| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 06/29/2023 |

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| MILLER BEACH TERRACE | 4905 MELTON RD<br>GARY, IN 46403 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00405722, IN00406958, IN00411179, and IN00411636.<br><br>Complaint IN00405722 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00406958 - State deficiencies related to the allegations are cited at R0086 and R0144.<br><br>Complaint IN00411179 - State deficiencies related to the allegations are cited at R0086 and R0144.<br><br>Complaint IN00411636 - State deficiencies related to the allegations are cited at R0052 and R0086.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: June 28 & 29, 2023<br><br>Facility number: 001140<br><br>Residential Census: 139<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 7/5/23. | R 0000 | | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and | | | |

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

January Szweda | Administrator | 08/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | (6) involuntary seclusion.<br>Based on observation, record review, and interview, the facility failed to ensure residents were free from physical abuse, related to an altercation between Resident D and Resident E which led to a gun being discharged twice, resulting in Resident E being injured by the gun shots. The facility staff were aware of the altercation and of a past altercation between the two residents and interventions were not put into place to separate and protect the resident and other residents and staff who were also present in the Dining Room from potential harm.<br><br>Finding includes:<br><br>An Indiana Department of Health (IDOH) reported incident, dated 6/26/23, indicated the incident occurred on 6/25/23 at 7:18 p.m. Resident D and Resident E had a verbal altercation and the residents were separated by the staff. Resident E then re-approached Resident D and another argument was started. Resident D then pulled out a gun and shot Resident E twice. The Security Guard then stepped in and Resident D exited the building, the Police were notified, and Resident E was transferred to the Hospital.<br><br>Upon entrance to the facility on 6/28/23 at 9:45 a.m., there were no signs posted that indicated the facility and the grounds were a weapon/gun free area/property.<br><br>During an interview on 6/28/23 at 10:43 a.m., Resident F indicated he was a witness to the incident on 6/25/23 and was fearful this might happen again.<br><br>During an interview with Resident E on 6/28/23 at 2:20 p.m., he indicated he had been shot twice by | R 0052 | Residents have been re-inserviced on the zero tolerance policy for weapons. We also re-inserviced on the policy regarding zero tolerance for alcohol.<br>Consistent with our weapon free campus policy weapon/gun free area signs have been purchased and posted at front and back entrances.<br>Counseling services have always been available seven days a week. Residents have been reminded that if they are feeling anxiety or fear to use the therapeutic services that are offered.<br>Administration has been in contact with therapist about warning signs that may have been missed regarding escalation of residents. New protocol has been set in place that therapist will contact administrator or DON regarding the possibility of escalating behaviors.<br><br>Residents have always received “resident rules” upon admission which indicates we are a weapon free campus.<br>The facility has a zero tolerance alcohol policy indicated in the resident rules.<br>Employees, upon hire, have always received facility handbook which indicates we are a weapon free campus.<br><br>1. Miler Beach Terrace will | 08/03/2023 |

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| | Resident D. His birthday was 6/25/23 and everyone had been drinking. He was in the Dining Room and Resident D had called him a derogatory name and then he pulled the gun out and shot him. Security had not responded to the altercation until the shots were fired. The Kitchen Staff came out and Resident D fled. He indicated when Resident D was intoxicated, he would talk, "crap". They have had altercations in the past and he tried to stay away from him. He was unsure how the facility was going to keep anyone else from bringing a gun in. The resident was observed with bandages on his left arm.<br><br>The facility investigation of the occurrence, contained written statements from staff at the facility.<br><br>An undated statement from the Security Guard, indicated on 6/25/23 at 6:38 p.m., Resident D had shot Resident E twice in the arm. The occurrence had started shortly after dinner when Resident E was in the lobby at 6:45 p.m. and had warned staff and security about fighting with Resident D. There had been a verbal altercation which started with Resident D calling Resident E a derogatory name. The staff had repeatedly asked Resident E to calm down and approximately 20 minutes later, Resident E entered the Dining Room again to confront Resident D. The Security Guard and a CNA followed Resident E into the dining area and a verbal altercation started and within 5 minutes after the altercation started again, Resident D pulled out a gun and shot twice at Resident E. Resident E yelled he had been shot and Resident D ran out of the building.<br><br>An undated and not signed statement from Employee 2 indicated, he was standing at the start of the ramp, and had seen Resident E was getting | | instruct through training employees on methods of conflict de-escalation and resolution as part of its regular periodic training. New employees will be required to complete a video training course on methods of conflict resolution. The Administrator will continue to conduct annual classes on conflict resolution and conflict de-escalation for all employees coming into contact with residents.<br><br>2. Miller Beach Terrace will require the employers of security personnel to certify that each member of their security staff will be trained in conflict resolution and conflict de-escalation through programs or videos generally accepted in the industry. Miller Beach Terrace will continue to offer security personnel the opportunity to participate in the annual classes on conflict resolution and conflict de-escalations.<br><br>3. Miller Beach Terrace will continue to maintain a comprehensive program to investigate, intervene, and resolve issues relating to resident altercations or physical confrontations. This will involve creating and maintaining case files for each incident occurring in the building or on the grounds of the facility. For each file: | |

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| | ready to fight Resident D. The altercation had been escalating. Resident E had yelled, "he's got a gun". Resident D was seen reaching into his pants and pulled out a handgun and discharged the gun twice. The Security Guard then got resident D under control. Resident E was removed to safety and his arm was wrapped and 911 was notified.<br><br>A written and unsigned statement, dated 6/25/23, from Employee 1 indicated before supper, Resident E had been talking about beating Resident D up in a past occurrence. Resident E was informed to leave the "situation alone." After dinner Resident E was at the dining table talking about Resident D and he was informed to leave Resident D alone and to go to his room and to just go and enjoy his birthday. Resident E then went to the lobby and waited for Resident D to leave the Dining Room to fight him outside. Security had listened to the threats Resident E had made. Resident E then walked to the Dining Room and was still making continual comments to Resident D. Resident D then stood up to Resident E. Another resident then attempted to stop the two from arguing, but the arguing continued. Resident E then threatened to go and get one of his friends, then Resident D produced the gun and fired three times, making contact with Resident E twice, one in the arm and one in the side.<br><br>During an interview on 6/28/23 at 10:51 a.m., Employee 1 indicated Resident E kept antagonizing Resident D. The two residents were separated and Resident E was told to go to his room. Instead he went outside the Dining Room to wait on Resident D. Resident D had never left the Dining Room. Resident E had been drinking and kept bringing up the past fight he had with Resident D when he reentered the Dining room. A | | a. A case file will be initiated and maintained as an open file until the Administrator is satisfied that the Case should be closed.<br>b. in each case file, there shall be a comprehensive report of each incident, including:<br>1. Names of the parties involved (including resident room numbers)<br>2. All resident or non-resident witnesses to the incident (including resident room numbers)<br>3. A description of the incident in detail prepared by the DON or Administrator<br>4. Copy of a completed request for written statements from each party involved and all witnesses to the incident<br>5. A copy of all written statements from each witness<br>6. A copy of the police report ( if available)<br>7. The Administrator will review the police report, and all party and witness statements and will conduct interviews as necessary to confirm and consolidate facts<br>8. For each case, a form completed by the Administrator incorporating comprehensive statement of the incident determined from the fact gathering, and also indicating that the incident was reported on a timely basis to the State FSSA and/or the local police, as required by Miller Beach Terrace Policies and Procedures and Indiana | |

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| | gun being fired was heard and then another shot. Security then entered the Dining Room.<br><br>During an interview on 6/28/23 at 1 p.m., the Administrator indicated that the facility could not afford metal detectors and there were no signs that indicated the facility and grounds were weapon free zones.<br><br>During an interview on 6/28/23 at 2:20 p.m., the Director of Nursing indicated that residents were not allowed to have alcohol on the premises and they go off the premises to drink. Resident E had been drinking the day of the incident. There was nothing the facility was able to do when the residents were intoxicated. Resident D and Resident E had no other behaviors.<br><br>The Security Guard was interviewed on 6/29/23 at 9:20 a.m. and indicated he was employed by an outside company. He indicated Resident E was in the lobby and had informed him he was getting into a fight with Resident D. Until he was informed by staff at the facility, he had not known the residents had a history of altercations. Resident E had waited in the lobby for Resident D to come out of the Dining Room for 30-45 minutes. Resident E then re-entered the Dining Room and was making statements to Resident D. Resident D then stood up and reached in his pants and Resident E was heard saying, "he's strapped." Resident D had a small hand gun and he discharged the gun. He had not been trained on how to respond to resident to resident altercations and had been informed if there were problems he was to notify the Police. His job description consisted of checking to make sure doors were locked and ensuring there were no visitors still on the property after 8 p.m. | | licensing requirements.<br><br>9. If it is determined that an involved resident needs to be removed from the building, either temporarily or permanently, such action shall be taken without violence. If it is determined that additional potential conflict will arise, local police shall become involved and assist in the removal of such resident. This process will be overseen by the Administrator (or if the Administrator is not present, by the DON).<br>c. within one business day following the incident, an assessment of employee involvement shall be made by the Administrator, and appropriate action shall be taken, including discipline and/or additional training if warranted.<br>d. within three business days after the termination of the incident, the Administrator shall brief all management staff on the incident and resolution, including lessons learned.<br>e. Annually, as a part of the ownership audit of the facility, a review of the case files will be undertaken and an interview of the Administrator and the DON will be conducted. Ownership will determine if additional steps are needed to improve the conflict resolution system.<br><br>Facility has strengthened | |

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| | During an interview on 6/29/23 at 10 a.m., the Director of Nursing indicated she had not been aware Resident D and Resident E had altercations in the past.<br><br>During an interview on 6/29/23 at 10:09 a.m., the Administrator indicated the facility abuse policy had not included interventions and procedures for resident to resident altercations. The staff received de-escalation training yearly and upon hiring.<br><br>A Police Report, dated 6/25/23, indicated the incident occurred at 6:32 p.m. and was reported at the same time. The report indicated Resident E was interviewed in the Emergency Room and he indicated he and Resident D had been "having a little drink," and had gotten into a little argument. Resident D pulled out a gun and fired three shots. He and Resident D had been into a fight before. They had a couple alcoholic drinks and had then went into the facility to eat and an argument started over some potatoes.<br><br>Resident D's record was reviewed on 6/28/23 at 3:31 p.m. The diagnoses included, but were not limited to, traumatic brain injury, depression, and anxiety.<br><br>An assessment, dated 4/26/23, indicated he was alert, friendly, cooperative, and independent with activities of daily living (ADL's). He occasionally used alcohol and counseling on the affects of alcohol have been given with expressed understanding.<br><br>The Service Plan, dated 1/23/23, indicated depression - known triggers (alcohol and street drugs) the interventions were that therapy would be attended. Anxiety, with known triggers of | | admission policy criteria to lessen the risk of confrontational behaviors.<br>Additional cameras with recording capabilities are being installed throughout the facility.<br>Staff has been reminded to call administrator and DON with concerns regarding behaviors.<br>Supervisory staff responsible for reporting resident behaviors in morning meeting. DON and administrator responsible to monitor behaviors visually, ongoing. | |

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| | alcohol. The interventions were to attend therapy and activities that helped calm him, bingo and music. Alcohol abuse and the intervention was to abstain from alcohol and street drugs. He had refused to sign his Service Plan.<br><br>The Service Plan had not included altercations and interventions for staff to use with other residents.<br><br>The Nurses' Progress Notes, dated 7/29/22 through 6/25/23, indicated behaviors of medication refusals.<br><br>The Nurse's Progress Note, dated 6/25/23 at 7 p.m., indicated he had discharged a firearm in the Dining Room and had struck another resident with the bullets. He then ran from the facility and had been detained by the local Police Department.<br><br>Resident E's record was reviewed on 6/28/23 at 3:06 p.m. The diagnoses included, but were not limited to depression and alcohol abuse.<br><br>An assessment, dated 4/21/23, indicated he was alert and oriented, socialized with others, was friendly and was independent with ADL's.<br><br>The Service Plan, dated 11/29/21, indicated alcohol usage. The intervention was to abstain from alcohol use and street drugs.<br><br>There was no Service Plan for altercations with other residents.<br><br>The Emergency Room History and Physical, dated 6/25/23, indicated a gun shot wound was present to the left axilla (arm). The resident admitted to drinking alcohol. The blood alcohol level was 212 (abnormal). A CT of the Chest indicated a left | | | |

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| | lower lobe contusion with a comminuted fracture of the left seventh rib with a bullet fragment in the left lower lung field. The diagnoses included, gunshot wound, contusion of the left lung, axilla injury, and closed fracture of one rib on the left side.<br><br>This State Residential finding relates to Complaint IN00411636. | | | |
| R 0086<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(a)(1-2)<br>Administration and Management - Deficiency<br>The licensee:<br>(1) is responsible for compliance with all applicable laws; and<br>(2) has full authority and responsibility for the:<br>(A) organization;<br>(B) management;<br>(C) operation; and<br>(D) control;<br>of the licensed facility.<br>The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.<br>Based on record review and interview, the Administration of the facility failed to ensure residents were kept safe from harm by other residents and there were adequate procedures for staff to follow to prevent or de-escalate resident to resident altercations, as well as failed to ensure residents followed the rules of the facility in regards to weapons and alcohol use for 2 of 2 residents reviewed for abuse. (Residents D & E) The Administration of the facility also failed to ensure the residents' daily living environment was safe and pest-free. This had the potential to affect all residents residing in the facility.<br><br>Findings include: | R 0086 | Abuse policy has been revised to indicate what procedure employees are to take for resident to resident altercations.<br><br>Residents have been re-inserviced on the zero tolerance policy for weapons. We also re-inserviced the policy regarding zero tolerance for alcohol.<br>Consistant with our weapon free campus policy weapon/gun free area signs have been purchased and posted at front and back entrances.<br>Counseling services have always | 08/11/2023 |

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| | Cross reference R0052.<br><br>1) The facility abuse policy, dated 1/2023 and received as current from the Administrator, indicated staff members would report immediately by phone or in person to the Administrator and Director of Nursing any suspected abuse and misconduct of another employee. The policy did not indicate what procedure the employees were to take for resident to resident altercations.<br><br>During an interview on 6/29/23 at 10:09 a.m., the Administrator indicated the facility abuse policy had not included interventions and procedures for resident to resident altercations. The staff were to inform her or the Director of Nursing immediately for abuse.<br><br>2) During an interview with the Administrator on 6/28/23 at 1 p.m., she indicated the facility did not allow weapons on the grounds. The rule was in the handbook and the residents sign they are aware of the rule. There were no signs posted to remind the residents of the rule.<br><br>During an interview with the Director of Nursing on 6/28/23 at 2:20 p.m., she indicated alcohol was not allowed on the facility property. The residents would go off the property to drink and there was nothing the facility could do if they were intoxicated.<br><br>The Security Job Description, received as current from the Administrator on 6/29/23 at 10:38 a.m., included, but was not limited to, ensure all visitor have left the building at 8 p.m., check for unusual behavior, and notify the Administrator and Director of Nursing as necessary.<br><br>The undated "Resident Rules", received from the | | been available seven days a week. Residents have been reminded that if they are feeling anxiety or fear to use the therapeutic services that are offered. Administration has been in contact with therapist about warning signs that may have been missed regarding escalation of residents. New protocol has been set in place that therapist will contact administrator or DON regarding the possibility of escalating behaviors.<br><br>Residents have always received “resident rules” upon admission which indicates we are a weapon free campus.<br>The facility has a zero tolerance alcohol policy indicated in the resident rules.<br>Employees, upon hire, have always received facility handbook which indicates we are a weapon free campus.<br>1. Miler Beach Terrace will instruct through training employees on methods of conflict de-escalation and resolution as part of its regular periodic training. New employees will be required to complete a video training course on methods of conflict resolution. The Administrator will continue to conduct annual classes on conflict resolution and conflict de-escalation for all employees coming into contact with residents. | |

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| | Administrator on 6/28/23 at 11:48 a.m. as current, indicated room searches were to be conducted on a regular basis to ensure the facility was safe. Weapons and illicit drugs would be turned over to the police. No weapons, including firearms, illegal drugs, and alcoholic beverages were allowed in the facility. Disruptive behavior, physical violence toward self or others, or threats of violence would not be tolerated.<br><br>A weapon policy, dated 1/23/23, indicated weapons, which included firearms of any kind, were not permitted in or around the building and the facility would have a zero tolerance policy for the residents and employees. The employees would be terminated and the residents would be re-located.<br><br>3) Cross reference R0144<br><br>Observations of resident rooms and interviews with residents indicated an ongoing issue with bed bugs, roaches, mice, room cleanliness and the state of repair of resident living areas, affecting daily resident safety.<br><br>Interviews with the Directors of Maintenance and Housekeeping indicated no reliable monitoring or upkeep method to ensure ongoing cleanliness, safety & a pest-free daily living environment.<br><br>Facility policies for pests and general housekeeping, received by the Administrator, were not being enforced.<br><br>This State Residential finding relates to Complaints IN00406958, IN00411179 and IN00411636. | | 2. Miller Beach Terrace will require the employers of security personnel to certify that each member of their security staff will be trained in conflict resolution and conflict de-escalation through programs or videos generally accepted in the industry. Miller Beach Terrace will continue to offer security personnel the opportunity to participate in the annual classes on conflict resolution and conflict de-escalations.<br><br>3. Miller Beach Terrace will continue to maintain a comprehensive program to investigate, intervene, and resolve issues relating to resident altercations or physical confrontations. This will involve creating and maintaining case files for each incident occurring in the building or on the grounds of the facility. For each file:<br>a. A case file will be initiated and maintained as an open file until the Administrator is satisfied that the Case should be closed.<br>b. in each case file, there shall be a comprehensive report of each incident, including:<br>1. Names of the parties involved (including resident room numbers)<br>2. All resident or non-resident witnesses to the incident (including resident room numbers) | |

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| MILLER BEACH TERRACE | 4905 MELTON RD<br>GARY, IN 46403 |

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| | | | 3. A description of the incident in detail prepared by the DON or Administrator<br>4. Copy of a completed request for written statements from each party involved and all witnesses to the incident<br>5. A copy of all written statements from each witness<br>6. A copy of the police report ( if available)<br>7. The Administrator will review the police report, and all party and witness statements and will conduct interviews as necessary to confirm and consolidate facts<br>8. For each case, a form completed by the Administrator incorporating comprehensive statement of the incident determined from the fact gathering, and also indicating that the incident was reported on a timely basis to the State FSSA and/or the local police, as required by Miller Beach Terrace Policies and Procedures and Indiana licensing requirements.<br><br>9. If it is determined that an involved resident needs to be removed from the building, either temporarily or permanently, such action shall be taken without violence. If it is determined that additional potential conflict will arise, local police shall become involved and assist in the removal of such resident. This process will be overseen by the Administrator | |

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| | | | (or if the Administrator is not present, by the DON).<br>c. within one business day following the incident, an assessment of employee involvement shall be made by the Administrator, and appropriate action shall be taken, including discipline and/or additional training if warranted.<br>d. within three business days after the termination of the incident, the Administrator shall brief all management staff on the incident and resolution, including lessons learned.<br>e. Annually, as a part of the ownership audit of the facility, a review of the case files will be undertaken and an interview of the Administrator and the DON will be conducted. Ownership will determine if additional steps are needed to improve the conflict resolution system.<br><br>Facility has strengthened admission policy criteria to lessen the risk of confrontational behaviors.<br>Additional cameras with recording capabilities are being installed throughout the facility.<br>Staff has been reminded to call administrator and DON with concerns regarding behaviors.<br>Supervisory staff responsible for reporting resident behaviors in morning meeting. DON and administrator responsible to | |

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| | | | monitor behaviors visually, ongoing.<br>Room temperature monitoring sheets have been modified to include dates and rechecks and where glue traps are placed and how often they are checked.<br><br>An additional heater has been purchased in addition to exterminator grade bed bug spray. Each room will be heated throughout the facility (one hall weekly) for a series of three months with room checks being done on Fridays. Any outbreaks will be heated same day. Rooms throughout the facility were checked and cleaned or heated as necessary.<br>Facility has terminated current housekeeping supervisor and director of maintenance. New housekeeping supervisor started July 20, 2023. New maintenance supervisor hired on August 03, 2023 and will be starting on August 11, 2023. New supervisors will be In-serviced and trained by administrator with new forms developed. Housekeeping staff will receive Internal Cleaning Checklist (ICC). ICC will include but not be limited to: furniture dusted and or washed, cobweb removal, furniture to be moved and vacuumed under weekly… Rooms will be deep cleaned with new housekeeping supervisor. | |

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| | | | Housekeeping supervisor responsible for checking random rooms daily against cleaning checklist. Administrator to monitor Housekeeping supervisor against Administrators Master List, 5 times weekly for 60 days, then weekly, ongoing.<br><br>New Maintenance supervisor has a preventative maintenance log including daily, weekly, monthly, semi-annual and annual tasks. Maintenance supervisor responsible for delegating tasks. Administrator to monitor log, weekly, ongoing.<br>Contracting crew including a plumber and electrician have been hired to do repairs throughout the building where necessary. Business Office Manager responsible for assigning rooms to contracting crews. Administrator to monitor progress, weekly, visually ongoing. | |
| R 0144<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(a)<br>Sanitation and Safety Standards - Deficiency<br>(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.<br><br>Based on observation, record review, and interview, the facility failed to maintain a sanitary environment related to cleanliness of residents' apartments, holes and water damage of a bathroom ceiling, musty odor and black substance in a bathroom cabinet, mirrors with the silvering | R 0144 | R144 a, 1, 2 a, b, c, d, e<br><br>Room temperature monitoring sheets have been modified to include dates and rechecks. An additional heater has been purchased in addition to | 09/01/2023 |

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| | chipping off, missing and loose base boards, broken bathroom tile, walls with cracks and holes, mouse droppings, bugs in mouse sticky traps, and signs of bed bugs on a mattress cover and complaints from residents about bed bugs and rodents for 5 of 9 rooms observed and 6 of 10 residents interviewed about pest/rodent control. (Rooms 309, 312, 101, 204, and 207. Residents F, C, G, H, J, and K)<br><br>Findings include:<br><br>1) During an interview on 6/28/23 at 10:43 p.m., Resident F indicated he had seen bugs in his room. The facility sprayed but it did no good.<br><br>During an interview on 6/28/23 at 12:30 p.m., Resident C indicated she has bed bugs in her room. The facility sprayed but the bed bugs come back.<br><br>During an interview on 6/29/23 at 10:42 a.m., Resident G indicated he has bed bugs in his room and has bites on his legs from the bed bugs.<br><br>During an interview on 6/29/23 at 10:55 a.m., Resident H indicated he had seen a mouse running around and put a glue trap down, he had killed a roach in his bathroom the day before the interview, and has bed bugs even with the heat treatment in his room.<br><br>During an interview on 6/29/23 at 11:05, Resident J indicated he saw a mouse in his room on 6/27/23. Resident K indicated they spray for bed bugs but "they are all over the building."<br><br>During an interview on 6/29/23 at 11:23 a.m., the Director of Maintenance indicated the facility used heat to kill the bed bugs. Heat was used in | | exterminator grade bed bug spray. Each room will be heated throughout the facility (one hall weekly) for a series of three months with room checks being done on Fridays. Any outbreaks will be heated same day. Rooms throughout the facility were checked and cleaned or heated as necessary.<br>Exterminating company will continue twice monthly visits. Facility is having a meeting (08/29/23) with exterminating company to advise and consult in the professional eradication of bed bugs.<br><br>Facility has terminated current housekeeping supervisor and director of maintenance. New housekeeping supervisor started July 20, 2023. New maintenance supervisor hired on Aug 03, 2023 and will be starting on August 11, 2023. New supervisors will be In-serviced and trained by administrator with new forms developed. Housekeeping staff will receive Internal Cleaning Checklist (ICC). ICC will include but not be limited to: furniture dusted and or washed, cobweb removal, furniture to be moved and vacuumed under weekly… Rooms will be deep cleaned with new housekeeping supervisor.<br><br>Housekeeping supervisor responsible for checking random | |

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| | the rooms the bed bugs were reported to be seen, then he went back and checked the rooms the next day for activity. He did not have a log when rooms were checked. He indicated glue traps were placed in rooms that have seen mice. He indicated the traps were checked, though has no record of when the traps were last checked. The Pest Control Company did not spray for bed bugs, they sprayed for roaches.<br><br>Review of the Pest Control reports, dated 4/11/23 through 6/28/23, indicated the facility had been sprayed for cockroaches, ants, and fruit flies. There was no evaluation or spraying in the building for bed bugs.<br><br>A Bed Bug Policy, dated 1/13/23 and received from the Administrator as current, indicated when bed bugs were reported, the room and adjacent rooms were to be treated immediately. The Procedure, dated 1/13/23, indicated the rooms would be heated up to 45 minutes and on occasion the bed bug spray would be used to help in the eradication.<br><br>The Temperature Log, received from the Director of Maintenance on 6/29/23 at 11:47 a.m., indicated what rooms had been heat treated with temperature checks every five minutes. There were no dates documented when the treatment occurred and no follow up checks documented to ensure there was no more bed bug activity. Residents F, C, H, J and K's rooms had not been documented as treated with heat for bed bugs.<br><br>2) During a tour of the facility on 6/29/23 from 10:42 a.m. to 11:23 a.m. with the Director of Housekeeping, the following was observed:<br><br>a) There was a large build up of trash, which | | rooms daily against cleaning checklist. Administrator to monitor Housekeeping supervisor against Administrators Master List, 5 times weekly for 60 days, then weekly, ongoing.<br><br>New Maintenance supervisor has a preventative maintenance log including daily, weekly, monthly, semi-annual and annual tasks. Maintenance supervisor responsible for delegating tasks. Administrator to monitor log, weekly, ongoing.<br>Contracting crew including a plumber and electrician have been hired to do repairs throughout the building where necessary. Minor tasks have been completed and room remodeling will be on-going.<br><br>Business Office Manager responsible for assigning rooms to contracting crews. Administrator to monitor progress, weekly, visually ongoing. | |

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| | included smoked cigarette butts behind the closet, multiple bright red blood streaks on the mattress pad (potential for bed bug infestation) on the bed by the door in room 309. The Director of Housekeeping stated at the time of the observation of the floor behind the closet, "that's not good."<br><br>b) There was a broken bathroom floor tile, a hole in the ceiling with brown water stains surrounding the hole, peeling silvering of the mirror, a musty smell with a large of amount of a black substance on the walls and flooring of the bathroom cabinet, which stored mouth wash and facial cleaning cloths in the bathroom of 312. There were mouse droppings on the carpet behind the bedside dressers. The Resident indicated they area behind the dressers had not been cleaned for a long time. The Director of Housekeeping indicated the facility has had "water issues".<br><br>c) There were three brown bugs in a mouse glue trap in room 101.<br><br>d) There was steel wool on the floor next to the wall by the bathroom in room 204. The resident indicated there was a hole in the wall so she shoved steel wool in there to keep the mice out. The base board on the wall by the bathroom door was off.<br><br>e) There was missing and loose base boards on the walls of room 207. The wall under the window had holes and cracks.<br><br>During an interview on 6/29/23 at 12:08 p.m., the Director of Housekeeping indicated there was no check off or form completed when rooms were cleaned. The rooms were to be cleaned from "top to bottom." | | | |

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| | The undated Resident Rules, received from the Administrator on 6/28/23 at 11:48 a.m., indicated the housekeeping staff were responsible for cleaning resident rooms and periodically all rooms must be cleaned thoroughly, which included drawers, closets, etc.<br><br>The undated Housekeeping Job Orientation, received from the Administrator on 6/29/23 at 12:07 p.m., indicated every resident room was to be cleaned daily. A deep cleaning would be completed on one room on every hall per day.<br><br>This State Residential finding relates to Complaints IN00406958 and IN00411179. | | | |
| R 0406<br><br>Bldg. 00 | 410 IAC 16.2-5-12(a)<br>Infection Control - Offense<br>(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.<br><br>Based on observation, record review and interview, the facility failed to ensure a glucometer (blood testing for glucose) testing was completed using a safe and sanitary procedure, related to gloves not worn during the procedure, for 2 of 2 glucometer procedures observed. (Resident L, Director of Nursing, and Employee 3)<br><br>Finding includes:<br><br>During an observation on 6/28/23 at 10:58 a.m., the Director of Nursing (DON) completed a glucometer test on Resident L while standing at the Medication Cart. The resident's finger was | R 0406 | Per CDC recommendations Glucometer testing policy has been revised to provide instruction for staff to wear gloves during testing. Insulin dependent diabetic resident files were reviewed and no residents were affected by not donning gloves. Charge nurses responsible, DON to monitor nurses visually, one time weekly, ongoing. | 07/07/2023 |

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| | pricked with a lancet and the DON then squeezed the finger to obtain enough blood for the testing strip. The DON had not donned gloves for the procedure. At the same time on another Medication Cart, Employee 3 had completed on a glucometer test on another resident and no gloves were donned by Employee 3 for the blood test.<br><br>During an interview at the time of the observation, Employee 3 indicated she had questioned also why gloves were not to be worn during the glucose testing. The DON indicated the facility policy did not say gloves had to be worn.<br><br>During an interview on 6/29/23 at 10:34 a.m., the Administrator questioned why gloves were required with glucometer testing and indicated she was unaware gloves needed to be worn. She indicated the facility policy had been written with the World Health Organization (WHO) recommendations.<br><br>The facility glucometer testing policy received from the Administrator as current and dated 1/23/23 was reviewed on 6/29/23 at 11:22 a.m. The policy lacked instructions for staff to wear gloves during the testing.<br><br>The 2003 Qualified Medication Aide Basic Curriculum, dated 2003, Lesson 60: Diabetic Testing, indicated when performing a blood glucose testing, hand hygiene was to be completed prior to the testing and gloves were to be worn.<br><br>The Centers for Disease Control (CDC), "Infection Prevention during Blood Glucose Monitoring and Insulin Administration", at website CDC.gov, indicated gloves to be worn during blood glucose monitoring and during any other procedure that | | | |

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| | involves potential exposure to blood or body fluids. The gloves were to be changed between resident contact. | | | |