

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 09/18/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00109721 and IN00114244.</p> <p>Complaint IN00109721-Substantiated. State residential deficiencies related to the allegations are cited at R0349.</p> <p>Complaint IN00114244-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 17 & 18, 2012</p> <p>Facility number: 001140 Provider number: 001140 AIM number: NA</p> <p>Survey team: Lara Richards, RN, TC Kathleen Vargas, RN</p> <p>Census bed type: Residential: 132 Total: 132</p> <p>Census payor type: Other: 132 Total: 132</p> <p>Sample: 10</p>	R0000		

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.

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 09/18/2012
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 19, 2012 by Bev Faulkner, RN</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0036	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure the resident's physician was notified after an emergency room visit for 1 of 10 sampled residents. (Resident #G)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 9/17/12 at 4:48 p.m. An entry in the Nursing progress notes, dated 11/26/11, indicated the resident was sent to the Emergency Room after being found on the floor at 5:20 a.m. The resident sustained a laceration to his head. Further documentation indicated the resident returned to the facility at 5:00 p.m. with 9 staples to his posterior head area.</p> <p>Review of the hospital discharge instructions, dated 11/26/11, indicated the resident was to follow up with his primary physician in 3 days. Review of the</p>	R0036	<p>Resident G went to primary physician 3 days after the event as ordered and had staples removed. Area is healed. Nurses have been in-serviced on documentation and follow up after a resident returns. Notifications of primary physician after return from hospital/ER will be done by charge nurse and indicated in nurses notes and physician orders. Physician order will indicate physician directions i.e. continue previous orders, etc. Nurses notes will indicate doctor notification of residents return and physician directions, if there are any. Nurses have been in-serviced on documentation required for resident discharge from hospital/ER. A review of residents discharged from ER and hospital did not find any other residents affected by practice. Charge nurse to complete documentation of residents returning from hospital. DON to monitor physician orders and nurses note of residents returning</p>	10/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Nursing progress notes dated 11/26, 11/27, and 11/28/11, indicated there was no documentation to indicate if the resident's primary physician had been notified of the resident's return.</p> <p>Interview with the Director of Nursing on 9/18/12 at 11:00 a.m., indicated that she was not aware if the resident's primary physician had been notified upon the resident's return from the Emergency Room.</p>		<p>from hospital weekly for three months, then monthly, ongoing. systemic changes will be completed by October 01, 2012</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0144	<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 missing cords for emergency call lights, stained and soiled walls, missing light shields, marred doors, discolored tile grout, dust on chandeliers and fans, a loose hand rail, torn carpeting, dust in an air vent, gouged walls, broken cove base, broken wall tiles, and torn and patched chair cushions for 3 of 3 units throughout the facility as well as the Great Room and the Dining Room. This deficient practice had the potential to affect 132 of 132 residents residing in the facility. (Dining Room, Great Room, 100 Unit, 200 Unit and 300 Unit)</p> <p>Findings Include:</p> <p>1. During the environmental tour on 9/18/12 at 9:50 a.m., with the Maintenance Supervisor, the following was observed:</p> <p>A. In Room 305, there was a missing cord in the bathroom for the emergency call light. A 3 foot by 1 foot section of the wall, above the window, was stained</p>	R0144	<p>CHANGE STATEMENT Each housekeeper is assigned a hall. The housekeeper is responsible for turning in a report of any needed repairs in their hall, rooms and hallway. These internal reports are turned into the housekeeping supervisor. The housekeeping supervisor reviews them and turns them into the maintenance supervisor and the assistant administrator. Maintenance supervisor is responsible for assigning duties. Assistant administrator with maintenance supervisor to monitor weekly, during rounds, ongoing, using internal reports. Systematic changes will be completed by October 05, 2012.</p> <p>A. In room 305 for emergency call light was replaced. Resident rooms were inspected throughout facility and call light cords were replaced as needed. Miller Beach Terrace is currently in process of replacing old siding which has caused some water damage in certain rooms. The section stained by water damage will be repaired and repainted as siding is replaced. All siding was replaced by 09/26/12 and room 305 will be repaired/repainted by 10/05/12. Please refer to change statement.</p>	10/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>from water damage. Two residents resided in the room.</p> <p>B. In Room 330, the wall above the window was stained from water damage. There were no residents residing in the room.</p> <p>C. In Room 359, there were 3 of 3 light shields missing on the bathroom light fixture. The wall above bed 1, was soiled and in need of cleaning. Two residents resided in the room.</p> <p>D. The door to Room 360 had white marred areas and was in need of paint. Two residents resided in the room.</p> <p>E. In Room 332, the bathroom tile grout above the bathtub, was black in color. There was a broken edge on the bathroom sink vanity 8 inches in length by 2 inches in width. One resident resided in the room</p> <p>F. In the Great Room, 2 of 2 chandeliers and 5 of 5 ceiling fans had an accumulation of dust.</p> <p>G. In the hall, between the Great Room and the Nurses' Station, there was a 6 foot piece of hand rail that was loose and in need of repair.</p> <p>H. Outside of the Television Room, there</p>		<p>B. Miller Beach Terrace is currently in the process of replacing old siding which has caused some water damage in certain rooms. The section stained by water will be repaired and repainted as siding is replaced. All siding was replaced by 09/26/12 and room 330 will be repaired/repainted by 10/05/12. Please refer to change statement.</p> <p>C. In room 359 the light shields missing in the bathroom were replaced. Resident rooms were inspected throughout facility and light shields were replaced as needed. The wall above bed one was cleaned. Please refer to change statement.</p> <p>D. Room to door 360 was painted. Resident rooms were inspected throughout facility and doors were repainted as needed. Please refer to change statement.</p> <p>E. In room 332 the bathroom tile grout above the bathtub was cleaned. The vanity was replaced. Resident rooms were inspected throughout facility and grout was cleaned as necessary and vanities repaired/ replaced as needed. Please refer to change statement.</p> <p>F. The accumulation of dust has removed from the ceiling fans and light bulbs in the Great Room. Please refer to change statement.</p> <p>G. The hand rail was repaired. The hand rails were inspected throughout facility and rails were replaced as needed. Please refer to change statement.</p> <p>H. The carpeting outside of the</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was torn carpeting, 4 feet in length by 1 inch in width.</p> <p>I. In the 200 hall, there was an accumulation of dust in the ceiling air vent.</p> <p>J. In Room 216, the walls and ceiling of the bathroom were soiled and in need of cleaning. The wall, near the window, had a gouge that was 18 by 12 inches in size. Two residents resided in the room.</p> <p>K. In Room 115, there were 3 of 3 light shields missing on the bathroom light fixture. Two residents resided in the room.</p> <p>L. There was broken cove base in the 100 Unit hall. An 8 foot section of cove base between Rooms 105 and 103 was broken. A 14 foot section of cove base was broken between Rooms 107 and 109.</p> <p>M. In Room 103, there were broken wall tiles near the floor in the bathroom and there was a section of broken wall tiles 3 feet in length by 2 inches in width around the bathroom sink vanity. The cords for the emergency lights in the bathroom and near bed 2 were missing. Two residents resided in the room.</p> <p>N. In the Main Dining Room, 14 of 14</p>		<p>TV room has been replaced. Carpeting was inspected throughout facility and repaired/replaced as necessary. Please refer to change statement.</p> <p>I. The ceiling air vent in the 200 hall has been cleaned. The ceiling vents were inspected throughout facility and no other vents in hallway were in need of cleaning. Please refer to change statement. J. In room 216, the bathroom walls and ceiling were cleaned. The wall near the window was sanded and painted. The bathroom walls and ceiling throughout the facility were inspected and cleaned as necessary. Please refer to change statement. K. In room 115 the light shields missing in the bathroom were replaced. Resident rooms were inspected throughout the facility and light shields were replaced as needed. Please refer to change statement. L. The broken cove base was replaced. The cove base in the hallways was inspected and broken cove base was replaced as needed. Please refer to change statement. M. In room 103, the broken tiles were replaced. In room 103 cords for emergency call light were replaced. Resident rooms were inspected throughout facility and call light cords were replaced as needed. Please refer to change statement. N. Miller Beach Terrace is currently obtaining bids for reupholstering booths in dining</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>chair booths had torn areas on the chair cushions. The areas were patched with tape. The chair booths were in need of replacement.</p> <p>Interview with the Maintenance Supervisor at the time of the environmental tour, indicated all of the above areas were in need of cleaning and/or repair.</p>		<p>room and will have a contract by 10/19/12. They should be finished by mid- November.</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on record review and interview, the facility failed to ensure the Consultant Pharmacist reviewed the residents' drug regimen at least every 60 days for 2 of 9 residents reviewed for pharmacy services in a sample of 10. (Residents #3 and #D)</p> <p>Findings include:</p> <p>1. The record for Resident #3 was reviewed on 9/17/12 at 3:30 p.m. The resident was admitted to the facility on 1/11/07. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and history of burns with finger contracture.</p> <p>The form titled, "Medication Managers Pharmacist Plan of Care" was reviewed. It</p>	R0298	<p>Consultant pharmacist review, every 60 days, all resident charts. On next pharmacy review in September 2012 pharmacist will review with DON resident charts to ensure that no resident is missed. A list of current residents will be provided to pharmacy when they arrive for audit. Pharmacist responsible to review, sign and date chart within 60 days. DON to monitor review with pharmacist prior to their exit to ensure resident has a review every 60 days of their drug regimen.</p>	10/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated the Consultant Pharmacist reviewed the resident's drug regimen on 1/20/12. The next time the Consultant Pharmacist reviewed the resident's drug regimen was on 5/8/12, more than 60 days from the previous review.</p> <p>2. The record for Resident #D was reviewed on 9/17/12 at 2:45 p.m. The resident was admitted to the facility on 3/16/92. The resident's diagnoses included, but were not limited to, schizophrenia.</p> <p>Review of the form titled, "Medication Regime Review" indicated the Consultant Pharmacist reviewed the resident's drug regimen on 1/20/12 and on 5/8/12. The resident's drug regimen was not reviewed in March of 2012.</p> <p>Interview with the Director of Nursing on 9/17/12 at 3:40 p.m., indicated there was no documentation that the residents' drug regimens were reviewed in March 2012. She indicated the Consultant Pharmacist was to visit every 60 days and review each resident's drug regimen.</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0349	<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.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation prior to and after an Emergency Room visit, the indication for the use of antibiotics and completing documentation related to turning and repositioning and a pressure ulcer assessment for 4 of 10 sampled residents. (Residents #B, #C, #D, and #E)</p> <p>Findings include:</p> <p>1. The record for Resident #C was reviewed on 9/18/12 at 10:30 a.m. Documentation in the Nursing progress notes, dated 5/24/12 at 10:34 a.m., indicated the resident told staff he returned from the Emergency Room during the evening hours on 5/23/12. The resident fell across the street at the grocery store and landed on his knees. The resident did not have any edema to</p>	R0349	<p>#1 Resident C fell in the parking lot at store and went to hospital from store. Nursing notes should have been recorded when resident advised nurse of fall and his trip to hospital from store. Nursing should have charted for the next 72 hours after return from hospital. Nurses have been in-serviced on documentation requirements following fall or undocumented fall per facility procedure. Nurses responsible to chart all unusual events in nurses notes and report to physician. DON to monitor by reviewing unusual reports weekly for 4 weeks, then monthly, ongoing. #2 Resident was sent to hospital without notation of his alcohol intoxication. Resident was placed on antibiotics without indication of why it was prescribed or how the resident was tolerating antibiotic treatment. Nurses were in-serviced on indicating why a resident was sent to hospital and monitoring medication that is ordered including reason. Nurses responsible for documentation of</p>	10/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>his knees at this time and was walking with a slow but steady gait.</p> <p>There was no documentation in the resident's record on 5/23/12 indicating that he had fallen and was sent to the Emergency Room. Further, the next documented entry after the entry on 5/24/12 was on 6/1/12.</p> <p>Interview with the Director of Nursing on 9/18/12 at 12:00 p.m., indicated documentation should have been completed in the nursing progress notes prior to the resident going out to the hospital and a follow up assessment should have been completed for at least 72 hours when the resident returned.</p> <p>2. The record for Resident #E was reviewed on 9/17/12 at 3:50 p.m. A hospital discharge instruction sheet, dated 6/30/12, indicated the resident was seen in the Emergency Room for acute alcohol intoxication. There was no documentation in the nursing progress notes indicating the resident was intoxicated or had been sent to the hospital.</p> <p>Interview with the Director of Nursing on 9/18/12 at 11:20 a.m., indicated there was no documentation of the resident being sent to the hospital on 6/30/12.</p>		<p>transfer to hospital with reason. Nurses responsible for documentation of medication, purpose and monitoring results. DON to monitor charts of residents sent to hospital weekly, for 4 weeks, then monthly, ongoing. #3 Nurses will document in nurses notes any symptoms presented to nurse by resident. If a physician order is acquired for symptoms, a note in the nurses notes will indicate it. Doctor will be contacted and nurse will indicate reason for order and monitoring of medication. Nurses were in-serviced on documentation of symptoms presented by resident, her actions i.e. call physician and new orders received, and monitoring results of new order. Charge nurses responsible to record and report to physician resident symptoms and response of physician. If doctor orders antibiotics, physician order will indicate reason for order. Charge nurse responsible for monitoring and recording resident response to treatment. DON to monitor transfer order and nurses notes of transfer resident weekly for 4 weeks, then monthly, ongoing. #4 The nursing staff was in-serviced on wound assessment and documentation. Wound assessment form will be utilized. (Internal Wound Assessment Form enclosed) Charting policy has changed to weekly on wounds or at dressing</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A Physician's order, dated 9/5/12, indicated the resident was to receive Cipro (an antibiotic) 500 milligrams (mg) by mouth twice a day for 10 days. There was no documentation in the resident's record to indicate why the Cipro was prescribed. Further, there was no documentation in the nursing progress notes related to how the resident was tolerating the antibiotic and what his symptoms were.</p> <p>Interview with the Director of Nursing on 9/18/12 at 11:20 a.m., indicated the resident was receiving the Cipro for cold like symptoms. She further indicated this should have been documented in the resident's record.</p>		<p>change. Turn schedule will be used by staff and placed in chart. Nursing staff CNA's and LPN's were in-serviced on use of turning schedule and document to be turned in daily. Nursing staff was in-serviced on proper procedure for sending a resident to the hospital. Documentation in chart and transfer form to be filled out. Order by physician will indicate reason why resident is being sent. Charge nurse responsible for documentation and monitoring. DON to monitor by reviewing transfer to hospital weekly for 4 weeks, then monthly, ongoing. Any wounds being assessed will be reviewed by DON daily for 5 days. Then weekly for 4 weeks, Then weekly, ongoing. No other resident have wounds that would be affected by the same practice. Nursing in-service was done on wound policy change to assess weekly or at dressing change. Assessment will include measurement in centimeters using "internal wound assessment form". Systemic changes will be completed by October 01, 2012. In regards to the addendum dated 10/02/12: R0349: Please describe why the facility did not correct the deficient practice for Residents #B, #D, and #E. Nurses were in-serviced on indicating why a resident is sent to hospital and monitoring medication that is ordered including reason. Nurses were in-serviced on documentation of</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3. The record for Resident #D was reviewed on 9/17/12 at 2:45 p.m. The resident was admitted to the facility on 3/16/92. The resident's diagnoses included, but were not limited to, schizophrenia.</p> <p>There was a Physician's Order, dated 4/3/12, that indicated, "Polymyxin sulfate (an antibiotic eye drop) 2 gtts (drop) qid (four times a day) x 10 days to both eyes."</p> <p>Review of the Nurse's Notes indicated there was an entry dated 3/2/12. The entry indicated, "Up and about ad lib. Alert and oriented times 3. Color good. Skin warm and dry no problem behavior." The next entry was dated 4/5/12 and indicated, "ADL (activities of daily living) per self. No medication side effects. No problem behavior. Alert and oriented times 3."</p> <p>There was no documentation in the Nurse's Notes of symptoms of an eye infection, drainage, redness, tearing or</p>		<p>symptoms presented by resident, her actions, i.e. called physician and new order received and monitoring results of new order. The nursing staff was in-serviced on wound assessment, care and documentation. Wound assessment form will be utilized, charting policy has changed to weekly on wounds or at dressing change.</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>complaints of pain. There was no documentation the resident was seen by a physician and antibiotic eye drops were initiated on 4/3/12.</p> <p>Interview with the Director of Nursing on 9/17/12 at 3:40 p.m., indicated there was no documentation of the resident's eye infection and the need for an antibiotic. She indicated staff should have documented the need for the eye antibiotic and the assessment of the resident's eye.</p> <p>4. The closed record for Resident #B was reviewed on 9/17/12 at 4:35 p.m. The resident was admitted to the facility on 5/11/12 and was discharged on 7/18/12. The resident had diagnoses that included, but were not limited to, hypertension, diabetes and quadriplegia.</p> <p>Review of the Nurse's Notes, dated 5/11/12 at 3:30 p.m., indicated the resident had arrived at the facility per the family car. The resident stated he had 2 healing open areas on his buttocks. An entry in the Nurse's Notes, dated 5/11/12 at 8 p.m., indicated "Resident has 2 pea sized openings superficial appears where he slides himself in his chair. Encouraged to go back to bed in daytime some hours to encourage skin to heal. 2 hour turn while in bed [sic]."</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 09/18/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Entries in the Nurse's Notes, with documentation related to the open areas, were as follows:</p> <p>An entry, dated 5/15/12, indicated, "Areas on buttocks appear to be healing." There was no description of the open areas.</p> <p>An entry, dated 6/8/12, indicated, "Areas on buttocks appear to be healing good [sic]."</p> <p>An entry, dated 6/9/12, indicated, "Areas on buttocks healing good [sic]."</p> <p>An entry, dated 6/10/12, indicated, "2 small pea sized areas scabbed appear to be healing good [sic]."</p> <p>An entry dated 7/4/12 at 1:50 p.m., indicated, ". . .writer observed nickel sized circular open area midline left buttocks... "</p> <p>An entry, dated 7/12/12 at 10:30 p.m., indicated, "... midline ulcer with granular tissue noted at edges (nickel sized wound) no signs and symptoms of infection . . .upper posterior left leg wound (dime sized) with pink granular tissue at wound edges, center pink no signs and symptoms of 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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>An entry, dated 7/15/12 at 1:35 p.m., indicated, "treatment to left midline upper inner buttock as per doctor's orders, ulcer with pink center and granular tissue at wound edges as well as small amount of dried blood on old 2 x 2, lower sore (posterior leg beneath buttock left side) remains pea sized pink in center of wound. . . "</p> <p>Review of the record, indicated bi-weekly documentation of the assessment of the resident's open wounds was not completed.</p> <p>There was a care plan, undated, for the open areas to the buttock. One of the interventions was to turn the resident every 2 hours while in bed.</p> <p>Review of the record for Resident #B indicated a form titled, "Turn and Reposition every 2 Hours." There was one form, dated 7/16/12, with documentation that indicated the resident was turned at 12 a.m., 2 a.m., 4 a.m., and 6 a.m. There was another form, dated 7/13/12, with documentation the resident was turned at 1:00 a.m., 4:00 a.m. and 6:00 a.m. There was no additional documentation to indicate the resident was turned or repositioned on any other days, while at the facility.</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 09/18/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>There was a letter, dated 7/4/12, addressed to the resident's attending Physician that indicated, "Your patient, (Resident #B's name) was recently seen and treated in our emergency department. Attached to this letter is a summary of the visit. Patient has stage II (a partial thickness loss of dermis) left gluteal decubitus (pressure ulcer) which requires daily application of DuoDerm patches in addition to routine wound care and oral box with Bactrim DS (an antibiotic) twice a day for 10 days. If you have any questions or concerns, please do not hesitate to call."</p> <p>Review of the Nurse's Notes, dated 7/4/12 through 7/6/12, indicated there was no documentation related to the resident's visit to the emergency room.</p> <p>The Policy titled, "Wound Care Policy" was provided by the Director of Nursing on 9/18/12. She indicated the policy was current. The policy indicated, "Nurse assessment of area is at least bi-weekly."</p> <p>Interview with the Director of Nursing on 9/18/12 at 11:15 a.m., indicated the open areas on the resident's buttocks were not assessed and documented at least bi-weekly. She also indicated the resident was to be turned every 2 hours when in bed and the turning was to be</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>documented. She indicated there was incomplete documentation the staff turned and repositioned the resident.</p> <p>Continued interview with the Director of Nursing, indicated there was no documentation related to the resident's emergency room visit on 7/4/12. She indicated the staff should have documented an assessment of the resident and information related to the need for the resident to be sent to the emergency room on 7/4/12.</p> <p>This State Residential tag refers to Complaint IN00109721.</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 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on record review and interview, the facility failed to ensure Emergency Information Files were completed for 3 of 7 records reviewed for Emergency Information Files in the sample of 10. (Residents #D, #2 and #3)</p> <p>Finding include:</p> <p>1. The record for Resident #2 was reviewed on 9/17/12 at 2:15 p.m. The resident was admitted to the facility on 1/19/98. The resident's diagnoses included, but were not limited to, schizophrenia.</p>	R0356	A current emergency file was completed for Miller Beach Terrace residents. The emergency file includes their name, sex, room, phone number, age, DOB, hospital preference, legal representative, physicians name and phone number, family phone numbers in the event of an emergency or death, a photo of resident, any known allergies and advanced directives, if available. DON responsible. Administrator to monitor weekly, for any new changes, for 4 weeks, then monthly, ongoing. Systemic changes will be completed by October 01, 2012.	10/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD GARY, IN 46403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of the resident's record indicated there was no Emergency Information File.</p> <p>2. The record for Resident #3 was reviewed on 9/17/12 at 3:30 p.m. The resident was admitted to the facility on 1/11/07. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and history of burns with finger contracture.</p> <p>There was no Emergency Information File available for review for Resident #3.</p> <p>3. The record for Resident #D was reviewed on 9/17/12 at 2:45 p.m. The resident was admitted to the facility on 3/16/92. The resident's diagnoses included, but were not limited to, schizophrenia.</p> <p>Review of the resident's record indicated there was no Emergency Information File.</p> <p>When interviewed on 9/17/12 at 3:40 p.m., the Director of Nursing indicated there were no Emergency Information Files available for the residents. She indicated she was not aware she was to have Emergency Information Files available for each resident.</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 09/18/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE