DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF HAMMOND	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 26, 2019 Facility number: 013801 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/2/19.	R 0000	December 13, 2019 Matthew Foster, Director of Long Term Care Indiana State Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006 Dear Mr. Foster: Please reference the enclosed 2567L as “Plan of Correction” for the November 26, 2019 State Residential Licensure Survey (CEVI11) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools December 13, 2019. 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	

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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			tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on December 13,2019 serves as our allegation of compliance. The provider respectfully request a Desk review on or after December 20,2019. Should you have any question or concerns regarding the Plan of Corrections, please contact me. Respectfully, Neysa Holman Stewart, HFA	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store and serve food under sanitary conditions related to food crumbs on the base of the plate warmer, a dirty and greasy fryer, dried food debris in the reach in cooler and salad bar, food and ice on the freezer floor, food debris under the shelves in the walk in cooler and expired food for 1 of 1 kitchens observed. (The main kitchen) Findings include: During the Full Kitchen Sanitation Tour on 11/26/18 at 9:12 a.m., with the Culinary Service	R 0273	**R273** **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**	12/20/2019

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	Manager indicated the following: a. The fryer was dirty and greasy. b. Inside the reach in cooler, there was dried cheese and food crumbs observed. c. Inside the salad bar, there was dried cheese, lettuce and food crumbs. d. There was an accumulation of food crumbs on the base of the plate warmer. e. There was frozen broccoli, squash, and an accumulation of ice on the freezer floor. f. There was paper debris and food crumbs under the shelves in the walk in cooler. g. There was a container of diced onions and green peppers with an open date of 11/18/19. h. The inside of the microwave oven was dirty. Interview with the Culinary Service Manager at that time, indicated all of the above was in need of cleaning. The 5/2/18 "Storage Refrigerated Food" policy, provided by the Culinary Service Manager on 11/26/19 at 2:50 p.m., indicated previously cooked foods will be held for up to 7 days and then discarded.		**have been affected by the deficient practice:** All areas cited during “Observation and Interview” were addressed immediately. On 11/26/19 the kitchen was deep cleaned A) The Fryer was cleaned of grease and dirt B) The small reach in cooler was cleaned of food debris C) The salad bar was cleaned of cheese, lettuce and food crumbs D) Plate warmer base cleaned of food crumbs E) The freezer floor was cleaned of food and accumulation of ice F) The under shelves in the walk-in cooler was cleaned of paper debris & food crumbs G) The container with onions & green peppers dated 11/18/19 was dispose of immediately. H) The inside of the microwave was cleaned 2. **The corrective action for those residents having the potential to be affected by the same deficient practice:** All residents that reside in this community and eat meals prepared in community’s kitchen are at risk for this alleged deficient practice. No residents were identified as being affected from this alleged deficient practice.	

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			3. **The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** On 11/27/19, 11/29/19 & 12/2/19 the Dietary Manger & Executive Director in-serviced Dietary Staff concerning kitchen sanitation and areas cited on 11/26/19. A revised “Dietary Cleaning Schedule” was implemented and staff were in-serviced regarding the revised cleaning schedule & Leftover food policy. 4. **To ensure the deficient practice does not reoccur, the monitoring system established is to:** Dietary Manager / Designee will **audit cleaning schedules for completion 5 days a week for four weeks and then 3 days a week for 3 months** to ensure all kitchen areas are kept clean, sanitized and leftover food is disposed of within 7 days. 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 two consecutive months. This plan to be amended when indicated.	

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			5. Completion date systemic changes will be completed: 12/20/19	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to ensure hand hygiene was completed after direct resident contact and after glove removal for 3 of 5 residents observed during medication administration. (Residents 9, 10, and 11) Finding includes: On 11/26/19 at 11:15 a.m., LPN 1 was observed preparing medications for Resident 9. The LPN did not wash his hands or use an alcohol based hand sanitizer before or after giving the resident her medications. At 11:19 a.m., the LPN was preparing Resident 10's medications. Again, the LPN did not wash his hands or use an alcohol based hand sanitizer. After the resident took her pill, the LPN donned a pair of clean gloves and checked the resident's blood sugar using a glucometer. After checking the resident's blood sugar, the LPN removed his gloves and removed the resident's insulin pen from the cabinet. He administered 15 units of Novolog insulin by the way of a flex pen in the resident's right upper arm. The LPN did not wear gloves and he did not wash his hands or use an alcohol based hand sanitizer after administering the insulin. At 11:30 a.m., the LPN was preparing Resident 11's	R 0414	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 414** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Staff member immediately re-educated regarding hand hygiene standards. Handwashing performed during the next medication administration for R# 9, 10,11. **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;**	12/20/2019

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	medications. The LPN did not wash his hands or use an alcohol based hand sanitizer before or after giving the resident her medications. Interview with the Wellness Director on 11/26/19 at 2:35 p.m., indicated she would have expected the LPN to wash his hands or at least use hand sanitizer after each direct resident contact. She also indicated the LPN should have washed his hands after removing his gloves.		All facility residents that staff administer medication to have the potential to be affected by the same deficient practice, DHW audited medication administration for compliance. No other residents affected by the alleged 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; Nurse was immediately re-educated and corrective action provided by the DHW. In-service provided to all QMA's and LPN's related to handwashing during medication administration on 11/26/2019-12/06/2019. 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 medication pass 5 times a week x 4 weeks then weekly until 100% accuracy is obtained 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	

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			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: 12/20/19**	