updated to computer system by pharmacy.	11/15/2013

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	A pharmacy batch order dated 1/29/2013 indicated Percocet changed from "as needed" to scheduled QID (four times daily) to start on 1/30/2013. Review of Physician's Orders for February 2013 indicated an order for "Percocet 10-325 tablet. Take 1 tablet by mouth QID: Four times daily at 8:00 AM; at 12:00 PM; at 4:00 PM; at 8:00 PM; Start date 1/30/2013 8:00 AM." A Controlled Drug Administration Record for Percocet administration from 1/3/2013 - 1/14/2013 indicated the medication was given on 1/14/13 at 3:30 p.m. & 8 p.m., not four times a day as ordered. No record was available after 1/14/2013. No January 2013 MAR (Medication Administration Record) was available to review for Resident #D. Interview with the DoN (Director of Nursing) on 10/3/2013 at 1:00 p.m. regarding the change in Percocet administration schedule for Resident #D, indicated the pain medication should have been changed to QID scheduled when the order was written on 1/11/2013 and not remained "as needed" until 1/30/2013. She further			

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	indicated staff was working on getting the MAR for Resident #D, but the computer system had changed since his discharge and they were having difficulty accessing the record. This State Residential Tag relates to Complaint IN00124248			

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R000306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, record review, and interview, the facility failed to ensure each resident's medications were disposed of after they had been discharged from the facility. (Residents #14, #15, #16, #17, #18, &, #B) Findings include: 1. On 10/3/13 at 1:00 p.m., a large clear plastic garbage bag full of unused medications was found on the floor in a closet in the Nurse's station. At that time, LPN #1 indicated the bag full of medications were meds that were from residents who have been discharged and she needed two	R000306	Pharmacy Policy book has been received. Medication is garbage bag was brought to activity room as it was found in closet without any tampering of contents. Discharged residents medications were destroyed indicating 1. name of resident 2. name and strength of drug 3. prescription number 4. reason for disposal 5. amount disposed of 6. method of disposition 7. date of disposal 8. signature of person conducting disposal of drug and 9. signature of witness. Procedure was reviewed with staff on the importance of timely disposal and proper storage of medication. No further medication as found. Charge nurse responsible for documenting drug disposal form and disposing of medications in a	11/15/2013

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MILLER BEACH TERRACE	4905 MELTON RD GARY, IN 46403

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	nurses to destroy the medications and she was the only nurse who worked during the day. The LPN was asked at the time, if the Director of Nursing (who was a LPN) could help her destroy the medication and act as a witness. On 10/3/13 at 1:30 p.m., the Director of Nursing brought the bag full of medications to the Activity Room. The bag full of medications now was only half full. It was unclear as to where the other unused medications were placed. At that time, the Director of Nursing indicated there was no place to store the unused medications so they kept dumping the pills into a garbage bag. Review of the medications that were in the bag were as follows: Resident #14 was discharged on 7/8/13 and there were unused medications for the week of 7/16/13. Resident #15 was discharged to the hospital on 9/9/13 and his medications for the weeks of 9/18, 9/25, and 10/2/13 were in the bag. Resident #16 was discharged from the facility on 10/2/13 and there were unused medications for the week of		timely manner. DON to monitor by cosigning all disposal of medications as needed, ongoing.	

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	9/23/13. Resident #17 was discharged from the facility on 9/26/13 and there were unused medications for the week of 5/30/13. Resident #18 had expired on 8/26/13 and there were unused medications for the week of 8/17/13. Resident #B was discharged from the facility on 8/7/13 and there were unused medications for the weeks of 8/3 and 8/7/13. Telephone interview with the Pharmacy Manager on 10/3/13 at 2:00 p.m., indicated she was unaware the facility had not destroyed or sent back the unused portions of the medications. She further indicated the pharmacy would except all unused medications that were in the original sealed plastic wrap containers. She also indicated the pharmacy does not except controlled medication and indicated it would have to be destroyed. Interview with the Director of Nursing on 10/3/13 at 2:45 p.m., indicated she was unaware and had always been told the pharmacy would not except the unused medications back. She			

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	further indicated she did not know where the pharmacy policy book was and indicated it could not be located.			

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R000349	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 ensure all clinical records were complete and accurately documented related follow up documentation and assessment of residents sent to the hospital with behaviors and for an infected foot for 3 of 18 residents reviewed for clinical records. (Residents #F, #G, and #H) Findings include: 1. The record for Resident #F was reviewed on 10/2/13 at 1:44 p.m. The resident's diagnoses included, but were not limited to, Schizophrenia. Review of Nursing Progress Notes dated 6/6/13 at 10:30 a.m., indicated the resident was being taunted by another resident. The resident responded by punching the other resident in the mouth which required sutures to the resident's lips. The resident's therapist was notified and	R000349	Nursing staff was inserviced on follow up documentation and assessment of residents sent to hospital with behaviors or medical problems. Behavior monitoring for was reviewed. Charge nurse responsible for follow up assessment and documentation of residents after return from hospital for 72 hours. DON to review charts of residents who have returned from hospital. DON to monitor daily, 5 times per week for 90 days, then weekly, ongoing.	11/15/2013

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	indicated he would meet with the resident on that day. The next documented entry in Nursing Progress Notes was on 6/7/13 at 10:00 a.m., (24 hours later) which indicated the resident was up walking around and delusional conversations were present. The next documented entry in Nursing Progress Notes was on 6/22/13 (15 days later) which indicated the resident was transferred to the hospital for a psychiatric evaluation. The facility had called 911 for police assistance. The resident was attempting to punch other residents and making statements to threaten to kill other residents. The resident was also making threats to blow the facility up. The resident returned to the facility on 6/22/13 at 9:40 p.m. The paramedics indicated to the facility the resident received an injection at the hospital which was unknown to them at the time. The resident's vital signs were taken at that time. The next and last documented entry in Nursing Progress Notes was on 9/12/13. There was no follow up documentation or monitoring of the resident after he physically assaulted			

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	another resident and threatened to kill other residents and punch them. Interview with the Director of Nursing on 10/2/13 at 2:00 p.m., indicated there was no further documentation or monitoring done for this resident. She indicated she would expect Nursing staff to document and monitor the resident for at least 72 hours. 2. The record for Resident #G was reviewed on 10/2/13 at 1:09 p.m. Review of Nursing Progress Notes dated 7/1/13 at 2:00 p.m., indicated the resident was noted to have a lesion on her left great toe. The top of the toe was observed to be swollen and red. The resident was refusing to go to the hospital, however, her family was notified and she was convinced to go. The resident returned to the facility on 7/1/13 at 9:00 p.m. The resident was to see her own Physician on 7/2/13. Review of Nursing Progress Notes dated 7/2/13 at 3:00 p.m., indicated the resident's Physician had given the ok for the resident to receive the gout medication. However, in 2012 the resident did have surgery on her left toe and wanted to make sure the resident's Physician was aware of			

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	that information. The next documented entry in Nursing Progress Notes was on 7/3/13 at 2:00 p.m., which indicated the resident's toe was very enlarged and now had serous sanguineous drainage noted. The next documented entry in Nursing Progress Notes was not until 8/10/13 (38 days later) at 6:00 p.m., indicating the resident was transported to the hospital from the Physician's office for treatment of an infected left great toe. The resident was seen by the Physician for follow up for left great toe pain. Interview with the Director of Nursing on 10/2/13 at 2:30 p.m., indicated there was no follow up assessment of the resident's enlarged and draining left great toe after 7/3/13. 3. The record for Resident #H was reviewed on 10/2/13 at 12:37 a.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia. Review of Nursing Progress Notes dated 6/25/13 at 10:55 p.m., indicated the resident was transferred to the hospital by the way of the police department after he assaulted his roommate with an extension cord from the air conditioner. Resident			

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	made delusional statements regarding roommate inappropriately making sexual comments towards him. The Physician and the Director of Nursing were both notified. The next entry in Nursing Progress Notes was on 6/26/13 at 8:30 p.m., which indicated the resident had returned from the hospital during the day shift. The resident's discharge diagnoses was situational stress. There were no new orders for the resident. The resident's vital signs were taken and the resident was pleasant and cooperative. The resident's roommate was moved to a different room. The next and last documented entry in Nursing Progress Notes was on 7/2/13 at 2:00 p.m. which indicated the resident the resident had delusional conversations, was easily agitated, and has trouble sharing a room with others. There was no further assessment or monitoring of the resident's behaviors after he had returned from the hospital. Interview with the Director of Nursing on 10/2/13 at 2:00 p.m., indicated there was no further documentation or monitoring done for this resident. She indicated she would expect			

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	Nursing staff to document and monitor the resident for at least 72 hours. This State Residential Tag relates to Complaint IN00131905			

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R000350	410 IAC 16.2-5-8.1(b)(1-2) Clinical Records - Noncomformance (b) Clinical records must be retained after discharge: (1) for a minimum period of one (1) year in the facility and five (5) years total; or (2) for a minor, until twenty-one (21) years of age. Based on record review and interview, the facility failed to retain clinical records in the facility after discharge for 1 of 13 residents reviewed for clinical records. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 10/2/2013 at 1:00 p.m. Diagnoses included but were not limited to: bipolar disorder, seizures, Crohn's disease, chronic obstructive pulmonary disease. No January 2013 MAR (Medication Administration Record) was available to review for Resident #D. Interview with the DoN (Director of Nursing) on 10/3/2013 at 1:00 p.m., indicated the staff was working on getting the MAR for Resident #D, but the computer system had changed since his discharge and they were having difficulty accessing the record.	R000350	Pharmacy computer services have been contacted and MAR's for resident #D have been requested. Resident charts have been audited and any resident that has missing MAR's have been requested. Charge nurse responsible. DON to monitor monthly times 3 months. Quarterly, ongoing.	11/15/2013

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	On 10/3/2013 at 3:30 p.m. at the time of exit, the DoN indicated the MARs were still not available.			