STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/13/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00362253 and IN00364103. Complaint IN00362253 - Substantiated. State deficiencies related to the allegations are cited at R0217. Complaint IN00364103 - Substantiated. State deficiencies related to the allegations are cited at R0349. . Survey date: 1/13/2022 Facility number: 001140 Residential Census: 128 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/18/22.	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and			

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

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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	revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure the Service Plan was updated to reflect the resident's status related to related to refusal of care, medications, and behaviors for 1 of 6 records reviewed. (Resident C) Finding includes: The record for Resident C was reviewed on 1/13/22 at 10:28 a.m. Diagnoses included, but were not limited to, Schizoaffective disorder and anxiety disorder. A review of the Medication Administration Records, dated September 2021 through December 2021, indicated the resident refused her medications 64 times in that time period. Interview with the Director of Nursing (DON) on 1/13/22 at 1:00 p.m., indicated the resident refuses care, refuses her medications, and slides herself to the floor from her bed. Review of the resident's Service Plan at that time, did not indicate that the	R 0217	New Director of Nursing will complete new Service Care Plans on residents to include problematic behaviors. Nurses will be inserviced on correct use of updating Service Care Plans. Charge Nurse responsible for updating Service Care Plan as needed. DON will monitor Care Plans monthly; ongoing	02/01/2022

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	resident refuses care or medications, or that the resident slides herself to the floor. The DON indicated that the Service Plan should be updated to reflect the resident's current care status. This State Residential finding relates to Complaint IN00362253.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical record was complete and accurately documented related to a gun shot wound, a resident altercation with staff, and a swollen ankle for 3 of 6 residents reviewed. (Residents F, E, and G) Findings include: 1. The record for Resident F was reviewed on 1/13/22 at 10:10 a.m. Diagnoses included, but were not limited to, major depression and arthritis. A Nurses' Note, dated 10/4/21 at 1:37 p.m., indicated the resident returned from the hospital after a gunshot wound. New orders were received and carried out. The resident denied pain or discomfort and had 4 dressings to the abdomen. There was no nursing documentation prior to	R 0349	Nurses have been inserviced, again, on the importance of documentation. Nursing staff has been instructed to document facts, not rumors. When nursing has conversation with outside personnel/contractors conversation and response shall be entered into nurses notes. Unusual occurrence reports were reviewed for the past thirty (30) days. No other deficiencies in charting were noted. Nurses responsible for correct charting. DON to monitor and review change of condition charting as necessary; ongoing.	01/28/2022

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10/4/21 indicating the resident was shot.

The hospital history and physical, dated 10/1/21 at 9:38 p.m., indicated the resident was admitted to the emergency room with a gunshot wound to the abdomen.

An IDOH incident report, dated 10/2/21, indicated the resident had walked to the gas station next door and 2 cars begun shooting at each other and the resident was struck in the abdomen.

There was no documentation in the resident's clinical record of the gunshot wound to the abdomen.

Interview with the Director of Nursing on 1/13/22 at 10:25 a.m., indicated the resident and another resident walked next door to the gas station. While there, 2 cars started shooting at each other and Resident F was shot in the abdomen. The resident did not return to the facility and went straight to the hospital. Other residents who saw what had happened came back to the facility to report the incident. The nurse on duty should have documented in nursing progress notes what had happened and the resident was sent to the hospital. There was no documentation in nursing notes of the incident on 10/1/21.

2. The record for Resident E was reviewed on 1/13/22 at 11:05 a.m.

A Medical Diagnostic Services form, dated 9/22/21, indicated an X-ray was completed for the left hand. The impression and results indicated there was no acute fracture or dislocation and mild soft tissue swelling of wrist and palm of hand.

Nurses' Notes, dated 9/22/21 at 1:08 p.m.,

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	indicated the resident appeared to be intoxicated and the medications were held. The next documented entry in Nurses' Notes was dated 9/29/21 at 9:43 p.m., which indicated an antibiotic was initiated for skin issues of swelling of the left thumb, which was decreasing. There was no documentation on 9/22/21 of left hand or wrist swelling. A Medical Diagnostic Services form, dated 10/25/21, indicated an X-ray of the left knee, tibia and fibula for pain after a fall. The impression for the left knee was mild soft tissue swelling with no evidence of recent fracture or dislocation and the left tibia and fibula was mild soft tissue swelling with no evidence of recent fracture or dislocation. A Nurses' Note, dated 10/14/21 at 11:16 a.m., indicated "Antibiotic/skin completed. No noted adverse reactions. Afebrile" The next documented Nurses' Note was on 11/24/21 at 8:48 p.m., which indicated an antibiotic was initiated for skin. There was no documentation on 10/25/21 indicating the resident had a fall or a swollen left leg and knee. Interview with the Director of Nursing on 1/13/22 at 12:15 p.m., indicated there should have been documentation in nursing notes of information regarding both X-rays and an assessment of the resident's hand and leg. 3. The record for Resident G was reviewed on 1/13/22 at 11:30 a.m.			

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	An incident report, dated 1/7/22, indicated an employee was called to downstairs to 300 hallway between female residents who were arguing. The facility's policy indicated residents were not allowed to visit in rooms after 4 p.m. He cleared the residents out of the room and a male resident who appeared to be high on an unknown substance visiting the room, proceeded to punch the employee in the face, head butted him and bit him. The employee left the area and went to the dining room, however, the resident chased him to the dining room, and dietary staff intervened and held the resident back. The incident happened on 1/5/22 and reported to the State Agency on 1/7/22. Nurses' Notes, dated 1/5/22 at 8:53 p.m., indicated "ME." (mistaken entry) There were no Nurses' Notes recorded for 1/5/22 regarding the altercation with the resident and the employee. Interview with Director of Nursing on 1/13/22 at 12:00 p.m., indicated there was no documentation of the incident at all in the nursing progress notes. She indicated the nurse had called her about the incident the night it happened and she was documenting things, she did not know if they were true or not and instructed her to only document what actually happened, just the facts, however, that was not completed. This State Residential finding relates to Complaint IN00364103.			