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	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF HAMMOND	5620 SOHL AVENUE HAMMOND, IN 46320

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00411306. Complaint IN00411306 - No deficiencies related to the allegations are cited. Survey dates: August 16 and 17, 2023 Facility number: 013801 Residential Census: 123 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/22/23.	R 0000	September 1, 2023 Brenda Buroker, Director of Long-Term Care Indiana Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006 Dear Ms. Buroker: Please reference the enclosed 2567L as “Plan of Correction” for the August 17,2023 State Residential Licensure Survey (IN00411306) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools September1,2023. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in	

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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			our community. The Plan of Correction submitted on September1,2023 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Corrections, please contact me. Respectfully, Neysa Holman Stewart, HFA	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the Physician was notified of blood pressure medication being held for 1 of 6 records reviewed. (Resident 8) Finding includes: The record for Resident 8 was reviewed on 8/16/23 at 1:40 p.m. Diagnoses included, but were not	R 0036	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory	09/08/2023

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	limited to, dementia without behavior disturbance and type 2 diabetes mellitus. A Physician's Order, dated 8/8/23, indicated the resident was to receive Metoprolol Tartrate (a medication to treat high blood pressure) 25 milligrams (mg) every 12 hours at 8:00 a.m. and 8:00 p.m. There was no order for blood pressure parameters. Nurses' Notes, dated 8/8/23 at 10:04 p.m., indicated the resident's evening dose of Metoprolol was held due to the resident's blood pressure being 112/50. There was no documentation of the resident's Physician being notified. Nurses' Notes, dated 8/11/23 at 3:01 a.m., indicated the resident's Metoprolol was held due to a low systolic (top number) blood pressure of 115. There was no documentation of the resident's Physician being notified. Interview with the Wellness Director on 8/17/23 at 4:30 p.m., indicated since the resident did not have parameters to hold the medication, the Physician should have been notified.		requirement. **R 036** **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 other residents 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 the potential to be affected by the same deficient practice, DHW reviewed the medication audit report related to medication hold and MD notification. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 8/18/23 Nursing staff was immediately re-educated regarding	

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			MD notification related to medication being held. DHW will review the medication admin audit report weekly to ensure that any medications held are in keeping with MD/ Provider orders or that the provider has been notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Health and Wellness or Designee will review medication admin audit report weekly for 3 months to ensure that any medications held are in keeping with MD / Provider orders or that the provider has been notified. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 9/8/23**	

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R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.			
	Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to marred walls, marred doors, stained carpet, holes in doors, dusty ceiling vents, dirty floors, and loose cabinets for 2 of 4 units throughout the facility. (The 1st and 4th floors) Findings include: During the Environmental Tour on 8/17/23 at 2:03 p.m. with the Administrator, the following was observed: 1. 1st Floor a. There was a heavy accumulation of dust and dirt on the bathroom ceiling vent in Room 104. There was dirt noted on the outside of the toilet bowl near the bottom on both sides. One resident resided in this room. b. The base of the door to Room 123 was marred and scratched. One resident resided in this room. 2. 4th Floor a. The carpet in Room 419 was stained. The door to the bathroom was marred at the base and there was a hole in the door below the door knob. One resident resided in this room. b. The door to Room 425 was scratched and marred at the base. The door frame to the bathroom and the resident's bedroom was scratched and marred. There was a hole in the	R 0144	**R 144** **PLAN OF CORRECTION** **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** 1. **The corrective action taken for the resident found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. On 8/18/23 all the environmental concerns identified during the survey were immediately addressed and / or resolved. First Floor: a. Room 104 bathroom ceiling vent was cleaned of dust on 8/18/23 The dirt noted on the bottom outside of the toilet bowl was cleaned on both sides. b. Room 123 marred door was painted on 8/18/23 Fourth Floor: a. Room 419 carpet was cleaned of stains, the hole in the bathroom door was repaired and	09/08/2023

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	base of the bedroom door. The cabinet door located under the kitchen sink was loose. One resident resided in this room. Interview with the Administrator at the time, indicated all of the above areas were in need of cleaning and/or repair.		bathroom door painted on 8/18/23 b. Room 425 door was repaired and painted, the scratches on the bathroom and bedroom door frame was repaired and painted. The hole in the bedroom door was repaired and painted. The cabinet door under kitchen sink was tightened on 8/1823 2. **The corrective action for those residents having the potential to be affected by the same deficient practice: A**ll residents that reside in the facility are at risk with this alleged deficient practice. No residents were identified as being adversely affected. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** On 8/18/23 the Administrator in-serviced the Assistant Maintenance Director and Housekeeping staff regarding environmental areas cited by ISDH. This included dusty ceiling vents, dirty toilet base, Marred doors, stained carpet, holes / scratched doors, and door frames. The housekeepers were re-educated regarding cleaning the base of toilet and ceiling vents in rooms. Environmental staff will monitor and place a maintenance request for repair if any of the above citations are found. A	

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			weekly carpeting cleaning, paint / door frame repair and ceiling vent cleaning schedule has been implemented. **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** Maintenance Director / Designee will monitor carpet, ceiling vents, marred/ scratched doors / door frame **2 days a week for four weeks**, then **weekly for 3 months** to ensure carpet is clean, doors / door frames are free of marred / scratched marks, ceiling vents free of dust. **Any issues found will be addressed immediately.** The audits will be discussed during our monthly QI meeting. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **5. Completion date systemic changes will be completed: 9/8/23**	
R 0147 Bldg. 00	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities.			

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	Based on observation, record review, and interview, the facility failed to ensure residents did not smoke in their rooms for 1 of 6 rooms observed during the environmental tour. (Resident 6) Finding includes: On 8/17/23 at 1:55 p.m., Resident 6 was observed in his room sitting on the side of his bed. The room was dark and the resident was smoking a cigarette. The smoke alarm in the room was beeping. There was a standing oxygen concentrator tank located by the bed and turned on. The resident was not wearing the oxygen while smoking. Interview with the resident at that time, indicated he was aware he was smoking and was not supposed to be smoking inside his room. The Administrator was immediately summoned to the resident's room. She walked into the resident's room and told him to extinguish the cigarette immediately. The resident was not supposed to be smoking in his room. The resident gave the Administrator approximately 5 packs of cigarettes and his lighter. The Facility Lease Agreement was provided by the Administrator on 8/17/23 at 2:45 p.m. The agreement indicated no resident or guest shall be permitted to smoke or vape or otherwise use any smoking or vape products in any common areas or in the units.	R 0147	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R 147** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #6 was immediately re-educated regarding the no smoking policy noted in his lease and was given a smoking warning letter. No other residents 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 that smoke residing in the community are at risk for this alleged deficient practice. To identify other residents having the potential to be affected by the same deficient practice, Maintenance Assist & ED completed a tour of the	09/09/2023

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			community for evidence of residents smoking in apartment. The smoking policy and designated smoking area memo will be discussed during Resident Council meeting. On 8/18/23 a memo regarding designated smoking area and smoking policy was disturbed to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 8/18/23 All staff immediately educated by the Executive Director regarding looking for evidence of resident smoking in apartment which is a violation of resident lease and a safety hazard. Housekeeping will serve resident with Smoking Warning Letter notice if evidence of smoking is observed in resident apartment and notify the Executive Director & Environmental Service Manager immediately. The ED or ESM will meet with the resident regarding safety hazard and lease violation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Executive Director or	

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			Designee will inspect Resident#6's apartment twice a week for evidence of smoking for 3 months any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 9/8/23**	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review, and interview, the facility failed to ensure insulin pens were primed before use for 1 of 1 insulin injections observed. (Resident 10) Finding includes: On 8/17/23 at 12:20 p.m., LPN 1 was observed preparing Resident 10's insulin. She dialed up 4 units of Humalog insulin via an insulin pen. She then proceeded to administer the insulin in the resident's right upper arm.	R 0247	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R 247**	09/08/2023

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	Interview with the LPN at that time, indicated she should have primed the resident's insulin pen with 1- 2 units of insulin prior to administering the 4 units. The record for Resident 10 was reviewed on 8/17/23 at 1:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. A Physician's Order, dated 3/27/23, indicated the resident was to receive 4 units of Humalog insulin three times a day before meals. The insulin was to be held if the resident's blood sugar was below 100. Interview with the Wellness Director on 8/17/23 at 4:30 p.m., indicated the LPN should have primed the insulin pen prior to the resident receiving his insulin.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. R10 was assessed no adverse reaction noted. The Nurse was immediately re-educated regarding priming insulin pen prior to administering insulin to residents by the Director of Health Wellness on 8/18/23. **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 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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			insulin pen prior to administering insulin on 8/18/23. On 8/30/230-8/31/23 the Director of Health Wellness / Designee observed all LPNs, QMAs & RNs completed a competency Insulin administration check list. The DHW or designee will observe LPNs, QMAs and RNs administration insulin medication and safety practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Health and wellness or designee will audit 5 resident’s insulin medication administration weekly x 4 weeks, then 2 resident’s insulin medication administration weekly for 8 weeks. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 9/8/23**	

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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 observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to treatment orders, medication use, oxygen orders, and discharge information for 5 of 6 records reviewed. (Residents 2, 8, 9, 3, and 4) Findings include: 1. On 8/16/23 at 1:20 p.m., Resident 2 was observed in her room seated on the couch. Her right leg was elevated on her rollator and a white bandage was observed on her right shin. The resident indicated she had a long standing area to the right shin and she received visits three times a week from home health for wound care. The record for Resident 2 was reviewed on 8/16/23 at 10:41 a.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, and pain. The August 2023 Physician's Order Summary (POS), indicated there were no orders for wound care or home health.	R 0349	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the 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 home care and wound care service. R#8 MD clarification order received with stop date for the antibiotics. R#9 & R#3 oxygen orders are on hand EMR updated. R#4 no longer reside in the facility. Nursing staff immediately re-educated regarding	09/08/2023

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	The May 2023 Pre-Admission Evaluation, indicated the resident had been receiving home health services three times a week for wound care. Interview with the Wellness Director on 8/17/23 at 4:30 p.m., indicated the order for home health did not get transposed from the pre-admission assessment. 2. The record for Resident 8 was reviewed on 8/16/23 at 1:40 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and type 2 diabetes mellitus. A Physician's Order, dated 8/8/23, indicated the resident was to receive Levofloxacin (an antibiotic) 750 milligrams (mg), 1 tablet daily. There was no stop date for the medication. The August 2023 Medication Administration Record (MAR), indicated the resident received the medication 8/9 through 8/17/23. Interview with the Wellness Director on 8/17/23 at 4:30 p.m., indicated the pharmacy had been faxed for a stop date. 3. The record for Resident 9 was reviewed on 8/16/23 at 3:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety. The resident was admitted to the facility on 7/7/23. A Physician's Order, dated 7/18/23, indicated the resident was to receive oxygen per nasal cannula for shortness of breath (SOB) as needed (PRN). There was no order for how many liters the resident was to receive.		the importance of documenting that resident / family received discharge instructions. No other residents 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 the potential to be affected by the same deficient practice, DHW or designee will audit clinical records related to discharge instructions, oxygen orders, provider order for stop date for antibiotic. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 8/18/23 Nursing staff was immediately in serviced regarding Home Health Care / wound care orders, order for Medication stop date if applicable, Oxygen orders with amount of oxygen noted, clinical record documentation related to discharge instructions by the Director of Health Wellness. A discharge communication form was implemented. The DHW will review all discharge documentation to	

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	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The July and August 2023 Medication and 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 clarified. 4. On 8/16/23 at 3:31 p.m., Resident 3 was observed in his room seated in his wheelchair. He was wearing oxygen by the way of a nasal cannula. The oxygen concentrator was set at 3 liters. Interview with the resident at that time, indicated that he wore his oxygen all day off and on. The record for Resident 3 was reviewed on 8/16/23 at 10:30 a.m. Diagnoses included, but were not limited to, emphysema and asthma. The resident was admitted to the facility on 6/29/23. A Physician's Order, dated 6/30/23, indicated the resident was to wear his oxygen at the liters 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., indicated the resident wore his oxygen most of the day unless he was outside. Interview with the Wellness Director on 8/17/23 at 9:30 a.m., indicated a clarification order for the oxygen needed to be obtained. 5. The closed record for Resident 4 was reviewed on 8/16/23 at 10:45 a.m. The resident was		ensure resident received discharge instructions, review antibiotic order for stop date, review oxygen orders for amount/ liters, ensure home health care / wound care orders are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Health and Wellness or Designee will monitor clinical records for discharge documentation to ensure resident received discharge instructions, review antibiotic order for stop date, review oxygen orders for amount/ liters, ensure home health care / wound care orders are in place weekly for 3 months. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 9/8/23**	

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	discharged home on 7/1/23. Nurses' Notes, dated 7/1/23 at 7:31 a.m., indicated the resident was out on pass. An entry documented at 3:31 p.m., indicated the resident had discharged home with his family. Interview with the Wellness Director on 8/16/23 at 11:02 a.m., indicated the resident was out on pass with his family and the family decided they were not going to bring him back. The facility was unaware he wasn't coming back. No discharge instructions were provided due to the resident/family not coming back to the facility. The resident moved his belongings out of his apartment without the facility being notified. Interview with the Wellness Director on 8/16/23 at 12:10 p.m., indicated the resident's sister came to the facility later that day on 7/1/23 and picked up the resident's medications, however, no documentation had been completed.			