Neysa

PRINTED: 01/30/2023 FORM APPROVED OMB NO. 0938-039

01/25/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/10/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
Bldg. 00	IN00390158, IN003 Complaint IN00390 deficiencies related Complaint IN00391 deficiencies related Complaint IN00395 deficiencies related R0144 and R0147.	the Investigation of Complaints 191087, and IN00395018.  1158 - Substantiated. No to the allegations are cited.  1087 - Substantiated. No to the allegations are cited.  1018 - Substantiated. State to the allegations are cited at	R 0000	January 25, 2023  Brenda Buroker, Director of Long-Term Care Indiana Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006	n		
	Survey date: Januar Facility number: 01 Residential Census: These State Resider accordance with 410 Quality review com	3801 104 atial Findings are cited in 0 IAC 16.2-5.		Please reference the enclose 2567L as "Plan of Correction the January 10,2023 State Resid Licensure Survey (IN003950 that was conducted at Silver of Hammond. I will submit signature sheets of the in-servicing, content of in-ser and audit tools January 25,20 Preparation and / or executio this plan of correction does n constitute admission or agree by the provider of the truth fa alleged or conclusion set fort the statement of deficiencies plan of correction is prepared or executed solely because it required by the provision of the Federal State Laws. This fact appreciates the time and dedication of the Survey Tea	" for lential 18) Birch  vice 023. on of ot ement cts h in . This d and / t is he cility		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE		

Any defiency statement 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.

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Stewart

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	a. Building <u>00</u>		00	COMPLETED	
					01/10/	2023	
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			OHL AVENUE		
OII VED I	BIRCH OF HAMMO	ND					
SILVER	SIRCH OF HAIVING	ind		HAIVIIVIC	OND, IN 46320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	,	TAG	DEFICIENCY)		DATE
					facility will accept the survey a	s a	
					tool for our facility to use in		
					continuing to better our Elders	in	
					our community.		
					The Plan of Correction submit	tad	
					on January 25,2023 serves as		
					allegation of compliance. The	Oui	
					provider respectfully request a		
					Desk Review on or after		
					February 3, 2023. Should you		
					have any question or concerns		
					regarding the Plan of Correction		
					please contact me.	,,,	
					produce contact me.		
					Respectfully,		
					Neysa Holman Stewart, HFA		
D 0144	440 140 400 5 4	F(a)					
R 0144	410 IAC 16.2-5-1.	• •					
Dida oo		fety Standards - Deficiency					
Bldg. 00		all be clean, orderly, and in					
		pair, both inside and out,					
	-	reasonable comfort for all					
	residents.	on and interview, the facility	D 01.4	4	Cilver Direk of Harris and		02/02/2022
		•	R 014	4	Silver Birch of Hammond		02/03/2023
		sanitary environment, related			Diagon accept the fallenting of	tho	
		rtons, dirt, carpet stains, toilet the floor in a resident's			Please accept the following as	ine	
	· ·				facility's credible allegation of		
	apartment. (Resider	n ()			compliance. This plan of	<b></b>	
	Finding includes:				correction does not constitute		
	Finding includes:				admission of guilt or liability by		
	Duning on abase	on of Davidant Glama are with			facility and is submitted only in	I	
	During an observati	on of Resident G's room with			response to the regulatory		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/10/2023			
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF HAMMOND			STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
	p.m., there were sty juice containers, dir	sing (DON) on 1/10/23 at 2:46 rofoam food containers, empty t, and trash on the tiled floor. e room had a black substance		requirement. R 144			
	The carpeting of the in several areas of t seat was stained. T unkempt appearance During an interview Executive Director cleaned on Friday a cleaned weekly.	e room had a black substance he carpeting, and the toilet he DON acknowledged the		What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice; Resident#G's apartment was immediately cleaned and sanitized. Housekeeping was educated regarding notifying Executive Director & Environmental Service Manasthe need of additional housekeeping service due to condition of apartment after weekly cleaning. Resident was re-educated regarding "Resident was re-educated regarding "Resident was re-educated regarding and Regulation Attachin 4" of the lease regarding disp of trash in the proper recepta by the Executive Director and Environmental Service Manasth 1/10/23. No other residents was affected by the deficient practice and what corrective action will be taken; All residents residing in the community are at risk for this	s the ger of as dent ment osal cle l ger on vere tice.		
				alleged deficient practice. To identify other residents having potential to be affected by the	g the		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
			B. WING		01/10/2023	
		l .	CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		OHL AVENUE		
SILVER	BIRCH OF HAMMO	ND		OND, IN 46320		
OIL VER I			I IAIVIIVI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				same deficient practice, the E	SM	
				and Housekeepers completed	а	
				community sweep of apartme	nts	
				to ensure cleanliness.		
				What measures will be put into		
				place or what systemic chang		
				will be made to ensure that the		
				deficient practice does not rec	eur;	
				On 1/10/23 Resident#G		
				housekeeping service was		
				increase to twice a week.		
				Housekeeping will monitor		
				resident apartment for the nee		
				additional housekeeping servi	ces	
				and notify the Environmental		
				Service Manager of the need	for	
				increase services.		
					20.1	
				How the corrective action(s) w		
				monitored to ensure the defici		
				practice will not recur, i.e., wh		
				quality assurance programs w	iii de	
				put into place;		
				The Environmental Service		
				Manager or Designee will insp		
				Resident#G's apartment once		
				week for 3 months to ensure t		
				apartment is maintain in a clea		
				and orderly condition. Any iss		
				will be addressed immediately	'· [	
				The audits will be discussed		
				during our monthly QI meeting	) tor	
				trends, patterns and areas of		
				concern. QI committee will		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/10/2023
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
SILVER I	BIRCH OF HAMMC	ND		OND, IN 46320	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				determine if continued auditin necessary once 100% compli threshold is achieved for three consecutive months. This plate be amended when indicated.  Date by which systemic corrections will be complete.	ance e an to
R 0147 Bldg. 00	(d) The facility sha safety standards, rules of the state it safety commission applicable to heal Based on observation interview, the facility safety standards relimidicators he had be (Resident G)  Finding includes:  During a confidentiat 2:29 p.m., it was been smoking in his During an observation the Director of Nump.m., there were five carpeting of the floot the tiled floor. In the from a cigarette local control of the safety standards and the safety standards are safety standards.	fety Standards - Deficiency all comply with fire and including the applicable fire prevention and building in (675 IAC) where the facilities.  In record review, and ty failed to comply with fire and atted to a resident with een smoking in his apartment.  all resident interview on 1/10/23 reported that Resident G had a sapartment.  Sion of Resident G's room with sing (DON) on 1/10/23 at 2:46 re cigarette butts found on the for and one cigarette butt on rebathroom there were ashes atted on the floor.	R 0147	Silver Birch of Hammond  Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only i response to the regulatory requirement.  R 147  What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; Resident #G was immediatel	02/03/2023 s the an y the n
		d he could not recall how the n his room and on the floor		re-educated regarding the no smoking policy noted in his le	ase

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/10/2023
NAME OF I	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP COD	
SILVER BIRCH OF HAMMOND				OND, IN 46320	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	COMPLETION DATE
		n smoking in his room.		and was given a smoking was letter. Resident #G's apartm	ent
	to go outside to sm	I the resident was aware he had		floor / carpet was cleaned of cigarette butts and ashes. N	
	to go outside to sin	oke.		other residents were affected	
	_	ent, dated 11/12/23 and		the deficient practice.	
		Executive Director as current,			
		ng or vaping would be allowed as or in the apartments.		How the facility will identify	,
		allowed on the exterior		other residents having the	
	grounds in designat	ted areas.		potential to be affected by	
		1		same deficient practice and	
	Inis Residential tag	g relates to Complaint		what corrective action will taken;	be
	1100373016.			All residents residing in the	
				community are at risk for this	3
				alleged deficient practice. T	
				identify other residents havir	-
				potential to be affected by the same deficient practice, ESM	
				ED completed a tour of the	// Q
				community for evidence of	
				residents smoking in apartm	ent.
				The smoking policy and	
				designated smoking area will discussed during Resident C	
				meeting and a memo will be	Couricii
				placed in resident monthly	
				newsletter.	
				What measures will be put in	nto
				place or what systemic chan	
				will be made to ensure that t	_
				deficient practice does not re	
				On 1/10/23 Housekeeping a	
				Environmental Service Mang was immediately educated by	
				Executive Director regarding	· I
				looking for evidence of resid	

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	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 01/10	LETED
NAME OF PE	OVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	)	
SILVER BIRCH OF HAMMOND				OHL AVENUE OND, IN 46320		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRIDEFICIENCY)  smoking in apartment wh violation of resident lease safety hazard. Housekee serve resident with Smok Warning Letter notice if e of smoking is observed in apartment and notify the Director & Environmental Manager immediately. The ESM will meet with the resident action of the control	inich is a e and a eping will king evidence n resident Executive I Service ne ED or esident	(X5) COMPLETION DATE
				regarding safety hazard a violation.  How the corrective action monitored to ensure the correctice will not recur, i.e quality assurance program put into place; The Executive Director of Designee will inspect Resident#G's apartment week for evidence of smoonths any issues will be addressed immediately, audits will be discussed of monthly QI meeting for the patterns and areas of corrections achieved for three consumnths. This plan to be a when indicated.  Date by which systemic corrections will be composed.	and lease  n(s) will be deficient e., what ms will be  r twice a oking for 3 e The during our rends, ncern. QI e if eessary hreshold secutive amended	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		01/10/2023	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF HAMMOND			STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE

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