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	06/05/2024

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 IN00433832 and IN00434652. This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR completed on 3/18/24 to the PSR completed on 1/4/24 to the State Residential Licensure Survey and the Investigation of Complaints IN00415971, IN00418339, IN00419781, IN00419985, and IN00420052 completed on 10/26/23. This visit was in conjunction with the PSR to the PSR completed on 3/18/24 to the Investigation of Complaints IN00421616, IN00424246, and IN00425117 completed on 1/4/24. Complaint IN00433832 - State deficiencies related to the allegations are cited at R0349. Complaint IN00434652 - State deficiencies related to the allegations are cited at R0243. Complaint IN00415971 - Corrected. Complaint IN00418339 - Corrected. Complaint IN00419781 - Corrected. Complaint IN00419985 - Corrected. Complaint IN00420052 - Corrected. Complaint IN00421616 - Corrected. Complaint IN00424246 - Corrected. Complaint IN00425117 - Corrected.	R 0000		

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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	Survey date: June 5, 2024 Facility number: 001140 Residential Census: 128 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/10/24.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, record review, and interview, the facility failed to ensure medications ordered by the Physician or Nurse Practitioner (NP) were given as ordered for 1 of 3 residents reviewed for hospitalization. (Resident C) Finding includes: During a random observation on 6/5/24 of Resident C's room at 9:30 a.m., there was a small box that was closed in a corner by the bed . The outside of the box indicated it was a nebulizer machine. The box was opened and the machine was still in the plastic wrap, sealed and had not been used. The record for Resident C was reviewed on 6/.5/24	R 0243	Due to a deliberate pharmacy over-sight, certain medications were not added to the MAR, yet the medications were in the facility, administered with hand written MAR and was shown to surveyor on June 05, 2024. Any resident that visits an outside doctor and receives new orders, per our policy, the orders and/or prescriptions are clarified with our medical director and documented. Nursing staff and office staff have been re-inserviced on the importance of communication and documentation regarding new orders. Genoa pharmacy is the	06/21/2024

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	at 10:45 a.m. Diagnosed included, but were not limited to COPD, and a history of myocardial infarction. A Service Plan, dated 1/15/24, indicated the resident frequently refused to use inhalers and the nebulizer treatments. Staff were to administer his medications. The resident could demonstrate proper use of the nebulizer/inhaler and may keep them both at the bedside. A Respiratory Evaluation was completed on 1/15/24, which indicated the resident could demonstrate correct use of the nebulizer and/or the inhaler and may keep it at the bedside. An After Visit Summary from an outside clinic, dated 3/6/24, indicated the NP had added the medication of Carvedilol (a medication to slow the heart rate) 12.5 milligrams (mg) take 1 tablet two times a day. Physician's Orders, dated 3/15/24 indicated Carvedilol 12.5 mg, 1 table two times a day. The medication was not ordered until 9 days after the initial clinic visit. Physician's Orders, dated 4/5/24, indicated the medications of Carvedilol 12.5 mg, Donepezil (a medication used to increase memory) 5 mg, Losartan (a medication used to treat high blood pressure) 50 mg, Sertraline (an antidepressant medication) 25 mg, and Vitamin D2 50,000 units weekly were all to be discontinued. An After Visit Summary from an outside clinic, dated 4/12/24, indicated the NP had reordered all the above medications and to start taking Hydralazine (a medication used to treat high blood pressure) 10 mg three times a day.		residents new pharmacy of choice. Resident MARs were audited and any pharmacy errors were corrected through new pharmacy. Charge nurses responsible for checking new orders. Charge nurses re-inserviced on the importance of correctly checking and documenting new orders. DON to monitor new orders weekly. DON and pharmacy consultant to monitor charts quarterly; ongoing for 100% compliance.	

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	The Medication Administration Record (MAR) for 4/2024 indicated the last dose of the Carvedilol 12.5 mg, the Donepezil 5 mg, the Losartan 50 mg, and the Sertraline 25 mg was on 4/7/24. The last dose of the Vitamin D2 50,000 units weekly was on 4/1/24. An After Visit Summary from a Physician's visit, dated 4/19/24, indicated the resident was to start taking Hydrochlorothiazide (a medication used to treat high blood pressure) 25 mg every 8 hours, Losartan 50 mg, Sertraline 25 mg, Furosemide (a diuretic medication) 20 mg daily. The 4/2024 MAR indicated the Hydrochlorothiazide 25 mg every 8 hours, Losartan 50 mg, Sertraline 25 mg, Furosemide 20 mg daily were not administered to the resident from 4/19-4/30/24. The resident was admitted to the hospital on 5/3/24 for exacerbation of COPD and acute respiratory failure. The After Visit Summary, dated 5/6/24, indicated the resident was to start taking Ipratropium Albuterol 0.5-2.5 (3) mg/3 ml nebulizer treatments every 6 hours while awake. The resident was to stop taking the Furosemide 20 mg and the Hydralazine 10 mg. The resident was to continue taking the Hydrochlorothiazide 25 mg every 8 hours, Losartan 50 mg, and Sertraline 25 mg. The 5/2024 MAR indicated the Hydrochlorothiazide 25 mg every 8 hours, Losartan 50 mg, Sertraline 25 mg, and the Ipratropium Albuterol 0.5-2.5 (3) mg/3 ml nebulizer treatments every 6 hours while awake were not transcribed onto the MAR, so the resident did not receive any of those medications.			

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Physician's Orders, dated 5/13/24, indicated the Carvedilol was changed to 6.25 mg twice a day.

The resident was admitted to the hospital on 5/15/24 and returned on 5/20/24. The resident was hospitalized for exacerbation of COPD. An After Visit Summary, dated 5/20/24, indicated the resident was to start Pulmicort 0.5 mg/2 ml nebulizer treatments twice a day and to stop taking the Sertraline 25 mg and Isosorbide (a medication used to increase blood flow to the heart) 30 mg daily. The resident was to change how he took the Losartan 50 mg, now in the a.m., and the Hydrochlorothiazide 25 mg, daily in the a.m. The resident should continue to take Ipratropium Albuterol 0.5-2.5 (3) mg/3 ml nebulizer treatments every 6 hours while awake.

The 5/2024 MAR indicated the Pulmicort 0.5 mg/2 ml nebulizer treatments twice a day was never added to the MAR, therefore, the resident did not receive it. The Isosorbide 30 mg daily was signed out as being administered 5/25-5/27, 5/29 and 5/31/24. The Losartan 50 mg in the a.m. and the Hydrochlorothiazide 25 mg daily in the a.m. were never added to the MAR, therefore the resident did not receive the medication. The Ipratropium Albuterol 0.5-2.5 (3) mg/3 ml nebulizer treatments every 6 hours while awake was still not on 5/2024 MAR.

There was no documentation in Nursing Progress Notes of why the medication was not initiated, discontinued, and Physician's Orders were not followed.

During an interview on 6/5/24 at 11:00 a.m., the Director of Nursing (DON) indicated the resident was going out and seeing too many NP's and

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	Physicians. Every time he would come back with new orders and she would always call the Medical Director and ask him what medications he should be on, and go with what he said, regardless of the what new medications were ordered by other providers. During an interview on 6/5/24 at 2 p.m., the DON indicated they had to switch pharmacies during the week of 5/20/24 and that pharmacy indicated they would supply all medications through 5/27/24, however, they did not. The old pharmacy continued to drop medications off of the MAR and not send medications as well. During an interview at the same time, the Administrator indicated the pharmacy told the facility they owed them money and they did not, so a lot of things were going on with medications not being delivered and the pharmacists would never come to the facility. This citation relates to Complaint IN00434652.			
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 clinical records were complete related to an admission assessment for 1 of 3 residents reviewed for Admission, Transfer and	R 0349	Nursing and office staff have been in-serviced on the importance of documentation and communication.	06/21/2024

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	Discharge. (Resident B) Finding includes: The record for Resident B was reviewed on 6/5/24 at 11:48 a.m. Diagnoses included, but were not limited to, anxiety, recent myocardial infarction, depression, and diabetes. The resident was discharged from the facility on 9/21/23 to jail as he was arrested. There were Physician's Scripts, dated 4/24/24, from the local hospital for new medications. There was no Admission Nursing Note, or an assessment of the resident on 4/24/24. During an interview on 6/5/24 at 10:00 a.m., the Director of Nursing indicated the resident was discharged last year because he was picked up by the police for robbing all of the stores around the facility and he went back to jail. While in jail, he must have had heart issues, because he was admitted to the local hospital and had open heart surgery. While she was on vacation, the nurse on duty readmitted him back to the facility on 4/24/24 after he had just had open heart surgery. The resident was admitted with a wound vac to a chest tube site, all of the post surgical bandages including the staples, and a defibrillator that had to be hooked up every night. She indicated that nurse had called her while on vacation, and she could not take the call due to being out of town, so she ended up calling her back hours later and was told by the staff nurse what had happened. The staff nurse told the DON the resident was admitted with all the above items and asked the nurse to change one of his bandages because it was falling off, that staff nurse told him she could		Discharge charts were audited to ensure they are complete. No other charts were found to be incomplete. In-serviced staff responsible for documentation. Administrator and DON to monitor documentation weekly; for six months, for 100% compliance.	

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	not do that, he got upset and called 911 and was taken back to the hospital. The DON told that staff nurse, he should have never been admitted to the facility because they could not take care of him and it was out of their scope of being a residential facility. On the following Monday, when the DON came back to work, the hospital called and wanted to send the resident back, the DON refused, indicating they could not take care of the resident, it was too high of level of care, however, the Social Service person would not listen to her. The resident was only in facility a very short time, no medications or orders were ever put in the computer, and he only came there with items from the hospital, and all of that was sent back with him. The DON indicated she did not have the staff to take care of any resident like that, and there would be no one on the night shift to even monitor him. She tried explaining that to the hospital but again they would not listen. There was no documentation of the resident even being in the facility on 4/24/24 in his clinical record. During an interview on 6/5/24 at 1:30 p.m., the Administrator indicated she got a phone call from the hospital indicating they were ready to send the resident to them. She indicated she was not aware he was coming back to the facility and the person on the phone told her they had already spoken to the DON 2 weeks ago and she said it was okay for him to come back. The hospital told her the resident was shown how to do the defibrillator and look after his wound vac, and assured her he was going to see the Physician next week and all of those things would be removed. At that time, she agreed to have him come back, so she texted the DON and informed her of all of this and DON indicated she did not give the OK to send him back. The Administrator			

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	immediately called the hospital back and no one would speak to her. By that time, the resident had arrived so she informed the nurse to just keep him if he knew what to do. She indicated within 2 hours of him being here, he walked to the nurse and asked her to change his bandage that was falling off, she told him she could not do that so he swore at her and called 911 to come back and pick him up and take him back to the hospital. This citation relates to Complaint IN00433832.			