PRINTED: 10/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	X3) DATE SURVEY COMPLETED 09/07/2023	
			B. W			09/07/	
	ROVIDER OR SUPPLIER			4905 M	ADDRESS, CITY, STATE, ZIP COD ELTON RD IN 46403		
		ET A TEMENT OF DEFICIENCIE	T	ID			(V.5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0000							
Bldg. 00	This visit was for a Post Survey Revisit (PSR) to Investigation of Complaints IN00406958, IN00411179, and IN00411636 completed on		R 0000				
	6/29/23.						
	Complaint IN00406	958 - Not corrected					
	Complaint IN00411	179 - Not corrected					
	Complaint IN00411	636 - Corrected					
	Survey date: 9/7/23	3					
	Facility number: 00	01140					
	Residential Census:	135					
	This State Residenti accordance with 410	ial Finding is cited in 0 IAC 16.2-5.					
	Quality review com	pleted on 9/12/23.					
R 0144	410 IAC 16.2-5-1.	• •					
Bldg. 00	(a) The facility sha a state of good rep	fety Standards - Deficiency all be clean, orderly, and in pair, both inside and out, reasonable comfort for all					
	Based on observation interview, the facility environment related apartments, holes are bathroom ceiling, mr in and beside a bath silvering chipping of bathroom tile, holes	on, record review, and ty failed to maintain a sanitary I to cleanliness of residents' and water damage of a musty odor and black substance room cabinet, a mirror with the off, missing base board, broken in the wall, and bugs in a for 4 of 5 rooms observed.	R 0	144	Closets throughout the facility were moved away from the wa and cleaned behind. Cleaning behind closets has been adde the housekeeping internal clear checklist. Housekeeping staff been inserviced on the imports of using the internal cleaning check list. Housekeeping staff	d to aning has ance	10/13/2023
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	3	TITLE		(X6) DATE

January Szweda Administrator 09/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays 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.

State Form Event ID: GV3J12 Facility ID: 001140 If continuation sheet Page 1 of 3

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	JILDING	onstruction 00	(X3) DATE COMPL 09/07/	ETED	
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE			STREET ADDRESS, CITY, STATE, ZIP COD 4905 MELTON RD GARY, IN 46403					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	(Rooms 309, 312, 1) Findings include: During a tour of the	01, and 204) facility on 9/7/23 from 9:52			responsible for moving closets cleaning behind them. Housekeeping supervisor to monitor visually, weekly; ongo	ing.		
	a.m. to 10:17 a.m. with the Director of Housekeeping, the following was observed:				Leaking toilet pipe and hole in the ceiling in the bathroom of room 312 have been repaired and ceiling			
	a) There was a large build up of trash behind the closet in room 309. Maintenance 1 indicated the area had not been cleaned.				painted. Floor tiles and mirror throughout the facility have be inspected by newly assigned housekeeping/maintenance			
	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				employee. Floor tiles have been repaired/replaced as necessary and anymirrors with peeling silver have been removed and discarded.			
	smell with a large of amount of a black substance on the walls and flooring of the bathroom cabinet and in the back corner on the floor tiles next to the cabinet, in the bathroom of 312. The Director of Housekeeping acknowledged the observation.				Bathroom cabinet in room 312 been replaced and bathroom I been deep cleaned. Bathroom throughout the facility have be	! has nas is		
	c) There was a mouse glue trap under the dresser in room 101, which contained had two small spiders and four unidentified bugs. Maintenance 2 identified the four bugs as Dominican roaches.				inspected and repaired and cleaned as needed. Newly assigned housekeeping/maintenance employee responsible for chec	cking		
	in the wall by the baboard on the wall by	wool on the floor next to a hole athroom in room 204. The base of the bathroom door was off. usekeeping acknowledged the			rooms for needed repairs and either repairing himself or repo needed repairs to maintenanc supervisor. Housekeeping supervisor to monitor rooms	•		
	9/7/23 at 10:23 a.m	with the Administrator on , she indicated they were			visually, daily; ongoing. Glue traps throughout the faci are checked daily and replace needed. Newly assigned	•		
	unaware there was a other traps were bei				housekeeping/maintenance employee responsible for ched and replacing glue traps. Maintenance Supervisor to ma	· ·		
		6958 and IN00411179.			visually, daily; ongoing.			

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	X3) DATE SURVEY COMPLETED 09/07/2023		
NAME OF PROVIDER OR SUPPLIER MILLER BEACH TERRACE			STREET ADDRESS, CITY, STATE, ZIP COD 4905 MELTON RD GARY, IN 46403				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	This State Residential finding was cited on 6/29/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			Steel wool has been removed the hole in the bathroom was room 204 has been repaired. Residents have been instruct not to use steel wool. Bathroughout the facility have inspected and repaired as not not not to use steel wool. Bathroughout the facility have inspected and repaired as not	official in discrete		

State Form Event ID: GV3J12 Facility ID: 001140 If continuation sheet Page 3 of 3