STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG		08/17/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			OHL AVENUE		
CII VED E	BIRCH OF HAMMO	MD		l	OND, IN 46320		
SILVER	SIRCH OF HAIVING	סאת		HAIVIIVI	JND, IN 40320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
	This visit was for a	State Residential Licensure	R 0	000	September 1, 2023		
	Survey. This visit included the Investigation of Complaint IN00411306.						
					Brenda Buroker, Director of		
	•	1306 - No deficiencies related to			Long-Term Care		
	the allegations are of	eited.			Indiana Department of Health		
					2 North Meridian Street		
	Survey dates: Augu	ust 16 and 17, 2023			Sec 4-B		
					Indianapolis, In 46204-3006		
	Facility number: 0	13801					
					Dear Ms. Buroker:		
	Residential Census:	: 123					
					Please reference the enclosed	t	
		ntial Findings are cited in			2567L as "Plan of Correction"	for	
	accordance with 41	0 IAC 16.2-5.			the		
					August 17,2023 State Resider		
	Quality review com	pleted on 8/22/23.			Licensure Survey (IN0041130	,	
					that was conducted at Silver E	Birch	
					of Hammond. I will submit		
					signature sheets of the		
					in-servicing, content of in-serv		
					and audit tools September1,20		
					Preparation and / or execution		
					this plan of correction does no		
					constitute admission or agree		
					by the provider of the truth fac		
					alleged or conclusion set forth		
					the statement of deficiencies.		
					plan of correction is prepared		
					or executed solely because it		
					required by the provision of th		
					Federal State Laws. This faci	шу	
					appreciates the time and	o. the	
					dedication of the Survey Tean		
					facility will accept the survey a	ıs a	
					tool for our facility to use in	in	
					continuing to better our Elders	in .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY  COMPLETED	
			B. WING		08/17/2023
	PROVIDER OR SUPPLIE		562	EET ADDRESS, CITY, STATE, ZIP COD 20 SOHL AVENUE MMOND, IN 46320	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
ind	REGGENTORT	R ESC IDENTIFIEND IN ORMATION	1710	our community.	BATE
				The Plan of Correction subron September1,2023 serve our allegation of compliance Should you have any quest concerns regarding the Plan Corrections, please contact	s as e. ion or n of
				Respectfully,	
				Neysa Holman Stewart, HF	A
R 0036	410 IAC 16.2-5-1 Residents' Rights				
Bldg. 00	(k) The facility muresident's physical representation of the control of the contr	ust immediately consult the cian and the resident 's ive when the facility has ecline in the resident 's or psychosocial status; or r treatment significantly, that ontinue an existing form of adverse consequences or to v form of treatment.			
		view and interview, the facility Physician was notified of	R 0036	Silver Birch of Hammond	09/08/2023
		dication being held for 1 of 6		Please accept the following facility's credible allegation compliance. This plan of correction does not constitu	of
	The record for Res	ident 8 was reviewed on 8/16/23 noses included, but were not		admission of guilt or liability facility and is submitted only response to the regulatory	by the

State Form Event ID: 6WMN11 Facility ID: 013801 If continuation sheet Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
			B. WI	NG		08/17/	2023
	ROVIDER OR SUPPLIER		•	5620 S	ADDRESS, CITY, STATE, ZIP COD OHL AVENUE OND, IN 46320	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	limited to, dementia	a without behavior disturbance			requirement.		
	and type 2 diabetes	mellitus.			·		
					R 036		
	A Physician's Order resident was to recemedication to treat milligrams (mg) even 8:00 p.m. There was parameters.  Nurses' Notes, date indicated the reside Metoprolol was help ressure being 112/documentation of the notified.  Nurses' Notes, date the resident's Metop systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation of the systolic (top number There was no documentation).	r, dated 8/8/23, indicated the give Metoprolol Tartrate (a high blood pressure) 25 ery 12 hours at 8:00 a.m. and as no order for blood pressure  d 8/8/23 at 10:04 p.m., and the sevening dose of diduction the resident's blood 50. There was no the resident's Physician being d 8/11/23 at 3:01 a.m., indicated prolol was held due to a low ery blood pressure of 115. The mentation of the resident's diffied.  Wellness Director on 8/17/23 at a since the resident did not have the medication, the Physician			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R#8 was assessed no adverse reactions noted. MD notified of medication hold for R#8. No oresidents were affected by the deficient practice.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents residing in the community are at risk for this alleged deficient practice. To identify other residents having potential to be affected by the same deficient practice, DHW reviewed the medication audit report related to medication have	e of there	
					and MD notification. No other	Jiu	
					residents were affected by the	<b>:</b>	
					deficient practice.		
					What measures will be put into		
				will be made to ensure that the			
					deficient practice does not rec	ur;	
					On 8/18/23 Nursing staff was	rdina	
			ı		immediately re-educated rega	rung	

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PRINTED: 09/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
			B. WING		08/17/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S DEAN 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	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				MD notification related to medication being he DHW will review the medication admin audit report weekly to ensure that any medications hare in keeping with MD/ Proviorders or that the provider has been notified.  How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance programs we put into place; The Director of Health and Wellness or Designee will revert medication admin audit report weekly for 3 months to ensure any medications held are in keeping with MD / Provider or or that the provider has been notified. Any issues will be addressed immediately. The audits will be discussed during monthly QI meeting for QI committee will determine if continued auditing is necessal once 100% compliance threst is achieved for three consecut months. This plan to be amen when indicated.  Date by which systemic corrections will be complete 9/8/23	on held der so will be ent at will be ent ders e that der e that ders e that ders e that ders e that d		

State Form Event ID: 6WMN11 Facility ID: 013801 If continuation sheet Page 4 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		08/17/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OHL AVENUE		
SII VER E	BIRCH OF HAMMO	ND			OND, IN 46320		
OIL V LI Y L		110		T IZ GVIIVIC	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
R 0144	410 IAC 16.2-5-1.	• /					
D		fety Standards - Deficiency					
Bldg. 00							
		pair, both inside and out,					
	-	reasonable comfort for all					
	residents.	an and interview the facility	D O	1.4.4	B444		00/00/2022
		on and interview, the facility n environment that was clean	R 0	l <del>44</del>	R 144		09/08/2023
		elated to marred walls, marred			PLAN OF CORRECTION		
		t, holes in doors, dusty			Please accept the following a	96	
	_	floors, and loose cabinets for 2			the facility's plan of correction		
		at the facility. (The 1st and			This plan of correction does		
4th floors)				constitute an admission of g			
					or liability by the facility and		
	Findings include:				submitted only in response t		
	· ·				the regulatory requirement.		
	During the Environ	mental Tour on 8/17/23 at 2:03					
	p.m. with the Admi	nistrator, the following was			1. The corrective action		
	observed:				taken for the resident found	to	
					have been affected by the		
	1. 1st Floor				deficient practice: No residen	nts	
		yy accumulation of dust and			were affected by the alleged		
		n ceiling vent in Room 104.			deficient practice. On 8/18/23	all	
		d on the outside of the toilet			the environmental concerns		
		m on both sides. One resident			identified during the survey we		
	resided in this room				immediately addressed and / o	or	
	h The bess of the	la an ta Da ana 122 yyaa mamad			resolved.		
		loor to Room 123 was marred resident resided in this room.			First Floor:	ilina	
	and scratched. One	resident resided in this room.			a. Room 104 bathroom cell	iiirig	
	2. 4th Floor				8/18/23		
		om 419 was stained. The door			The dirt noted on the bottom		
	_	s marred at the base and there			outside of the toilet bowl was		
		for below the door knob. One			cleaned on both sides.		
	resident resided in t				b. Room 123 marred door v	was	
					painted on 8/18/23		
	b. The door to Roo	m 425 was scratched and			Fourth Floor:		
	marred at the base.	The door frame to the			a. Room 419 carpet was		
		esident's bedroom was			cleaned of stains, the hole in t	he	
	scratched and marre	ed. There was a hole in the			bathroom door was repaired a		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPI 08/17	LETED		
	PROVIDER OR SUPPLIEI BIRCH OF HAMMC		STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	located under the k resident resided in the Interview with the Intervi	Administrator at the time, above areas were in need of		bathroom door painted of b. Room 425 door was and painted, the scratched bathroom and bedroom of was repaired and painted. The door under kitchen sink witightened on 8/1823  2. The corrective act those residents having potential to be affected same deficient practice. The residents that reside in the are at risk with this alleged deficient practice. No residents that reside in the area trisk with this alleged deficient practice. No residents that reside in the area trisk with the abeing affected.  3. The measures put place and a systemic change to ensure the definite practice not reoccur: Of 8/18/23 the Administrator in-serviced the Assistant Maintenance Director and Housekeeping staff regal environmental areas cited ISDH. This included dust vents, dirty toilet base, Modors, stained carpet, how scratched doors, and door the housekeepers were re-educated regarding change of toilet and ceiling rooms. Environmental stamonitor and place a main request for repair if any cabove citations are found above citations are found and place are found and p	s repaired es on the door frame d. The r was e cabinet was  ion for the by the : All ne facility ed sidents adversely  into nange icient on r d rding d by ty ceiling larred oles / or frames. eaning the vents in aff will netenance of the			

State Form Event ID: 6WMN11 Facility ID: 013801 If continuation sheet Page 6 of 16

PRINTED: 09/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
			B. WI	ING		08/17/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					weekly carpeting cleaning, paidoor frame repair and ceiling of cleaning schedule has been implemented.  4. To ensure the deficient practice does not reoccur, the monitoring system establish is to: Maintenance Direction / Designee will monitor carpet, ceiling vents, marred/scratchedoors / door frame 2 days a wear for four weeks, then weekly for scheduler of marred / scratched marks, ceiling vents free of dust. Any issues found will be address immediately. The audits will be discussed during our monthly meeting. QI committee will determine if continued auditing is necessary once 100 compliance threshold is achieved for three consecutive months. plan to be amended when indicated.  5. Completion date systemic changes will be completed: 9/8/23	vent  t ne ed ctor ed reek for efree	
R 0147	410 IAC 16.2-5-1.	• •					
Bldg. 00	(d) The facility sha safety standards,	•					

State Form Event ID: 6WMN11 Facility ID: 013801 If continuation sheet Page 7 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		08/17/	2023
					-		
NAME OF F	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
011.1/55.1	315011.051111111				OHL AVENUE		
SILVER	BIRCH OF HAMMO	DND		HAMM	OND, IN 46320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Based on observation	on, record review, and	R 0	147	Silver Birch of Hammond		09/09/2023
	interview, the facili	ty failed to ensure residents did		,			
		rooms for 1 of 6 rooms			Please accept the following as	the	
	observed during the environmental tour.				facility's credible allegation of		
	(Resident 6)				compliance. This plan of		
	- /				correction does not constitute	an	
	Finding includes:				admission of guilt or liability by		
					facility and is submitted only in		
	On 8/17/23 at 1:55	p.m., Resident 6 was observed			response to the regulatory	•	
		on the side of his bed. The			requirement.		
		the resident was smoking a			Toquiroment.		
	cigarette.	the resident was smoking a	R 147		P 147		
	organotto.				K 147		
	The smoke alarm ir	the room was beeping. There			What corrective action(s) will	ı	
		gen concentrator tank located			be accomplished for those	-	
		ed on. The resident was not			residents found to have beer	1	
	wearing the oxygen				affected by the deficient	•	
					practice;		
	Interview with the r	resident at that time, indicated			Resident #6 was immediately		
		as smoking and was not			re-educated regarding the no		
		oking inside his room.			smoking policy noted in his lea	ase	
	11	5			and was given a smoking warr		
	The Administrator	was immediately summoned to			letter. No other residents were	-	
		She walked into the resident's			affected by the deficient practi		
		to extinguish the cigarette			amount pract		
		esident was not supposed to be					
		n. The resident gave the			How the facility will identify		
		oximately 5 packs of cigarettes			other residents having the		
	and his lighter.	5 - 1			potential to be affected by th	e	
					same deficient practice and	•	
	The Facility Lease	Agreement was provided by			what corrective action will be	<u>,</u>	
	,	on 8/17/23 at 2:45 p.m. The			taken;	-	
		d no resident or guest shall be			All residents that smoke residi	na	
	_	or vape or otherwise use any			in the community are at risk fo	•	
	•	oducts in any common areas or			this alleged deficient practice.		
	in the units.	and the many committee areas of			identify other residents having		
	in the tillts.				potential to be affected by the	u IC	
					same deficient practice,		
					Maintenance Assist & ED		
			1		completed a tour of the		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		08/17/2023	
			<u> </u>	CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CIL VED I		MD			OHL AVENUE		
SILVER	BIRCH OF HAMMO	טאט		HAIVIIVIC	OND, IN 46320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					community for evidence of		
					residents smoking in apartmer	nt.	
					The smoking policy and		
					designated smoking area men	no	
					will be discussed during Resid		
					Council meeting. On 8/18/23 a		
					memo regarding designated	<b>'</b>	
					smoking area and smoking po	dicy	
					was disturbed to all residents.		
					was disturbed to all residerits.		
					What measures will be put into		
					-		
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec		
					On 8/18/23 All staff immediate	ly:	
					educated by the Executive		
					Director regarding looking for		
					evidence of resident smoking		
					apartment which is a violation	of	
					resident lease and a safety		
					hazard. Housekeeping will ser		
					resident with Smoking Warnin	g	
					Letter notice if evidence of		
					smoking is observed in reside		
					apartment and notify the Exec	utive	
					Director & Environmental Serv		
					Manager immediately. The ED	or or	
					ESM will meet with the resider	nt	
					regarding safety hazard and le	ase	
					violation.		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici		
					practice will not recur, i.e., who	at	
					quality assurance programs w		
					put into place;		
					The Executive Director or		
			1		THE EXECUTIVE DIRECTOR OF		ĺ

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLE S COMPLE 08/17/2	ETED
	ROVIDER OR SUPPLIER		5620 S	ADDRESS, CITY, STATE, ZIP COD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0247 Bldg. 00	410 IAC 16.2-5-4(4) Health Services - I (7) Any error in meshall be noted in the physician shall be medication adminicatual or potential resident. Based on observation interview, the facility	e)(7) Deficiency edication administration ne resident 's record. The notified of any error in stration when there are any detrimental effects to the on, record review, and y failed to ensure insulin pens	R 0247	Designee will inspect Resident#6's apartment twice week for evidence of smoking months any issues will be addressed immediately. The audits will be discussed during monthly QI meeting for trends patterns and areas of concern committee will determine if continued auditing is necessal once 100% compliance thresh is achieved for three consecut months. This plan to be amer when indicated.  Date by which systemic corrections will be complete 9/8/23  Silver Birch of Hammond Please accept the following as	for 3 g our , . QI ry hold ive hded	09/08/2023
	were primed before use for 1 of 1 insulin injections observed. (Resident 10)  Finding includes:			facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by	an	
	preparing Resident in units of Humalog in	p.m., LPN 1 was observed 10's insulin. She dialed up 4 sulin via an insulin pen. She dminister the insulin in the r arm.		facility and is submitted only in response to the regulatory requirement.  R 247		

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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 COMPLETED 00 B. WING 08/17/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5620 SOHL AVENUE SILVER BIRCH OF HAMMOND HAMMOND, IN 46320 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Interview with the LPN at that time, indicated she What corrective action(s) will should have primed the resident's insulin pen with be accomplished for those 1-2 units of insulin prior to administering the 4 residents found to have been units. affected by the deficient practice; No residents were The record for Resident 10 was reviewed on affected by the alleged deficient 8/17/23 at 1:00 p.m. Diagnoses included, but were practice. R10 was assessed no not limited to, type 2 diabetes mellitus. adverse reaction noted. The Nurse was immediately re-educated A Physician's Order, dated 3/27/23, indicated the regarding priming insulin pen prior resident was to receive 4 units of Humalog insulin to administering insulin to three times a day before meals. The insulin was to residents by the Director of Health be held if the resident's blood sugar was below Wellness on 8/18/23. 100. Interview with the Wellness Director on 8/17/23 at How the facility will identify 4:30 p.m., indicated the LPN should have primed other residents having the the insulin pen prior to the resident receiving his potential to be affected by the insulin. same deficient practice and what corrective action will be taken; All facility residents that staff administer insulin medication to have the potential to be affected by the same deficient practice. No other occurrence noted during the insulin pen priming demonstration on 8/18/23 by the DHW. No other residents affected by the alleged deficient practice. Upon review of occurrence, incident found to be isolated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service provided to all QMA's, LPN's and RNs related to priming

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
			B. WIN	IG		08/17/	2023
NAME OF F	PROVIDER OR SUPPLIER				DHL AVENUE		
SILVER I	BIRCH OF HAMMO	ND	HAMMOND, IN 46320				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
140	REGULATORT OF	A DOCUMENT LING INFORMATION			insulin pen prior to administeri insulin on 8/18/23. On 8/30/230-8/31/23 the Director Health Wellness / Designee observed all LPNs, QMAs & R completed a competency Insu administration check list. The DHW or designee will observe LPNs, QMAs and RNs administration insulin medicati and safety practices.  How the corrective action(s) we monitored to ensure the deficie practice will not recur, i.e., what quality assurance programs we put into place;  The Director of Health and wellness or designee will audit resident's insulin medication administration weekly x 4 weethen 2 resident's insulin medication administration weeks. Any issues will be addressed immediately. The audits will be discussed during monthly QI meeting for trends, patterns and areas of concern committee will determine if continued auditing is necessar once 100% compliance thresh is achieved for three consecut months. This plan to be amen when indicated.  Date by which systemic corrections will be completed 9/8/23	of Ns Ilin on fill be ent at ill be y our y old ive	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/17/2023		
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE HAMMOND, IN 46320			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0349 Bldg. 00	on each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on observation interview, the facility records that were condocumented related medication use, oxy information for 5 of (Residents 2, 8, 9, 3).  Findings include:  1. On 8/16/23 at 1:: observed in her room right leg was elevate bandage was observed in the right shin and shade week from home her the record for Resident 10:41 a.m. Diagral limited to, major depain.  The August 2023 Planta in the responsibility of the record of the	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that e records must be as sumented.  Sible.  Organized.  On, record review, and ty failed to maintain clinical complete and accurately to treatment orders, and discharge of 6 records reviewed.  A, and 4)  20 p.m., Resident 2 was m seated on the couch. Hered on her rollator and a white and a long standing area to the received visits three times a sealth for wound care.  dent 2 was reviewed on 8/16/23 moses included, but were not pressive disorder, anxiety, and thysician's Order Summary ere were no orders for wound	R 0.	349	Silver Birch of Hammond  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.  R 349  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  R#2 MD orders noted for hom care and wound care service.  MD clarification order received stop date for the antibiotics. R:  & R#3 oxygen orders are on h EMR updated. R#4 no longer reside in the facility. Nursing s immediately re-educated regal	an  / the  n  l  R#8  I with  #9  and	09/08/2023

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building 00		00	COMPLETED	
			B. WING			08/17/2023	
			1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					OHL AVENUE		
SILVER BIRCH OF HAMMOND							
SILVEN DINOR OF HAIVIIVIONU			-	HAMMOND, IN 46320			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the importance of documenting	g	
	The May 2023 Pre-Admission Evaluation,			that resident / family received			
	indicated the resident had been receiving home			discharge instructions. No other			
	health services thre	e times a week for wound care.	ound care.		residents were affected by the deficient practice.		
	T.,4	I-11 Di4 9/17/22 -4					
		Wellness Director on 8/17/23 at			Ham the feelite will be de-		
	-	d the order for home health did			How the facility will identify		
	not get transposed from the pre-admission			other residents having the			
	assessment.				potential to be affected by th	е	
	2. The record for Decident 8 was reviewed on				same deficient practice and		
	2. The record for Resident 8 was reviewed on 8/16/23 at 1:40 p.m. Diagnoses included but we				what corrective action will be	=	
	8/16/23 at 1:40 p.m. Diagnoses included, but were				taken;		
	not limited to, dementia without behavior disturbance and type 2 diabetes mellitus.				All residents residing in the		
	disturbance and type 2 diabetes mellitus.				community are at risk for this alleged deficient practice. To		
	A Physician's Order, dated 8/8/23, indicated the				identify other residents having	the	
	resident was to receive Levofloxacin (an			potential to be affected by the			
	antibiotic) 750 milligrams (mg), 1 tablet daily.				same deficient practice, DHW		
	There was no stop date for the medication.			designee will audit clinical records			
	There was no stop date for the medication.				related to discharge instruction		
	The August 2023 M	ledication Administration			oxygen orders, provider order		
_		icated the resident received the			stop date for antibiotic.		
medication 8/9 throu							
		-			What measures will be put into	o	
	Interview with the	Wellness Director on 8/17/23 at			place or what systemic change		
4:30 p.m., indicated		ed the pharmacy had been faxed			will be made to ensure that the		
	for a stop date.				deficient practice does not rec	ur;	
					On 8/18/23 Nursing staff was		
	3. The record for Resident 9 was reviewed on				immediately in serviced regard	ding	
	8/16/23 at 3:00 p.m. Diagnoses included, but w				Home Health Care / wound care		
	not limited to, chronic obstructive pulmonary		or		orders, order for Medication stop		
	disease (COPD) and anxiety. The resident was				date if applicable, Oxygen ord	ers	
	admitted to the facility on 7/7/23.			with amount of oxygen noted,			
					clinical record documentation		
	A Physician's Order, dated 7/18/23, indicated the				related to discharge instruction	ns	
	resident was to receive oxygen per nasal cannula				by the Director of Health		
	for shortness of breath (SOB) as needed (PRN).			Wellness. A discharge			
		for how many liters the			communication form was		
	resident was to receive.				implemented. The DHW will re		
				all discharge documentation to	)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING		08/17/2023		
				CTD FFT A	ADDRESS STEW STATE ZID SOD		
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
					OHL AVENUE		
SILVER BIRCH OF HAMMOND			HAMMOND, IN 46320				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		rc	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	The July and August 2023 Medication and				ensure resident received discharge		
	Treatment Administration Records did not include the PRN oxygen order.  Interview with the Wellness Director on 8/17/23 at 4:30 p.m., indicated the resident was to receive 3 liters of oxygen and the order should have been			instructions, review antibiotic for stop date, review oxygen		•	
					orders for amount/ liters, ensure		
				home health care / wound			
					orders are in place.		
					' '		
	clarified. 4. On 8/16/23 at 3:31 p.m., Resident 3 was				How the corrective action(s) will be		
	observed in his room seated in his wheelchair. He				monitored to ensure the deficient		
	was wearing oxygen by the way of a nasal				practice will not recur, i.e., what		
	cannula. The oxygen concentrator was set at 3				quality assurance programs w		
	liters.				put into place;		
	interior.				The Director of Health and		
	Interview with the resident at that time, indicated				Wellness or Designee will mor		
	that he wore his oxygen all day off and on.				clinical records for discharge		
	and he were his oxygen an day on and on.				documentation to ensure resid		
	The record for Resident 3 was reviewed on 8/16/23				received discharge instructions		
	at 10:30 a.m. Diagnoses included, but were not				review antibiotic order for stop		
	limited to, emphysema and asthma. The resident				date, review oxygen orders for		
	was admitted to the facility on 6/29/23.			amount/ liters, ensure home			
		Ž			health care / wound care order	·s	
	A Physician's Order	r, dated 6/30/23, indicated the			are in place weekly for 3 mont		
	resident was to wea	r his oxygen at the liters			Any issues will be addressed		
	ordered via nasal cannula at bedtime related to emphysema.  Nurses' Notes, dated 8/13/23 at 10:25 a.m. and 4:20 p.m., indicated the resident was in his room with his oxygen in use.  Interview with QMA 1 on 8/16/23 at 3:21 p.m.,				immediately. The audits will b	е	
					discussed during our monthly		
					meeting for trends, patterns ar		
					areas of concern. QI committee		
					will determine if continued aud		
					is necessary once 100%	J	
					compliance threshold is achiev	/ed	
					for three consecutive months.		
	indicated the resident wore his oxygen most of the			This plan to be amended when			
	day unless he was outside.				indicated.		
	Interview with the Wellness Director on 8/17/23 at				Date by which systemic		
	9:30 a.m., indicated a clarification order for the oxygen needed to be obtained.				corrections will be completed:		
					9/8/23		
	5. The closed record for Resident 4 was reviewed						
	on 8/16/23 at 10:45	a.m. The resident was					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/17/2023			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5620 SOHL AVENUE					
SILVER BIRCH OF HAMMOND				HAMMOND, IN 46320				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	the resident was ou documented at 3:31 had discharged hon Interview with the 11:02 a.m., indicate with his family and not going to bring I unaware he wasn't instructions were president/family not The resident moved apartment without to Interview with the 12:10 p.m., indicate the facility later tha	d 7/1/23 at 7:31 a.m., indicated ton pass. An entry p.m., indicated the resident ne with his family.  Wellness Director on 8/16/23 at ad the resident was out on pass the family decided they were nim back. The facility was coming back. No discharge rovided due to the coming back to the facility. It his belongings out of his the facility being notified.  Wellness Director on 8/16/23 at add the resident's sister came to the day on 7/1/23 and picked up reations, however, no						

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