

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/09/2026	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4905 MELTON RD, GARY, , 46403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE			
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 470203, 471763, and 471848. Intake 470203 - State deficiencies related to the allegations are cited at R0050. Intake 471763 - State deficiencies related to the allegations are cited at R0052. Intake 471848 - State deficiencies related to the allegations are cited at R144, R241, R273, and R297. Survey dates: September 8 and 9, 2026 Facility number: 001140 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective 10/10/26				

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	Quality review completed on 9/14/26.			
R 0050	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(t)(1-10) (t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars (\$100) in an interest-bearing	R 0050	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C has received her money for May 2026 on September 10, 2026 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An internal audit was conducted for the last 6 months of funds disbursement and no other resident failed to receive their monthly PNA. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The current policy was reviewed and updated to ensure disbursement of funds within 30 days. All residents currently sign upon receipt of funds.	09/10/2026

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account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars (\$100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon		A new monitoring form has been created and will be used to track if a resident has received their PNA (personal needs allowance) each month. The business office manager has received education on the new policy and form. Residents were made aware of the need to pick up their funds within 30 days. If they fail to pick up their funds, the facility will make them aware of the need to do so timely. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All documentation will be kept securely in the business office. Administrator to monitor at the end of the month when closing out PNA paperwork monthly. 5. By what date the systemic changes will be completed. October 9, 2026	
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the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate.

Based on record review and interview, the facility failed to ensure accurate documentation and distribution of resident's funds for 1 of 1 resident reviewed for resident funds. (Resident C)

Finding includes:

The facility's resident fund records for April through August 2026 were reviewed on 9/8/26 at 10:05 a.m.

The record indicated Resident C received \$52 on 4/9/26, 6/10/26, 7/8/26, and 8/5/26. There was no documentation the resident received their monthly disbursement for May 2026.

During an interview on 9/8/26 at 1:55 p.m., the Business Office Manager indicated they wrote the resident's name on the list when they came down to get their money. The resident signed the record when they picked up their money each month. They did not keep a record of when residents did not

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	pick up their money. She indicated if the resident told them they missed a disbursement, they could get both distributions the next month. During an interview on 9/9/26 at 11:35 a.m., the Administrator indicated they did not document when residents did not pick up their money each month, and she did not know why Resident C did not receive her distribution in May 2026, or a double payment in June 2026. This citation relates to Intake 470203.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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 a resident was free from neglect and continuity of care	R 0052	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident E no longer resides at this facility. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this practice. The facility policy regarding Resident Assessment and	10/09/2026

was provided for a safe discharge related to facility staff dropping off a dependent resident with mental instability who was considered a danger to herself to a relative's home without their prior knowledge, consent, and the ability to care for them for 1 of 2 residents reviewed for discharge. This resulted in the resident being taken to the local hospital for care. (Resident E)

Finding includes:

The closed record for Resident E was reviewed on 9/9/26 at 9:25 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), paranoid schizoaffective disorder, and substance abuse.

A 4/21/26 Service Plan indicated the resident required dependent assistance for cognition. She refused showers, hygiene, meals and medication frequently. The resident required extensive assistance with activities and socialization related to being argumentative, verbally aggressive, not easily directed, and extremely poor hygiene. Dressing/grooming, toileting, housekeeping, transportation, monitoring/wellness and mood required dependent care.

A Minimum Data Set (MDS)

Notice of Transfer and Discharge has been reviewed. A new cognitive assessment (Mini Mental State Examination) has been implemented. All residents have been assessed using this tool. All resident service plans have been updated to include cognitive status. Residents noted to have impaired cognition as defined on the MMSE will have their service plan updated to include need for assistance and reassurance in making safe decisions regarding discharge. Additionally any resident noted to have documented mental illness has been identified as at risk for making unsafe decisions and their service plans have been updated.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

The facility policy regarding Resident Assessment and Notice of Transfer and Discharge has been reviewed and updated.

All staff were educated on policy updates, Resident Rights, Notice of Transfer and Discharge and safe discharge practices.

The new cognitive assessment has been implemented.

summary, dated 6/12/26, indicated the resident was moderately impaired and had disorganized thinking. She had delusions and was resistive to care and mood was irrational. The resident was usually understood and could usually make her needs known. A July 2026 Physician's Order Summary (POS) indicated the resident was taking haloperidol (antipsychotic medication) 10 milligrams daily and Invega (antipsychotic medication) 156 milligram intramuscular injection every 30 days. Problematic charting, dated 6/12/26 at 12:00 a.m., indicated the office manager informed the writer (Administrator) that the manager from a nearby grocery store called to inform them Resident E had defecated on the floor and asked for guidance. The office manager had told him to call the police and let the therapist know of her behavior if taken to the hospital. Problematic charting, dated 7/9/26 at 10:03 a.m., indicated the resident was discharged against medical advice (AMA), and had no current place to go. The resident spoke of her father and her hometown several times. She was taken to her father's home in South Bend. Problematic charting, dated	Assessments will be completed upon admission, Quarterly and with a significant change. Any resident requesting discharge will be assisted in the process to ensure a safe transition. In the event a resident with impaired cognition or mental instability refuses assistance with discharge and leaves from the facility AMA ; the Administrator or Director of Nursing will immediately notify the local authorities, resident's responsible party, physician, adult protective services and notify IDOH per the reporting guidelines. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All potential discharges will be discussed in the daily staff meeting. The Director of Nursing will audit all discharges for appropriate documentation and compliance Notice of Transfer and Discharge. This will be ongoing. 5. By what date the systemic changes will be completed? October 9th, 2026	
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	7/9/26 at 3:12 p.m., indicated, "due to non-compliance, resident decided to discharge AMA. When asked where she would like to go, she said she wanted to see her dad. MBT (Miller Beach Terrace) drove her to her father's house in South Bend, IN. Employees rang the bell, pounded on the door and left. Father called writer and had conversation regarding what he could do for her, Employee [name] from a hospital called and asked about [Resident name] and her behavior, [Resident name] is a danger to herself and this was explained to father and hospital. i.e. walking in traffic, defecating on the floor in grocery store, playing with a lighter and burning the tips of her fingers, smoking crack. Her bad behavior keeps escalating." During a telephone interview on 9/8/26 at 10:37 a.m., the Prosecutor's Office Investigator (POI) indicated the Administrator had chuckled and told him they "kind of dumped her" because the staff was afraid the family would refuse to take the resident. The POI indicated the Administrator had tried to back track after she realized how serious the investigation was. During his investigation and interview with the Administrator, she reported that the staff had tried to contact			
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the resident's dad many times by telephone and would "blow his phone up" and he would never answer. They had tried to send the resident to the hospital multiple times, but they would not treat the resident, they would send her immediately back. The hospital was afraid the facility would not accept the resident back. Resident E was free to leave, if the dad had not been home or he indicated he was unable to care for her, they would have had to find an alternate place for her to go. The POI had spoken with the dad of Resident E and he said he was never called and they just dropped her off and did not speak with him. He had to take his daughter to the hospital as he could not care for her. The POI had received the phone records, and they showed the facility or staff did not call once. He had also received a copy of the father's phone bills and the phone was in working order and never shut off due to non-payment.

During an interview on 9/9/26 at 11:00 a.m., LPN 1 indicated Resident E had become increasingly a danger to herself and the community. Staff had attempted to call her dad multiple times, and they tried to redirect her daily. LPN 1 was told by the Administrator that the resident was leaving AMA and

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	going to her dad's house. The resident always talked about her dad and going to visit him, so she did not feel it was odd the resident was going there. LPN 1 was not involved with the discharge; the Administrator had taken care of it. The resident was not reluctant at all when she left the facility. Housekeeping and CNA 3 were the staff members who transported her. The resident was at her baseline, which was not well mentally, she had never been well in that capacity. Staff could not get her to go to appointments; she would attempt to jump out of the car or refuse. The resident was never fully cognitively intact, but she believed the resident had the ability to say she wanted to leave. During an interview on 9/9/26 at 11:12 a.m., the Administrator indicated they do not have AMA paperwork because they are residential and the residents can come and go as they please. Resident E wanted to go home, she left AMA. Her behavior had been escalating but she knew she wanted to go home. They had tried to send her repeatedly to the hospital and the hospital would not see her, they would send her immediately back. There were also times she would refuse to go to the hospital. When asked if they			
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had tried other hospitals, she indicated she was not aware if they had attempted to try another hospital. The staff members (Housekeeping Supervisor and CNA 3) had driven the resident to South Bend, IN where her dad lived. They knocked on the door, and they talked to the resident's dad, and he was very welcoming to her. The Housekeeping Supervisor got back in the car and returned to the facility. There was no change in the resident behavior, she had exhibited the same behavior as the day before, and "I do believe she was aware of what was going on". When she left the facility, she was excited, she wanted to go, that's the only reason she got into the vehicle. The Housekeeping Supervisor reported that she spoke with someone before they left. The Administrator indicated the father had called her and "he said no one spoke to him". The Housekeeping Supervisor later said, " we had an entire conversation". They tried calling her dad every 15 minutes one day, "blowing up his phone", he never answered. She had two staff members who had said they spoke with the dad and handed him paperwork. Nobody ever asked her if he answered the door and she could not recall her documentation under problematic charting, "I'm not			
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	aware and don't remember what was documented". The Administrator indicated the dad called her and he asked, "what do I do with her?", and she said, "she wanted to see you". The Administrator understood the concern and confirmed that resident E was discharged to her dad's house without his prior knowledge and consent to receive her and care for her. "If we had not taken resident E to her dad's house, she would have had nowhere to go." There was no documentation in the resident's record to indicate any attempts to send the resident to the hospital, any refusals to go to the hospital, or any refusals to be seen from any hospital. During an interview on 9/9/26 at 11:44 a.m., the Housekeeping Supervisor indicated the resident was fine during transport, and she was quiet the entire time. She was advised to drop Resident E off at her dad's house and come back, there was no paperwork. She knocked on the door, and nobody had answered, she went around back and did not see anyone, so she came back around and knocked on the front door again and he had finally answered the door. She and CNA 3 told him here was the resident she wanted to			
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	come home, they turned around and left. There was no paperwork or medications to pass along, just the resident. There was no documentation in the resident's record to indicate she continuously voiced wanting to leave the facility to go to her dad's house and there was no documentation in the record indicating she received any discussion or medical advice against leaving the facility to lead to any AMA designation. There was no discussion or documentation to indicate the discharge was necessary for the resident's welfare or that needs could not be met in the facility. There was no documentation the facility had attempted to give the resident any discharge notice or plan. There was no documentation to indicate the facility had discharged the resident with her medications or any instructions for ongoing care. This citation relates to Intake 471763.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are	R 0090	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	10/09/2026

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OMB NO. 0938-0391

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:

No residents were affected by this practice.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents had the potential to be affected by this practice.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Administrator was re-educated on and received a copy of the current reporting guidelines. The Administrator was also educated on her role in ensuring that the reporting guidelines are met timely.

The Business Office Manager, who is also a licensed administrator, has been given Gateway access to report occurrences at the direction of, or absence of the Administrator.

Both were educated on the availability of calling in an initial report in the event of a power or internet outage.

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(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a 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 ensure the State Agency was notified of a significant and prolonged power outage. This had the potential to affect all 110 residents living in the facility. Finding includes: During an interview on 9/8/26 at 10:00 a.m., the Administrator indicated the facility was without power for nine days after the derecho (widespread, long-lived, straight-line wind storm that was associated with a fast-moving complex of severe thunderstorms) event on 8/11/26. The owners had		All power outages exceeding 4 hours will be reported. A log of occurrences will be kept ongoing. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The log of occurrences will be reviewed monthly to ensure all occurrences were reported timely. All findings will be reported to ownership. 5. By what date will the systemic changes be completed? October 9, 2026	
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	brought three generators to the facility on 8/12/26 and they also purchased battery operated lights for the residents. The phone system and internet were down for almost 12 days after the storm. She indicated she "had no way to report the power outage." She also indicated she was able to use her cell phone to communicate with staff and the owners. During an interview on 9/9/26 at 10:45 a.m., the Administrator indicated she was aware she needed to report the power outage, and will be providing the owners with the facility the Gateway information so they could do the reporting for the future.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (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 ensure the resident's environment was clean and in a state of good repair related to stained walls, dirty carpet, smoked-filled rooms, stained ceilings and floors, holes in bed	R 0144	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. Beginning on 9/9/2026 all the environmental concerns identified during the survey were addressed and or resolved. Room 111 - the bathroom floor and wall have been cleaned. The vents on the air conditioner have been cleaned. Bed lines have been replaced. Room 113 - The walls have been painted and the carpets are scheduled for replacement. The bathroom	10/09/2026

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linen, and peeling paint from ceilings and walls for 3 of 3 units throughout the facility. (100, 200, and 300 Units)

Findings include:

During the Environmental Tour on 9/9/26 at 11:49 a.m. with the Housekeeping Supervisor, the following was observed:

1. 100 Unit

a. Room 111 - the bathroom floor was dirty and stained. There were smeared brown stains on the bathroom walls. There were ashes from cigarettes on the side of the bathroom vanity. There was a heavy accumulation of a brown substance on the outside base of the toilet. The room walls were smeared with a brown substance and the vents on the air conditioner were dirty. There were burn holes in the blanket on the bed and room smelled like cigarette smoke. There was one resident who resided in the room and used the bathroom.

b. Room 113 - there was cigarette smoke in the room. The walls were yellow stained and the carpet was dirty and stained. The bathroom ceiling was water stained. There were two residents who resided in the room and shared the bathroom.

ceiling has been repaired and painted. The carpet in the 200 Hall is scheduled for replacement. Room 307 - The bathroom ceiling vent has been cleaned and the floor tile has been repaired. The water pressure in the sink has been restored. Room 321 - The bed linen has been replaced. The wall by the window has been repaired and painted. The bathroom ceiling vent has been cleaned and the ceiling has been repaired and painted. The water pressure in the sink has been restored. Room 326 - The bathroom ceiling vent has been cleaned and the ceiling has been repaired and painted. The bed linen has been replaced. 300 Hall carpet is scheduled for replacement. Room 351 - The mattress for bed two has been replaced. The room walls have been cleaned and painted and carpet is scheduled for replacement. Room 355 - The room walls have been cleaned and painted and carpet is scheduled for replacement. Room 358 - The water pressure in the sink has been restored. The floor tile has been cleaned and repaired. The vinyl floor has been repaired.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective

2. 200 Unit a. Room 208 - the resident was smoking in the room. During an interview at that time, he was aware he was not supposed to smoke in the room. There were two residents who shared the room. b. The carpet in the hallway was stained and buckled. 3. 300 Unit a. Room 307 - the bathroom ceiling vent was dusty and the floor tile was chipped. There was no running water in the sink. There were two residents who resided in the room and used the bathroom. b. Room 321 - there were holes in the bed linen and wall was peeling by the window. The bathroom ceiling vent was dusty and the ceiling had peeling paint and was water stained. There was no running water in the sink. There were two residents who resided in the room and used the bathroom. c. Room 326 - the bathroom ceiling vent was water stained and the paint was peeling. The bed linen was black stained. There was one resident who resided in the room and used the bathroom. d. The carpet in the upstairs 300	action will be taken? All residents that reside in the facility are at risk with this alleged deficient practice. All occupied resident rooms have been audited for dusting ceiling vents, dirty toilet bases, marred/dirty walls, stained carpet, smoked stained walls scratched/peeling paint, low water pressure in bathroom sinks, and burn holes in bed linens. All items identified during the audit have been corrected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The Administrator in-serviced the Maintenance Director and Housekeeping staff regarding environmental areas cited by IDOH. This included dusting ceiling vents, dirty toilet base, marred/dirty walls, stained carpet, smoked stained walls scratched/peeling paint, low water pressure in bathroom sinks, and burn holes in bed linens. The Maintenance Director and housekeeping staff were educated regarding policy and procedure for daily cleaning and maintenance of apartments. A cleaning / maintenance checklist was developed for use by housekeeping and maintenance to ensure resident rooms remain clean and in a state of good repair. A work	
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hallway was buckled and stained throughout.

e. Room 351 - the mattress for bed two was caved in. The room walls and carpet was stained throughout. There were two residents who resided in the room.

f. Room 355 - there was a strong odor of cigarette smoke in the room. During an interview at that time, the resident indicated his roommate smoked in the room all the time. The walls were stained yellow and the carpet was dirty and stained. There were two residents who resided in the room.

g. Room 358 - there was no water pressure in the bathroom sink and the floor tile was stained by the toilet. The vinyl floor was peeling and missing in the main room. There was one resident who resided in the room and used the bathroom.

During an interview at that time, the Housekeeping Supervisor indicated all of the above was in need of cleaning and/or repair.

order will be completed for any item that requires maintenance. The administrator will review all work orders and ensure timely repair.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director or designee will monitor environmental areas cited by IDOH including dusting ceiling vents, dirty toilet base, marred/dirty walls, stained carpet, smoked stained walls, scratched/peeling paint, low water pressure in bathroom sinks, and burn holes in bed linens. The audits will occur weekly for one year then monthly there after. Items identified on audits will be addressed and or resolved.

5. By what date will the systemic changes be completed?

October 9, 2026

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	During an interview on 9/9/26 at 1:10 p.m., the Administrator indicated residents were not allowed to smoke in their rooms. She was aware some rooms had no water pressure in the sinks and there were shower rooms available. The current and undated "Smoking Policy", provided by the Business Office Manager on 9/9/26 at 2:00 p.m., indicated smoking was prohibited in resident rooms. This citation relates to Intake 471848.			
R 0147	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(d) (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 and interview, the facility failed to comply with fire prevention and building safety standards related to residents smoking in their rooms on 3 of 3 halls observed during the environment tour. (100 hall, 200 hall, 300 hall) Findings include:	R 0147	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Smoking safety assessments were completed on residents affected. All smoking materials were removed from apartments if the resident was deemed not safe to smoke safely. All affected apartments were deep cleaned. All damaged bedding and linens were removed and replaced.	10/09/2026

During the Environmental Tour on 9/9/26 at 11:49 a.m. with the Housekeeping Supervisor, the following was observed: 1. 100 Unit a. Room 111 - the bathroom floor was dirty and stained. There were smeared brown stains on the bathroom walls. There were ashes from cigarettes on the side of the bathroom vanity. There was a heavy accumulation of a brown substance on the outside base of the toilet. The room walls were smeared with a brown substance and the vents on the air conditioner were dirty. There were burn holes in the blanket on the bed and room smelled like cigarette smoke. There was one resident who resided in the room and used the bathroom. b. Room 113 - there was cigarette smoke in the room. The walls were yellow stained and the carpet was dirty and stained. The bathroom ceiling was water stained. There were two residents who resided in the room and shared the bathroom. 2. 200 Unit Room 208 - the resident was smoking in the room. During an interview at that time, he was aware he was not supposed to smoke in the room. There were two residents who shared the	2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Smoking safety assessments were completed on all residents who wish to smoke. All smoking materials were removed from apartments if the resident was deemed not safe to smoke safely. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? A new smoking safety assessment has been implemented to determine the safety of residents who wish to smoke. Assessments will be completed upon admission, quarterly, and with a significant change. All staff were educated on the new policy, acceptable smoking practices, and expectation of reporting all violations to the policy immediately to the Administrator. Residents were informed of the new smoking policy and asked to sign a Safe Smoking Acknowledgement Form which included no smoking within the
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	room. 3. 300 Unit Room 355 - there was a strong odor of cigarette smoke in the room. During an interview at that time, the resident indicated his roommate smoked in the room all the time. The walls were stained yellow and the carpet was dirty and stained. There were two residents who resided in the room. During an interview on 9/9/26 at 1:10 p.m., the Administrator indicated residents were not allowed to smoke in their rooms. The current and undated "Smoking Policy", provided by the Business Office Manager on 9/9/26 at 2:00 p.m., indicated smoking was prohibited in resident rooms.		community, including resident apartments, and possible issuance of a notice to discharge if smoking standards are not followed. Staff responsible for washing bedding and linen will remove damaged bedding and linen from service and replace it with bedding and linen that is in good repair. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will complete an audit of smoking assessments monthly. The administrator will complete walking rounds of the building 5 times weekly to monitor for compliance of smoking policy. 5. By what date the systemic changes will be completed? October 9, 2026	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as	R 0241	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	10/09/2026

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 ensure medical care was provided as instructed by the physician related to urgent follow up testing for 1 of 5 active resident records reviewed. (Resident D) Finding includes: The record for Resident D was reviewed on 9/8/26 at 2:28 p.m. Diagnoses included, but were not limited to, chronic schizophrenia and diabetes. A physician's letter, dated 8/19/25, indicated a mammogram done on that day showed an area of concern, and a biopsy was necessary. The letter indicated it was very important that Resident D called and scheduled this appointment as soon as possible. The record lacked documentation that the biopsy was performed or refused. A Service Plan, updated on 5/5/26, indicated staff was to	Resident had biopsy scheduled for 09/21/2026. Resident refused to go PCP was notified of delay in treatment. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident charts were reviewed for appointment needs and appointment dates and times were confirmed. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The facility has assigned scheduling duties to the current housemother position. The staff member was trained on the importance of timely follow-up and documentation. Documentation of all appointments dates and times will be completed in the eMAR. Clinical staff were educated on appropriate documentation and communication of appointment requests. An appointment request form was created and is to be completed and provided to the	
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	arrange resident appointments and transportation. During an interview on 9/8/26 at 3:50 p.m., the scheduler indicated she did not know about the letter. She managed resident appointments, but this was missed. She indicated she should have known about it, because it was important. It should have been done right away, not a year later. During an interview on 9/9/26 at 10:29 a.m., the Director of Nursing (DON) indicated she thought the resident had the biopsy done, and would look for documentation. During an interview on 9/9/26 at 1:40 p.m., the scheduler indicated she and the DON were wrong. They had no documentation that the resident had completed or refused the biopsy. She thought the resident might have wanted a second opinion at that time, but there was no documentation of that either. This citation relates to Intake 471848.		scheduler upon receipt of any new appointment needed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing will review nursing documentation and appointment requests 5 days a week on work days and verify that the appointments are scheduled in a timely manner and documented in the eMAR system. 5. By what date the systemic changes will be completed? October 9, 2026	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving	R 0273	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	10/09/2026

areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.

Based on observation and interview, the facility failed to serve food under sanitary conditions related to dirty floors, ceilings, and equipment, lack of separation of food and chemicals, unlabeled food items, and lack of dishwasher temperature monitoring for 1 of 1 kitchen. (The Main Kitchen)

Findings include:

During the Kitchen Sanitation Tour with the Kitchen Manager on 9/8/26 at 9:23 a.m., the following was observed:

1. In a small storage area near the entrance of the kitchen, there was a container of cereal, disposable cups, and food serving utensils on shelves with cleaning chemicals.

practice?

No residents were affected by this practice.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents had the potential to be affected by this practice. All kitchen staff have been re-educated on sanitation and safe food handling practices. All cleaning materials have been removed from food storage areas and placed in a separated designated chemical storage area.

The blue jug has been discarded. The dry storage area floors and shelves have been cleaned.

The bins in the food prep area have been cleaned, labeled and dated. The mislabeled container on the counter and its contents have been removed.

	2. In the dry storage area, there was an accumulation of dirt and food debris on the floor. There was a large, unlabeled, transparent jug filled with a blue liquid that was on a shelf near food items. The Kitchen Manager indicated she did not know if the liquid was a food product or cleaning chemical, and that they used it to prop the back door open. 3. In the food prep area, there were three large storage bins filled with what the Kitchen Manager identified as sugar, cornmeal, and flour. The bins were unlabeled and undated with visible food spillage. There was a container labeled as frozen cantaloupe on the counter which was filled with canned peaches. The Kitchen manager indicated they re-used the container and did not label it.		The contents of the two large bins in the cooking area were discarded the bins have been cleaned and are appropriately labeled and dated. The ovens have been cleaned. The pots, steam table containers and bowls were washed and now stored inverted. A temperature log is now in place for the dishwasher. The identified ceiling tiles have been replaced. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The Kitchen Manager received education on the importance of following all food safety and kitchen guidelines. The Dietary staff have been reeducated on safe food handling practices to food storage, thawing, cleaning and documentation of all temperature logs. A cleaning schedule has been developed for the dietary personnel to include all equipment, food prep areas and storage. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	
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4. In the cooking area, there were two large bins filled with what the Kitchen Manager identified as chicken base and beef base. The bins were unlabeled, undated, and had an accumulation of an orange dripped substance on them. The ovens had an accumulation of food spillage and debris on the inside, and on the outside of the doors. The pots, steam table containers, and large bowls were not inverted for storage.

5. In the walk-in cooler, there was an unlabeled, undated, clear plastic bag of meat inside of a bucket. The Kitchen Manager indicated it was pepper steak that was thawing. There were two boxes of breakfast sausage stacked. The top and one side of the box were dark and appeared wet with spillage. The Kitchen Manager indicated ice from the freezer probably melted on the box.

6. There was no temperature log for the dishwasher. The Kitchen Manager indicated they had not started a log for September yet, but it should be done with each meal service.

7. Throughout the kitchen, there were several buckling, stained, and loose ceiling tiles.

During an interview at that time, the Kitchen Manager indicated

The Kitchen Manager is responsible for auditing temperature logs 5 times weekly. The Kitchen manager will perform rounds three times daily to ensure safe food handling practices are in place. Any identified areas will be immediately corrected. The Kitchen Manager will complete a work order for any area in the kitchen that requires maintenance. The administrator will review all work orders and ensure timely repair. The Administrator will conduct weekly kitchen rounds. All monitoring will be ongoing.

5. By what date the systemic changes will be completed?

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	all of the above were in need of cleaning / repair. This citation relates to Intake 471848.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure the resident received their medication as ordered by the physician for 1 of 7 sampled residents. (Resident B) Finding includes: The record for Resident B was reviewed on 9/8/26 at 2:10 p.m. Diagnoses included, but were not limited to, stage 4 chronic kidney disease stage 4, type two diabetes with chronic kidney disease. The 5/2026 Medication Administration Record (MAR)	R 0297	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All medication orders have been reviewed and medications are available for administration. The resident's Primary Care Provider has been notified of the missed medication. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident MARs have been audited for unavailable medications. Residents' Primary Care Providers were notified of missed administrations. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?	10/09/2026

indicated the medication of Lokelma (oral powder mixed with water to treat high blood potassium levels) 5 gram Pak mix 1 pack with at least 3 tablespoons of water and stir well daily at 8:00 a.m. was awaiting delivery from the pharmacy on 5/23-5/26/26. The resident did not receive the medication.

The 6/2026 MAR indicated the Lokelma 5 gram was awaiting delivery from the pharmacy 6/20, 6/22, 6/23, 6/24, 6/27 and 6/29/26. The resident did not receive the medication. The medication of Sodium Bicar 325 milligrams (mg) give one tablet every morning and one tablet every evening and one tablet at bedtime was not signed out as being administered and awaiting delivery from the pharmacy on 6/25 at 4:00 p.m. and 8:00 p.m., on 6/27, 6/28, and 6/29/26 at 8:00 a.m., 4:00 p.m., and 8:00 p.m. The resident did not receive the medication. The medication of Gabapentin (a medication used to treat nerve damage) 600 mg give one tablet twice a day was not administered and awaiting delivery from the pharmacy on 6/25/26 at 8:00 p.m., on 6/27/26 at 8:00 a.m., and 8:00 p.m., on 6/28 at 8:00 p.m., and on 6/29 at 8:00 a.m. The resident did not receive the medication.

All staff who have the authority to administer medications have been educated on the proper use of exceptions during medication administration and the process for using the back up pharmacy.

The Primary Care Provider will be notified of all missed medications for medication unavailability after 3 doses.

The pharmacy has contracted with a back-up pharmacy, CPS Solutions, for emergency medications or new orders that are unavailable for timely delivery from the pharmacy and provided the community with a direct phone number.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Director of Nursing will review the medication administration exception report daily on work days for medication availability, notification of PCP, and notification to the pharmacy. Any delays in medication delivery will be reported to the Administrator.

5. By what date the systemic changes will be completed?

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	The 7/2026 MAR indicated the medication of Atorvastatin (used to treat high cholesterol) 20 mg give one tablet daily at 8:00 p.m., the medication of Calcitriol (a medication used to treat and prevent low calcium levels) 0.5 mg take two capsules daily at 12:00 p.m., the medication of Cetirizine (an allergy medication) 10 mg take one tablet daily at 10:00 a.m., the medication of Furosemide (a water pill) 40 mg take 1 and 1/2 tabs daily at 8:00 a.m., the medication of Jardiance (used for diabetes) 25 mg give 1 tablet every morning at 8:00 a.m., the medication of Lisinopril (used to treat high blood pressure) 40 mg give one tablet daily at 8:00 a.m., and the Amlodipine (used to treat high blood pressure) 10 mg give one tablet daily at 8:00 a.m. and the medication of Lokelma 5 gm give 1 packet daily at 8:00 a.m., were all not signed out as being administered due to awaiting delivery from the pharmacy on 7/29-7/31/26 The 8/2026 and 9/2026 MAR indicated Atorvastatin 20 mg give one tablet daily at 8:00 p.m., was not signed out as administered and awaiting delivery from the pharmacy on 8/30-9/1. The medication of Gabapentin 600 mg give one tablet twice a day was not administered and was awaiting		October 9, 2026	
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delivery from the pharmacy on 8/31, 9/1 at 8:00 a.m., and 8/31/26 at 8:00 p.m. The medication of Amlodipine 10 mg give one tablet daily at 8:00 a.m. was not signed out as administered and awaiting delivery from the pharmacy on 8/31 and 9/1/26 and the Furosemide 40 mg give 1 and 1/2 tabs at 8:00 a.m., was not signed out as being administered and awaiting delivery from the pharmacy on 8/31 and 9/1/26.

During an interview on 9/8/26 at 11:26 a.m., LPN 1 indicated the pharmacy comes out to the facility to deliver medication at least monthly and sometimes more often depending on what was going on. As far as monthly medications, they were delivered all at once or in two back to back days. If the resident brought her new orders from a physician visit on a Friday, no medications would be available until the following Monday or later, depending if there needed to be prior authorization from insurance, it may take longer to get the medication. She indicated there was no back up pharmacy for the facility to make sure the residents had their medications.

During an interview on 9/9/26 at 10:25 the Director of Nursing indicated the resident can get

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	their daily medication from the nurse up until 2:00 p.m., and pharmacy delivered medications at least monthly. They have trouble getting prior authorizations for medications that they used to be able to get before for the residents. This citation relates to Intake 471848.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to ensure over the counter medications and insulin pens were dated and labeled after opening for 2 of 2 medication carts. Findings include: 1. During the medication pass observation on 9/8/26 at 11:00 a.m. with LPN 1, the following was observed in both	R 0300	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were affected by this practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All medication carts were audited. All opened, unlabeled medications were disposed of	10/09/2026

medication carts: a. There was an opened bottle of over the counter Tussin DM with no label on it. b. There was an opened bottle of 15 allergy pills with no label on it. c. There was an opened bottle of Fexofenadine (allergy medication) with only initials of a resident on the outside. d. There was an opened bottle of over the counter Aspirin with no label. e. There were three opened bottles of over the counter Vitamin D3 with no label. f. There was an opened bottle of over the counter Complete Multi Vitamin with no label. g. There was an opened bottle of over the counter Allergy Relieve with the resident's first name on the outside. h. There was an opened bottle of over the counter All Day Pain Relieve with no label. i. There was an opened bottle of over the counter Ibuprofen with no label. j. There were two Novolog flex pens with no label.		and replaced. All staff responsible for accepting medications were educated on proper labeling of medications, procedure for dating medications/insulin pens when opened, and disposing of expired medications. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing will monitor medication carts for proper labeling of medications and expired medications weekly for 1 month, every other week for 2 months, monthly for 3 months. 5. By what date the systemic changes will be completed? October 9, 2026	
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	k. There was one Novolog flex pen with an open dated of 8/4/26. l. There was one Lispro flex pen with no date opened. m. There was one Lantus flex pen with no date opened. During an interview at that time, LPN 1 was aware the medications needed to be labeled and dated when opened. She indicated many of those over the counter medications were "house stock" that had no labels on them. During an interview on 9/8/26 at 11:25 a.m., the Director of Nursing (DON) indicated she was aware the medications needed to be dated when opened and labeled, including house stock. The current and undated "Pharmaceutical Services" policy, provided by the DON on 9/8/26 at 12:18 p.m., indicated all drugs shall be labeled with the patient's name and name of physician.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained	R 0349		10/09/2026

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 observation, record review, and interview, the facility failed to ensure medication times were accurately documented related to the times of administration for 3 of 5 residents observed during medication pass. (Residents 9, 5, and 10)

Finding includes:

1. During medication pass on 9/8/26 at 11:09 a.m., Resident 9 entered the medication room to take her morning medications. LPN 1 gave her 10 medications, which included Ferrous Sulfate 325 milligrams (mg) one tablet.

The record for Resident 9 was reviewed on 9/8/26 at 11:50 a.m.

A Physician's Order, dated 3/18/26, indicated Ferrous Sulfate three times a day at 8:00 a.m., 12:00 p.m., and 4:00 p.m.

During an interview on 9/8/26 at

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

All medication orders for affected residents were reviewed. New orders were obtained to update administration times to meet the needs of the individual residents. Individual Service Plans were updated to reflect the needs of the residents.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Medication orders for all residents were reviewed. New orders were obtained to update administration times to meet the needs of the individual residents. Individual Service Plans were updated to reflect the needs of the residents.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

All staff who are qualified to pass medication were educated on rights of medication administration, including Right time and a one hour before or

2:45 p.m., the Director of Nursing indicated the medications the resident received at 11:09 a.m. were her morning medications and residents have until 2:00 p.m. daily to receive them.

2. During medication pass on 9/8/26 at 11:12 a.m., Resident 5 entered the medication room to take his morning medications. LPN 1 gave the resident 3 medications, which included Gabapentin (a medication to treat nerve damage) 600 milligrams (mg) one tablet.

The record for Resident 5 was reviewed on 9/8/26 at 3:37 p.m.

A Physician's Order, dated 7/12/24, indicated Gabapentin 600 mg one tablet twice a day at 8:00 a.m. and 8:00 p.m.

During an interview on 9/8/26 at 2:45 p.m., the Director of Nursing indicated the medications the resident received at 11:12 a.m. were his morning medications and residents have until 2:00 p.m. daily to receive them.

3. During medication pass on 9/8/26 at 11:20 a.m., Resident 10 entered the medication room to take his morning medications. LPN 1 gave the resident 4 medications, which included Benztropine (a medication used for movement disorders) 2

after limit.

All new orders will be reviewed and approved by the Director of Nursing to ensure that medication orders have been timed appropriately to meet the needs of the residents.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Director of Nursing will monitor the Med Variance Report in QuickMar 5 times weekly on work days to ensure medications are administered within the correct time frame. Any discrepancies will be reported to the Administrator.

5. By what date the systemic changes will be completed?

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FORM APPROVED

OMB NO. 0938-0391

milligrams (mg) one tablet and Famotidine (Pepcid) 20 mg one tablet.

The record for Resident 10 was reviewed on 9/8/26 at 11:50 a.m.

A Physician's Order, on the current 9/2026 recap, indicated Benztropine 2 mg, take one tablet two times a day at 8:00 a.m. and 4:00 p.m., and Famotidine 20 mg two times a day, take one tablet at 8:00 a.m., and 4:00 p.m.

During an interview on 9/8/26 at 11:20 a.m., LPN 1 indicated the resident had just received his morning medications.

During an interview on 9/8/26 at 2:45 p.m., the Director of Nursing indicated residents have until 2:00 p.m., to receive their morning medications. The facility has a liberal medication pass process because some of the residents do not come down early in the morning to get their meds. For residents who have medications for two and three times a day, the nurse would not pass those medications until later in the day, so they would not get the medication right after each other. She indicated the medication administration record did not reflect the liberal pass times, only the scheduled times.

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FORM APPROVED

OMB NO. 0938-0391

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJanuary Szweda	TITLEAdministrator	(X6) DATE10/05/2026
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