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	03/30/2023

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 Complaints IN00401275, IN00401216, IN00401399, IN00404388, and IN00404660. Complaint IN00401275 - No deficiencies related to the allegations are cited. Complaint IN00401216 - No deficiencies related to the allegations are cited. Complaint IN00401399 - No deficiencies related to the allegations are cited. Complaint IN00404388 - State deficiency related to the allegations is cited at R0349. Complaint IN00404660 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: March 29 and 30, 2023 Facility number: 001140 Residential Census: 139 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/6/23.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
January Szweda	Administrator	05/04/2023

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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	or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to protect a resident's right to be free from misappropriation of resident property related to missing medications for 3 of 7 residents reviewed for misappropriation of property. (Residents K, L, and M) Findings include: 1. Interview with the Administrator and DON on 3/29/23 at 10:25 a.m., indicated LPN 1 had been suspended since 3/22/23 due to allegations of missing medications. The Administrator was still completing the investigation at this time. She had not called the police or filed a state reportable regarding the situation as she was still investigating what had happened with the missing medications. On 3/4/23, an oncoming nurse refused to work after LPN 1 after the medication count at the beginning of the shift was inaccurate. The Director of Nursing (DON) was informed about the medication count being incorrect and she had LPN 1 correct it. LPN 1 indicated at the time that the medication was dropped on the floor and she forgot to write that it was wasted. On 3/18/23 a tramadol (narcotic pain medication) medication punch card was missing along with the corresponding narcotic count sheet. The DON was immediately contacted. At that time, the Administrator was on vacation and the DON did not feel as though she could suspend the staff member until the Administrator was back in the building. 2. On 3/29/23 at 2:45 p.m., the DON provided Resident K's hydrocodone-acetaminophen	R 0064	Resident Narc sheets and cards were audited; no other residents were affected Nurses were re-inserviced on the importance of auditing Narc count sheets and cards to ensure they are the same number at 3 pm shift change Nurses responsible for audits DON to monitor daily, five (5) times weekly, ongoing	04/01/2023

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	(narcotic medication) 5-325 milligram tablet narcotic count sheet and indicated the count sheet was off on 3/4/23. On 3/3/23 at 8:00 p.m., the amount remaining was 24. On 3/4/23 at 8:00 p.m., the amount remaining was 20. The DON then spoke with LPN 1 once she was aware of the discrepancy and LPN 1 had indicated that on 3/1/23 at 4 p.m., a tablet was dropped and was not given to the resident, but there was no documentation regarding the 4 pills missing between 3/3/23 and 3/4/23. 3. On 3/29/23 at 2:45 p.m., the DON provided Resident L's alprazolam (anxiety medication) 0.5 milligram count sheet which indicated the resident had 56 tablets left. The medication card had 48 pills left. She was unable to provide documentation of the 8 missing tablets. 4. On 3/29/23 at 2:45 p.m., the DON provided an Investigation Report, which indicated LPN 2 had received a card of 30 tabs of tramadol for Resident M on 3/15/23. On 3/16/23 the tramadol was still in the cart and was full with a count sheet present. On 3/18/23, the entire medication card and count sheet was missing. The DON was contacted at that time. Interview with the DON at that time, indicated she was unable to locate documentation related to the missing tramadol medication card and count sheet.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four			

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	(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: (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			

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	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 a report was filed with the Indiana Department of Health (IDOH) after becoming aware of an unusual occurrence related to misappropriation of residents' medications. (Residents K, L, and M and LPN 1) Findings include: 1. Interview with the Administrator and Director of Nursing (DON) on 3/29/23 at 10:25 a.m., indicated there was a drug diversion that they were aware of in the facility. They became aware of the situation on 3/4/23 and the investigation was still in progress. A staff member had reported a narcotic count sheet for Resident K's hydrocodone-acetaminophen 5-325 mg tablet was inaccurate after LPN 1's shift was completed on 3/4/23. There were four pills not accounted for on the narcotic count sheet. The DON was informed immediately on 3/4/23. Upon reviewing all narcotics during an audit, the DON discovered Resident L's alprazolam (anxiety medication) 0.5 mg tablet count sheet indicated there were 56 pills left on 3/4/23. The medication card was reviewed and contained 48 pills. She was unable to find documentation accounting for the 8 missing pills. Per the Investigation Report on 3/18/23, LPN 2 reported Resident M's tramadol (narcotic medication) 50 mg tablet medication card, which contained 30 pills, was unable to be found as well as the narcotic count sheet. She had received the medication card on 3/15/23 and it was in the medication cart on 3/16/23 when she had worked. 2. On 3/29/23 at 2:45 p.m., the DON provided	R 0090	Resident Narc sheets have been audited; no other residents have been affected Supervisors have been re-inserviced on the parameters of unusual occurrences and reporting to administrator at the time of occurrence Administrator responsible for, at the onset of an investigation regarding misappropriation of medication, contacting the IDOH, IPLA and police DON and Office Manager will monitor that Administrator has followed proper reporting guidelines.	04/01/2023

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	Resident K's hydrocodone-acetaminophen (narcotic medication) 5-325 milligram tablet narcotic count sheet and indicated the count sheet was off on 3/4/23. On 3/3/23 at 8:00 p.m., the amount remaining was 24. On 3/4/23 at 8:00 p.m., the amount remaining was 20. The DON then spoke with LPN 1 once she was aware of the discrepancy and LPN 1 had indicated that on 3/1/23 at 4 p.m., a tablet was dropped and was not given to the resident, but there was no documentation regarding the 4 pills missing between 3/3/23 and 3/4/23. 3. On 3/29/23 at 2:45 p.m., the DON provided Resident L's alprazolam (anxiety medication) 0.5 milligram count sheet which indicated the resident had 56 tablets left. The medication card had 48 pills left. She was unable to provide documentation of the 8 missing tablets. 4. On 3/29/23 at 2:45 p.m., the DON provided an Investigation Report which indicated LPN 2 had received a card of 30 tabs of tramadol for Resident M on 3/15/23. On 3/16/23 the tramadol was still in the cart and was full with a count sheet present. On 3/18/23, the entire medication card and count sheet was missing. The DON was contacted at that time. A follow-up interview with the DON and the Administrator on 3/29/23 at 2:45 p.m., indicated they had not suspended LPN 1 until 3/22/23 due to the DON and Administrator being on vacation. They had not filed a report to the Indiana Department of Health (IDOH) or filed a police report until 3/29/23 as they were still investigating the missing medications. They were waiting to submit a report until the investigation was completed. The Administrator indicated misappropriation of property should have been			

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	reported within 24 hours of knowledge of the occurrence.			
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 manage medications appropriately related to administering medications as ordered for 3 of 3 residents reviewed for unnecessary medications. (Resident B, C, and E) Findings include: 1. Resident B's record was reviewed on 3/29/23 at 11:16 a.m. Diagnoses included, but were not limited to, schizophrenia. The Semi-annual Assessment, dated 2/10/23, indicated the resident had no disorientation or confusion and was independent for all activities of daily living (ADLs). The March Physician's Order Summary (POS) indicated orders for the following: - aripiprazole (antipsychotic medication) 20 milligram (mg) one tablet by mouth daily - trazodone (antidepressant medication) 150 mg one tablet by mouth at bedtime The March 2023 Medication Administration	R 0349	LPN1 has been terminated MARs were audited; no other residents were affected LPN's were re-inserviced on proper MARs documentation DON will continue to monitor MARs daily, five (5) times weekly, ongoing Charge nurses will monitor each other when DON is on vacation	04/01/2023

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	Record (MAR) indicated the medications were not signed off as given on the following dates and times: - aripiprazole 20 mg tablet was not signed out as administered on 3/12/23 and 3/13/23 at 8:00 a.m. - trazodone 150 mg tablet was not signed out as administered on 3/17/23 at 8:00 p.m. Interview with the Administrator and Director of Nursing on 3/29/23 at 2:39 p.m., indicated LPN 1 was working on the morning of 3/12/23 and 3/13/23 as well as the evening shift on 3/17/23. They could not provide any documentation the medications were signed out as given. 2. Resident C's record was reviewed on 3/29/23 at 1:48 p.m. Diagnoses included, but were not limited to, diabetes mellitus. The March 2023 Physician's Order Summary (POS) indicated orders for the following: - aspirin 81 milligram (mg) chewable tablet one time a day - atorvastatin 20 mg tablet once a day - citalopram 40 mg tablet once a day - glipizide 5 mg tablet two times a day - humulin 100 units/milliliter twice a day per sliding scale - metformin 1000 mg tablet twice a day - tamsulosin 0.4 mg capsule once a day The March 2023 Medication Administration Record (MAR) indicated the following medications were not signed off as given on the following dates and times: - On 3/12/23 and 3/13/23 at 8:00 a.m., the aspirin was not marked as given - On 3/17/23 at 8:00 p.m., the atorvastatin was not marked as given - On 3/12/23 and 3/13/23 at 8:00 a.m., the			

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	citalopram was not marked as given - On 3/12/23 and 3/13/23 at 8:00 a.m. and 3/17/23 at 4:00 p.m., the glipizide was not marked as given - On 3/12/34 at 8:00 a.m. and 3/13/23 at 8:00 a.m., and 3/17/23 at 4:00 p.m., the humulin was not marked as given - On 3/12/23, 3/13/23 at 8:00 a.m., and 3/17/23 at 4:00 p.m. the metformin was not marked as given - On 3/12/23 and 3/13/23 at 8:00 a.m., the tamsulosin was not marked as given Interview with the Administrator and the Director of Nursing on 3/29/23 at 2:39 p.m., indicated LPN 1 was working on the morning of 3/12/23 and 3/13/23 as well as the evening shift on 3/17/23. They could not provide any documentation the medications were signed out as given. 3. Resident E's record was reviewed on 3/29/23 at 2:30 p.m. Diagnoses included, but were not limited to, schizophrenia and hypercholesterolemia. The March 2023 Physician's Order Summary (POS) indicated orders for the following: - haloperidol (antipsychotic medication) 5 mg (milligrams) every day - meloxicam (non-steroidal anti-inflammatory drug) 15 mg every day - sertraline (depression medication) 50 mg every evening - simvastatin (cholesterol medication) 20 mg at bedtime The March 2023 Medication Administration Record (MAR) indicated the medications were not signed off as given on the following dates and times: - On 3/12/23 and 3/13/23 at 8:00 a.m., the haloperidol and meloxicam were not marked as			

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	given - On 3/17/23 at 8:00 p.m., the sertraline and simvastatin were not marked as given Interview with the Administrator and Director of Nursing on 3/29/23 at 2:39 p.m., indicated LPN 1 had worked on the above days and times. They could not provide any documentation the medications were signed out as given. This state residential finding relates to Complaint IN00404388.			