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	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00391619. Complaint IN00391619 - Substantiated. State Residential Findings related to the allegations are cited at R0217. Survey date: October 17 and 18, 2022. Facility number: 014034 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 19, 2022	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe	Coliins	11/10/2022

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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	(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview and record review, the facility failed to revise resident's fall service plans for 3 of 4 residents reviewed (Resident C, Resident D and Resident E). Findings include: 1. Resident C's clinical record was reviewed on 10/17/22 at 2:36 p.m. Diagnoses included, but were not limited to, essential hypertension, osteoarthritis, vitamin D deficiency and chronic pain. Her orders indicated wellness check every 24 hours everyday shift visually check resident for wellness. The clinical record lacked a Fall assessment. Her nurses notes indicated the following: On 12/31/21 at 6:35 a.m., she was found on her floor in front of her recliner. She stated that her balance had been off, she did not hit her head, but she did hit her left shoulder. On 4/25/22 at 1:30 a.m., she was on the floor, on	R 0217	Silver Birch of Muncie Assisted Living's (014024) POC response and submission for the alleged state deficiencies findings for 410 IAC 16.2 that were found while responding to Complaint Survey IN00391619 performed on October 18, 2022, is the following: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Resident C** no longer resides in our community due to not returning to our community after being sent to the ER on 06/05/2022. The ER sent the resident to a SNF for rehab and daughter requested permanent placement. **Resident D** no longer resides in our community due to not returning to our community after being sent to ER on 09/20/2022. The ER sent the resident to a SNF	11/18/2022

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	her knees in front of her recliner. She stated that she had been dizzy for the past couple days and she was not hurt. On 4/25/22 at 3:20 a.m., she was on the floor in the bathroom doorway. She stated that she was watering her plants, fell backwards and busted her head open. She had a puddle of blood under her head. The CNA tried to get her up off the floor but could not. The nurse called 911 for her to be taken to the emergency room. . On 6/5/22 at 12:56 a.m., she lost her balance coming back from the bathroom. She stated she did not hit head and had no noticeable injuries. She refused to go to the emergency room. On 6/5/22 at 8:57 a.m., she wanted to be sent to the emergency room due to pain in her hip. She was not able to walk on her own. 911 was called to pick the resident up. On 6/8/22 at 4:57 p.m., the hospital nurse indicated she had a right hip fracture with a total right hip replacement done yesterday. She would be going to a skilled nursing facility (SNF) for rehab when she discharged from hospital. The residnet had a 4/26/21 revised service plan for transferring. The goal was for her to be able to transfer safely with/without assistance, revised on 10/25/21. Her interventions were report any changes in ability to transfer to nurse, revised on 4/26/21, she required weight bearing assistance to get in and out of bed, chair, car etc. at times and she would call for assistance, revised on 5/11/22. She had a 4/26/21 revised service plan for mobility. Her goal was that she would be able to move about the community with/without		for rehab and resident requested permanent placement. **Resident E** agreed to call for assistance before attempting to transfer herself and allowing staff to assist with decluttering her apartment to remove trip hazards during a conversation with the Director of Nursing & Wellness and the Executive Director at the Rehab prior to returning to the community. Resident's apartment has been cleaned, organized, and trip hazards removed. Resident is given frequent reminders to call for assist before attempting to transfer or ambulate per self and her service plan has been updated to reflect this. **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 of Silver Birch of Muncie have the potential to be affected by the alleged deficient practice. The Director of Nursing & Wellness has educated nursing staff on clinical documentation, including completion of a fall risk assessment, and follow through for any resident that has fallen or been found on the floor, checking the area for possible causes of the fall, completing an incident report, and communicating with co-workers if new services are in	

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	assistance, revised on 5/11/22. Her interventions were mobile with assistive device revised on 8/10/21, she required assistance with long distances revised on 5/11/22 and report any changes in mobility to the nurse initiated on 11/20/19. Her clinical record lacked a service plan for falls. During an interview with the DON, on 10/17/22 at 3:03 p.m., she indicated Resident C walked with a walker and was independent in her room. She had increased weakness and she was educated to call with assistance. She did not normally need assistance and she administered her own medication. As a direct result from prior fall, she had increased pain and difficulty getting up. She went for a rehab stay and was not able to progress, she required maximum assistance of two staff members and family wanted her to stay in the SNF. 2. Resident D's clinical record was reviewed on 10/17/22 at 1:09 p.m. Diagnoses included, but were not limited to, Parkinson's disease, orthostatic hypotension, dizziness and giddiness and chronic pain syndrome. A significant change Fall assessment, dated 3/11/22, indicated he was a high risk for falling. His nurses notes indicated the following: On 4/18/22 at 1:46 a.m., he fell while in the bathroom, hit his head on the toilet and the wall. He stated that he was in pain and would like to go to the emergency room. EMS was called and he was transferred out. On 4/18/22 at 5:38 a.m., he returned from the		place. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Director of Nursing & Wellness or designee will review incident reports 5 time weekly for 4 weeks, then weekly ongoing for clinical documentation, fall risk assessments for each occurrence, and residents' conditions that require service plan updates. Any findings will be addressed at the time of discovery by the Director of Nursing & Wellness or designee. The Director of Nursing/Wellness or designee will review any service plan updates with the resident and their family or POA. If the resident and their representative are in agreement with the service plan updates the resident, Director of Nursing & Wellness or Executive Director will sign the service plan and place it in the resident's chart or upload it to PCC. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing & Wellness will report findings of the incident report reviews to the Quality Assurance Committee monthly until 100% compliance has been met for three (3)	

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	hospital. On 4/21/22 at 5:00 a.m., he was found on the floor on his knees next to his bed. He stated that he was trying to go to the bathroom when he fell. On 4/22/22 at 5:19 p.m. he requested to go to the emergency room due to right side pain. On 5/3/22 at 3:24 p.m., the hospital indicated he was transferred to a SNF on 4/30/22. On 9/20/22 at 5:42 p.m., he put on the call light, was found in men's restroom on the 1st floor, he had fallen and complained of right hip pain. EMS was called. On 10/1/22 at 12:47 p.m., he would be transferred to a SNF for permanent placement per his choice after his rehab stay. He had a 12/7/21 initiated service plan for transferring. His goal was that he would be able to transfer safely with/without assistance. He would call for assistance as needed revised on 9/12/22. His intervention was to report any changes in his ability to transfer to the nurse. The intervention was initiated on 12/8/21. His clinical record lacked a service plan for falls. During an interview with the DON, on 10/17/22 at 2:27 p.m., she indicated they were working on getting him into a SNF before his fall. Then he had the fall and went to the hospital. He had increased weakness and he was declining, they were waiting for the approval for him to go to a SNF. He had a medical group referral for depression and declining health because he was upset that others were getting around and he was		consecutive months, then ongoing quarterly or until the Quality Assurance Committee determines resolution. **By what date the systemic changes will be completed?** November 18, 2022	

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	having difficulty. 3. Resident E's clinical record was reviewed on 10/18/22 at 9:15 a.m. Diagnoses included, but were not limited to, vitamin D deficiency, unspecified convulsions, peripheral vascular disease and type 2 diabetes with diabetic polyneuropathy. An annual Fall assessment, dated 2/3/22, indicated she was at a high risk for falling. Her progress notes indicated the following: On 1/8/22 at 3:07 p.m. she fell on the floor while trying to go to bathroom. She complained of hand pain, left hip pain and stated she hit her head on the floor. She refused to go to the hospital. On 1/8/22 at 6:40 p.m., she was laying on the floor in her kitchen stating she fell again. She denied hitting her head, but stated that her left hip was hurting and that's why she fell to her knees on the way to the bathroom. She was sent to the emergency room. On 1/11/22 at 6:15 p.m. she returned from the hospital. On 1/13/22 at 5:10 p.m., she had fallen in her room with no injuries. She had knocked over her walker into her plant. The resident indicated she slid on magazines. On 1/22/22 at 10:37 p.m., she returned from hospital. On 3/17/22 at 6:48 a.m., she used her PHB (Personal Help Button). She was on the floor in the doorway of her bedroom. She stated that she was going to the bathroom, got tangled up in her			

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	blanket and fell. She was not hurt but did hit her left cheek and head. She declined to go to the emergency room. On 3/17/22 at 7:00 a.m., she was educated to call for assistance with transfers. On 4/7/22 at 9:47 p.m., she turned on her call light. She was found laying on her side on the floor in her room. She stated she was bending over to pick her food up out of her chair and lost her balance. She denied hitting her head or any pain or discomfort. She was advised not to get up on her own and to use call light for any assistance. On 4/8/22 at 10:30 a.m., she turned on her call light and requested to go to hospital. She complained of left hip, leg pain and unable to bare weight. EMS called. On 4/8/22 at 9:08 p.m., she was admitted to the hospital with a left femoral neck fracture. On 4/28/22 at 11:58 p.m., spoke with her daughter with her permission about getting assistance with organizing apartment and getting rid of all the boxes. The resident was educated her apartment had multiple trip hazards, they needed to make sure the apartment was safe to avoid falls and injury. Daughter stated she was bringing her mother back today and will look at the apartment, her and resident will make a plan to get it organized, empty out boxes, and clear out pathways this week. On 5/12/22 at 2:57 p.m., she fell and stated that she was fine. On 5/18/22 at 6:09 p.m., she had an unwitnessed fall. She was sitting on the floor in front of her			

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	recliner. She stated that she had her walker and backed up to sit down, she guessed she just didn't get back far enough because her butt slid right off the end of the chair. On 5/29/22 at 5:01 a.m., she slid out of her wheelchair as she transferred to it to go to the bathroom. She stated that she is ok and did not want to go to the hospital. On 5/29/22 at 5:40 a.m., she fell getting off the toilet. The nurse informed her she needed to hit her button for help getting up. She stated that she did not want to go out to the hospital and she was okay. On 5/29/22 at 6:00 a.m., she fell in her bathroom headfirst, on her neck, was stuck in between the wall, power chair and the toilet. Once again the nurse educated the resident about utilizing her PHB when she needed help. The nurse called 911 and she went to the hospital to be checked out. On 5/31/22 at 11:30 a.m., she was admitted to the hospital for UTI and hemorrhagic stroke. On 6/1/22 at 4:47 p.m., she returned to facility. She was given a call pendant and educated on importance of using it to call for help with needs and transfers. She voiced understanding. On 6/9/22 at 2:13 p.m., she fell while transferring from wheelchair. She stated that she was fine and did not want to go to the emergency room. On 6/9/22 at 6:07 p.m., she was asked to put her call light on when she wanted to transfer in and out of her wheelchair. 6/14/22 at 6:19 a.m., she used her PHB. She was on			

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	the floor in her bedroom. She stated that she was coming back from getting cleaned up and was trying to plug in her powerchair and got tripped up by the cord. She stated she heard her hip pop and asked writer to call an ambulance. On 6/19/22 at 2:23 p.m., she was transferred to a skilled nursing facility per hospital. On 7/20/22 at 1:12 p.m., the nurse went to the skilled nursing facility to assess her. She was alert and oriented to person, place and time. Her speech was clear, able to make needs and wants known. She was standby assist with transfers at that time. There was a discussion with the nurse, Executive Director and her. She agreed she would call for assistance with transfers in her apartment for safety and to allow assistance with removing trip hazards in her apartment, for her safety. On 7/20/22 at 6:02 p.m. she returned to the facility. On 8/4/22 at 9:40 p.m. she was found sitting on the floor next to her chair but stated she did not fall that she slowly lowered herself to the ground with her walker. On 8/20/22 at 10:58 a.m., she was found by CNA on the floor. She stated that she used her walker to take some things to the sink to be cleaned she was going to the bathroom to get cleaned up for the day when she slipped and fell. When she fell, she hit her right hip. At the time she stated that there was no pain but that she wanted to get checked out at the emergency room. QMA called EMS and printed out face sheet with med list. When EMS got to the facility, she complained of pain going down in her right leg into her knee area.			

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	On 8/20/22 at 11:17 a.m., she did not call for assistance with transfer. She was alert and oriented to person, place and time. Would continue to be educated to calling for assistance with transfers when she returned to the facility. On 8/28/22 at 12:02 p.m., receptionist called CNA's and told them, she had fell from a phone call from her son. Upon entering the room, she was laying on the floor in front of her recliner. She said that she was getting up to get a pair of socks and her feet came out from under her. She was assisted up and back into her recliner and assisted with putting her socks on. Writer called maintenance to notify them her pendant did not work and the call button rang in as another room. She had a 3/24/22 initiated service plan for transferring. Her goal was that she would be able to transfer safely with assistance, will call for assistance with transfers revised on 9/20/22. Her interventions were report any changes in ability to transfer to the nurse initiated on 3/24/22, she required assistance to get in and out of bed, chair, car etc. She would call for assistance, revised on 9/20/22. She had a 12/6/19 initiated service plan for mobility. Her goal was that she would be able to move about the community without assistance. She would call for assistance as needed revised on 9/20/22. Her interventions were that she used a powerchair revised on 12/22/20 and she was independent with mobility, once in powerchair revised on 9/20/22. A falls (weakness) service plan was initiated on 10/16/20. Her goal was she would be encouraged to call for assistance with transfers. Continue			

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	education to call for assistance with transfers, revised on 7/20/22. Her intervention was to remind her to call for assistance, initiated on 10/16/20. During an interview with Resident E, on 10/18/22 at 9:39 a.m., she indicated she had a terrible summer. She had fallen and broke the ball joint off in her left hip, had hip replacement. Four weeks to the day, she had a stroke and ended up between wall and toilet bowl. She yelled for help, she was not able to get a hold of the string in the bathroom and she had a call light pendent around her neck but couldn't find it. She yelled until she passed out and woke up in the hospital. They told her she had a brain bleed and a mini stroke. She was released after three days. A week and half later, she broke right hip so bad that it was mangled, it needed screws, plates and rods. The first time she fell over cords in her room walking from bedroom to living room. The right hip, she was bent over to plug in her power chair and fell on her side. Her interventions to prevent further falls were that someone came in to check on her in the early morning. During an interview with the Administrator, on 10/18/22 at 9:00 a.m., he indicated that they did not do an internal investigation. They did talk to the resident and did education, but he knew the saying "if it's not documented it's not done." During an interview with the Administrator, on 10/18/22 at 9:30 a.m., he indicated he received a text from the ADON that the interventions were located under service plans in Point Click Care (PCC) under falls, mobility, transfers. During an interview with the ADON, on 10/18/22 at 12:07 p.m., she indicated for residents who had falls they do an assessment, neurological checks			

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	if they hit their head and encourage them to go to the hospital. They would update the service plan and go over it with them, continue wellness checks or complete more frequent wellness checks throughout the day. They would also do an incident report and talk to resident about using the call light. With Resident E, she had more frequent falls recently and she would not put on call light when she transferred. She would put call light on but indicated she did not fall and just sat on the floor. They think she feared that if she put on her call light that she may have to leave the facility. She was very independent. If there were an increase in assistance or change of condition, by policy they would get revised bi-annually. If there were an increase in falls then service plan would be updated, but if it was just a trip and fall it would not be updated. Resident E's service plan should had been updated. A current facility policy, titled "Service Plans," provided by the Administrator, on 10/18/22 at 11:50 a.m., indicated the following: "...Policy: Each resident will have a service plan that is developed based on initial Level of Service Assessment/Evaluation, quarterly evaluation reviews and/or changes in resident needs. This plan will be available for staff view to assist in the daily care/services provided to the resident...." This state residential finding relates to complaint IN00391619.			