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	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF TERRE HAUTE	650 LAFAYETTE AVENUE TERRE HAUTE, IN 47807

(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: January 15 and 16, 2025 Facility number: 014291 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 23, 2025.	R 0000	This plan of correction is submitted as required under federal and state regulation. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this plan of correction as our credible allegation of compliance. We are requesting a desk review for paper compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 12 of 12 months of fire drills reviewed. Findings include: The facility's fire drill records, dated January 2024 through December 2024, were reviewed on 1/16/25 at 10:54 a.m. The records indicated fire drills had been conducted as follows:	R 0092	It is the practice of this facility to ensure fire exit drills are conducted quarterly on each shift for at least 12 drills held per year. **1 What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?** No residents were identified as being affected. Fire exit drills are recorded into a TELS program. All quarterly fire drills are scheduled in the program and any fire drills	02/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill Stott	Executive Director	02/03/2025

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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	a. On 2/28/24 at 8:35. The record lacked documentation of the drills being conducted at 8:35 a.m., or 8:35 p.m. b. On 4/2/24 at 12:13 p.m. c. On 7/31/24 at 4:44 p.m. d. On 10/8/24 at 2:35 p.m. e. On 10/11/24 at 5:05 a.m. f. On 11/24/24 at 6:30 p.m. g. On 12/29/24 at 12:30 p.m. The records lacked documentation of drills being conducted quarterly on each shift and totaling 12 drills for the year, per State regulation. During an interview, on 1/16/25 at 11:40 a.m., the Maintenance Director indicated he had only been in the position since September 2024. He could not answer as to why the fire drills were not conducted according to the State regulations prior to him assuming the position. During an interview, on 1/16/25 at 1:09 p.m., the Executive Director indicated she did not know why the fire drills had not been conducted properly. She did not believe the facility had a specific policy regarding fire drills, but the expectation was that the drills would be conducted per the State guidelines.		that are not conducted at least quarterly on each shift, as scheduled, are highlighted in red to alert non-compliance. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. The Environmental Services Manager will follow the schedule and perform fire drills quarterly on each shift for at least 12 drills held per year. **3 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 Environmental Services Manager will ensure fire drills are scheduled quarterly on each shift for at least 12 drills held per year as part of the routine schedule and are planned in advance annually. **4 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 Executive Director will perform an audit quarterly to ensure fire drills have been conducted in accordance with state guidelines.	

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			Any noncompliance discovered will be corrected at the time of discovery and trends will be reported to the QA Committee for further recommendations. **5. =”” span=””>By what date the systemic changes will be completed?** February 6, 2025	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 1 of 1 medication storage rooms reviewed for medication storage. Finding includes: On 1/16/25 at 1:25 p.m., the second-floor medication storage room contained an undated multi use vial of Tubersol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution. The vial contained a label on it that indicated it was delievered to the facility from the pharmacy on 10/18/24. During an interview, on 1/16/25 at 1:27 a.m., the Director of Nursing (DON) indicated she was not sure how long Tubersol solution was good once it had been opened, she would have to check the facility policy. She indicated she was not aware of how long it had been opened. During an interview, on 1/16/25 at 1:50 p.m., the Executive Director (ED) indicated the facility	R 0301	It is the practice of this facility to ensure medication is labeled properly for all medications in storage rooms. **1 What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?** No residents were identified as being affected. The multi-use vial of Tubersol solution was immediately destroyed and replaced with a new unopened vial. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. The licensed nurse will be responsible to ensure all medications that are opened are	02/16/2025

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	followed manufacturer guidelines regarding Tubersol solution storage and use. On 1/16/25 at 1:58 p.m., the ED provided a document, dated February 23, 2022, titled, "Tubersol," and indicated it was the current policy used by the facility. The policy indicated, "...Label 30-day expiration once vial has been punctured and discard after the 30 days...."		following manufacturer's guidelines regarding storage and use of the medication. **3 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 will educate all licensed nurses by February 16, 2025, regarding following manufacturer's instructions to ensure all medication is labeled properly for all medications in storage. **4 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 Nurses will conduct random audits as part of the QAPI process to ensure all medication is labeled properly for all medications in storage rooms daily, 5x a week for 4 weeks, 3x a week for 4 weeks and 1x a week for 4 weeks. Any noncompliance will be immediately corrected and reported to the QA Committee for further recommendations. Audits will be complete once 100% compliance has been maintained for 4 weeks. **5. By what date the systemic changes will be completed?** February 16, 2025	

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