

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<br>A. BUILDING<br>B. WING |  | (X3) DATE SURVEY COMPLETED<br><br>12/05/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER BEACH TERRACE |                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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                                                   | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00395476.</p> <p>Complaint IN00395476 - Substantiated. State deficiency related to the allegations is cited at R0144.</p> <p>Survey date: 12/5/22</p> <p>Facility number: 001140</p> <p>Residential Census: 134</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 12/6/22.</p> | R 0000                                                                     |                                                                                                                                                                                                                                                                  |                                                      |  |                                              |  |
| R 0144                                                   | <p>Sanitation and Safety Standards - Deficiency</p> <p>410 IAC 16.2-5-1.5(a)</p> <p>(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort</p>                                                                                                                                                                                                       | R 0144                                                                     | <p>1. Dietary employees have been inserviced on following the internal kitchen cleaning policy. Kitchen maintenance person responsible for following internal cleaning sheet. Dietary supervisor to monitor visually, daily, five (5) times weekly; ongoing.</p> |                                                      |  | 12/23/2022                                   |  |

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FORM APPROVED

OMB NO. 0938-0391

for all residents.

Based on observation, record review, and interview, the facility failed to maintain a sanitary environment related to an accumulation of dust, debris, and mouse droppings on the floors for 5 out of 9 resident rooms (312, 314, 306, 351, and 353), 2 of 2 storerooms in the kitchen, and light covers in 1 of 1 kitchen areas. (The Main kitchen)

Findings include:

1) The kitchen was observed on 12/5/22 at 9:18 a.m. The small store room was observed with dirt, debris, and mice droppings on the floor under the bottom shelf. In the larger storeroom with can goods, there were mouse droppings seen in the corners and on the floor under the bottom shelves.

2) During a tour of the facility on 12/5/22 at 9:31 a.m. through 10:28 a.m. with the Maintenance Director, the following was observed:

a. In room 312, there were mouse droppings seen on the floor next to the baseboards behind the head of the two beds in the room.

b. In room 314, there were mouse droppings, dirt, and debris, on the floor behind the

2. A,B,C,D,E

Resident rooms have been set up on a deep room clean out schedule to include vacuuming under all beds and in corners. The begin date for deep room clean outs is December 19; to be concluded December 23. Housekeeping, maintenance and office personnel responsible for deep room clean outs. Administrator to monitor process visually. Housekeepers have been re-inserviced on the deep cleaning procedures. Housekeepers responsible for using internal deep cleaning procedure forms. Housekeeping supervisor to monitor using the internal deep cleaning procedure form; ongoing

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furniture and in the corners of the room.

c. In room 306, there were mouse droppings, dirt, and debris, on the floor behind the furniture and along the baseboards.

d. In room 351, there were dirt and debris on the floors behind the furniture and in the corners of the room.

e. In room 353, there were dirt and debris on the floors behind the furniture and in the corners of the room.

The Maintenance Director acknowledged all of the above resident room observations.

An undated cleaning kitchen cleaning policy, received from the Business Office Manager as current on 12/5/22 at 11:57 a.m., indicated the floors in all areas, under all racks, shelves and equipment would be swept and mopped three times per day and as needed.

The Housekeeping Specific Orientation form, received from the Administrator as current on 12/5/22 at 11:51 a.m., indicated every resident room was to be cleaned daily and a deep cleaning would be scheduled as one room on every hall per day.

This State residential finding relates to Complaint

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IN00395476.

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|--|-----------------------------------------------------------------|--|--|--|
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| 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.) |  |  |  |  |
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|-----------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|-----------------------------------------------------------------------|-------|-----------|