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	08/28/2024

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. This visit included the Investigation of Complaints IN00433138, IN00438844, and IN00441212. Complaint IN00433138 - State deficiencies related to the allegations are cited at R217 and R243. Complaint IN00438844 - No deficiencies related to the allegations are cited. Complaint IN00441212 - No deficiencies related to the allegations are cited. Survey dates: August 27 and 28, 2024 Facility number: 013801 Residential Census: 112 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/3/24.	R 0000	September 13, 2024 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 28, 2024 State Residential Licensure Complaint Survey (IN00433138, IN00438844, IN00441212) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools September13, 2024. 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Neysa Holman Stewart	Executive Director	09/13/2024

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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			continuing to better our Elders in our community. The Plan of Correction submitted on September 13,2024 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 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 5 of 8 resident records reviewed. (Residents D, B, C, E, and F) Findings include: 1. The Record for Resident D was reviewed on 8/27/24 at 1:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes and urinary tract infection (UTI). A Physician's Order, dated 2/19/24 and listed as current on the 8/2024 Physician's Order Summary (POS), indicated the resident was to receive Novolog insulin three times a day per sliding scale. A Physician's Order, dated 3/26/24 and listed as current on the 8/2024 POS, indicated the resident was to receive Humalog insulin three times a day per sliding scale.	R 0217	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. **R217** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents D, B, C, E and F Service Plans were reviewed and revised as appropriate / updated. Resident # D MAR-Medication Administration Record was	09/27/2024

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	A Service Plan, reviewed on 6/17/24, indicated the resident was unable to self-inject or self-administer pre-poured medications. The Medication Administration Records (MAR's), dated 4/2024 through 8/2024, indicated the resident was self-administering her Novolog and Humalog insulin. The Service Plan had also not been updated to address the resident's UTI and the need for antibiotic therapy. During an interview on 8/28/24 at 2:25 p.m., the Director of Nursing indicated the resident's service plan should have been updated related to the resident administering her insulin. 2. The record for Resident B was reviewed on 8/27/24 at 12:55 p.m. Diagnoses included, but were not limited to, major depressive disorder, Alzheimer's disease, major depressive disorder, high blood pressure and type 2 diabetes. Nurses' Notes, dated 3/11/24 at 8:55 p.m., indicated the resident had called the nurses' station and indicated there were green lights over all her walls. Nurses' Notes, dated 3/12/24 at 10:40 a.m., indicated the resident had told the staff there were ants in her apartment and on the ceiling. Nurses' Notes, dated 3/20/24 at 3:25 p.m., indicated the resident was having intermittent periods of confusion and hallucinations. Nurses' Notes dated 3/25/24 at 2:00 p.m., indicated the resident's daughter had phoned in and reported her mother indicated the wall in her		updated to reflect MD order for self-administration of Insulin and Service Plan updated to reflect diagnosis of UTI and the need for antibiotic therapy. Resident #B Service plan was updated to reflect new diagnosis of Dementia. Resident #C Service Plan was updated to reflect antipsychotic medication and behaviors exhibited. Resident #E Service Plan was updated to reflect Renal Dialysis. Resident #F Service Plan was updated to reflect Foley Catheter. Nursing staff was immediately re-educated regarding the importance of reviewing and revising Service Plan to reflect resident care needs and/or services by the DHW - Director of Health Wellness. 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 MAR and Service Plans related to new diagnosis and any change of condition.	

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	apartment had fallen down and bugs came out of it and then the wall went back up. The physician was notified and new orders were obtained to admit the resident into the neurological psychiatric hospital on 3/26/24. The resident returned back to the facility on 4/2/24 with the new diagnosis of dementia and was started on new medication. The Service Plan, signed and dated by the resident on 8/26/24, indicated there was one need for the resident regarding medications. The resident would be supported to take all medications safely and as ordered. There was no other information on the service plan regarding the resident's care, cognition, or health. During an interview on 8/27/24 at 4:10 p.m., the Director of Nursing indicated the service plan lacked documentation regarding the current needs of the resident and the new diagnosis of dementia. 3. The record for Resident C was reviewed on 8/27/24 at 2:05 p.m. Diagnoses included, but were not limited to, high blood pressure, type 2 diabetes, chronic pain, and major depressive disorder. An initial Service Plan, signed and dated by the resident on 4/30/24, indicated ADLs (Activities of Daily Living) were addressed as well as medication administration, hearing, and vision. There was no information regarding the resident's antipsychotic medication use, or any of the		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 8/28/24 applicable nursing staff were immediately in-serviced regarding updating Service Plan to reflect change in condition and new diagnosis as appropriate and Medication Administration Record to reflect appropriated medication administration by the Director of Health Wellness. The DHW and/or designee will review the 24HR Report weekly to ensure change in condition and/or new care or services are updated and reflected on the Service Plan and MAR. 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 24HR and Medication Administration Report weekly for 3 months to ensure resident's Service Plans reflect change in condition, new diagnoses, and that the MARs reflect care and/or services rendered. 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	

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	resident's behaviors. A Physician's Order, dated 4/30/24, indicated Perphenazine (an antipsychotic medication) 4 milligrams 1 tablet two times a day. The medication had been reduced and increased several times and the current Physician's Order, dated 8/14/24, indicated Perphenazine 4 mg three times a day. During an interview on 8/28/24 at 9:20 a.m., the Director of Nursing indicated the resident's service plan did not address the antipsychotic medication or behaviors she had exhibited. 4. The record for Resident E was reviewed on 8/27/24 at 12:55 p.m. The diagnoses included, but were not limited to, high blood pressure, diabetes, dependence on renal dialysis, depression, and gout (increase in uric acid production). The Service Plan, dated 6/17/24, indicated the resident was cognitively intact for daily decision making. The Service plan was not updated to include the resident's renal dialysis. During an interview on 8/28/24 at 9:20 a.m., the Director of Nursing (DON) indicated Resident E's service plan should have included the resident's dialysis treatment. 5. The record for Resident F was reviewed on 8/27/24 at 2:48 p.m. The diagnoses included, but were not limited to, hypertension (high blood pressure), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD), and benign prostatic hyperplasia (enlarged prostate).		is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 9/27/24**	

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	The Service Plan, dated 6/13/24, indicated the resident was cognitively intact for daily decision making. The Service plan was not updated to include the resident's urinary catheter status. The Level of Service assessment, dated 6/13/24, indicated the resident had a Foley catheter. During an interview on 8/27/24 at 2:44 p.m., the Wellness Nurse indicated Resident F had home health services comes in weekly to assist with Foley catheter care. This citation relates to Complaint IN00433138.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on record review and interview, the facility failed to ensure medications administered to the resident were signed out in the Medication Administration Record (MAR) after competition for 1 of 8 residents reviewed for medications. (Resident B) Finding includes: The record for Resident B was reviewed on 8/27/24 at 12:55 p.m. Diagnoses included, but were not limited to, major depressive disorder, Alzheimer's disease, major depressive disorder, high blood pressure and type 2 diabetes. Physician's Orders, on the current Physician Order Statement dated 8/2024, indicated Humalog insulin 5 units before meals three times a day.	R 0243	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 243** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No other residents were affected by the alleged deficient	09/27/2024

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	The 7/2024 MAR indicated the Humalog insulin was not signed out as being administered before breakfast and before lunch on 7/1, 7/2, 7/5, 7/6, 7/11, 7/15, 7/19, 7/20, 7/23, 7/25, and 7/26/24. The 8/2024 MAR indicated the Humalog insulin was not signed out as being administered before breakfast and before lunch on 8/2, 8/3, 8/5, 8/6, 8/8, 8/15, 8/20, and 8/22/24. During an interview on 8/28/24 at 12:55 p.m., the Director of Nursing had no additional information regarding the blanks on MAR for the resident's insulin administration. This citation relates to Complaint IN00433138.		practice. R#B was assessed no adverse reaction noted. The Nurse and QMA noted were immediately re-educated regarding signing out medication in the MAR by the Director of Health Wellness on 8/28/24. **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 medication have the potential to be affected by the same deficient practice. DHW audited Medication Administration Records related to missed medication to ensure medication administration records were complete. No other residents were 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; In-service provided to all QMA's, LPN's and RNs related to signing out medication in the MAR on 8/28/24 – 8/9/24 by the Director of Health Wellness. The Director of Health and Wellness or designee will audit applicable Medication Administration Reports to ensure	

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			medication administration is documented on the MAR. 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 Medication Administration Report 5 days a week x 4 weeks to identify potential opportunities of documentation oversight, then 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: 9/27/24**	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency Based on observation, record review, and interview, the facility failed to label insulin pens with the resident's name, physician's name, and	R 0300	Silver Birch of Hammond Please accept the following as the	09/27/2024

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	dosage instructions for 1 of 1 medication refrigerator and 1 of 2 medication carts reviewed. (Residents 2, 3, 4, 5, 6, 8 and 7) Findings include: 1. On 8/28/24 at 9:15 a.m., the following was observed in the medication refrigerator in the nurses' office with QMA 1: a. A Humalog insulin Kwik Pen and Lantus insulin pen for Resident 2 was on the top shelf in the medication refrigerator. The pens were uncontained and did not list the resident's physician and how much insulin was to be given. b. A Tresiba insulin pen for Resident 3 was on the top shelf in the medication refrigerator. The pen was uncontained and did not list the resident's physician and how much insulin was to be given. c. A Humalog Kwik Pen for Resident 4 was on the top shelf in the medication refrigerator. The pen was uncontained and did not list the resident's physician and how much insulin was to be given. d. A Lantus insulin pen for Resident 5 was on the top shelf in the medication refrigerator. The pen was uncontained and did not list the resident's physician and how much insulin was to be given. e. A Novolog Flex Pen for Resident 6 was on the top shelf in the medication refrigerator. The pen was uncontained and did not list the resident's physician and how much insulin was to be given. f. A Lantus insulin pen for Resident 8 was on the top shelf in the medication refrigerator. The pen was uncontained and did not list the resident's physician and how much insulin was to be given.		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 300** **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. R#2, R#3, R#4, R#5, R#6, R#8 and R#7 insulin pens were immediately labeled with resident name, physician's name and dosage instructions, open date, and expiration date. The Nurse and QMA noted at the time of the finding were immediately re-educated regarding labeling insulin pens with physician name and dosage instruction by the Director of Health Wellness on 8/28/24. **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 receive insulin pen medication have the potential to be affected by the	

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	g. A Lantus insulin pen located on the top shelf in the refrigerator was not labeled with a resident's name, physician's name, and amount of insulin to be given. There was also a Fiasflex insulin pen and a Humalog Kwik Pen that were not labeled. 2. On 8/28/24 at 9:24 a.m., the following was observed in Medication Cart 1 with QMA 1: a. A Novolog Flex Pen for Resident 7 was not labeled with the name of the resident's physician nor the dose to be given. The resident also had a Toujeo insulin pen that was not labeled with the physician's name and the amount of insulin to be given. b. A Novolog Flex Pen was not labeled. During an interview at that time, QMA 1 indicated the staff looked at the Medication Administration Record (MAR) to see how much insulin was to be given. During an interview on 8/28/24 at 11:00 a.m., the Director of Nursing (DON) indicated she thought the insulin pens only needed to be labeled with the resident's name and the date opened. The current facility policy, titled, "Consultant Pharmacy Services" was provided by the DON on 8/28/24 at 12:52 p.m. The policy indicated all medications were to be labeled in accordance with local, state and federal laws, rules and regulations.		same deficient practice. An audit of all residents with insulin pen medication was completed to ensure all were labeled with resident name, physician name and dosage instruction, open date and expiration date. 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 insulin pen medication labeling and new process for insulin pen medication labeling packaging by the Director of Health Wellness on 8/28/24-8/29/24. All insulin pen medication will remain in original pharmacy packaging with label noting resident name, physician name, dosage instructions, staff will write open date and expiration date on insulin pen medication in use. 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 20 Insulin pen medication to ensure packaging note the resident name, physician name, dosage instructions, open date and expiration date weekly x 12	

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			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: 9/27/24**	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication and treatment orders, medication availability, and documentation of insulin administration for 1 of 8 resident records reviewed. (Resident D) Finding includes: The record for Resident D was reviewed on 8/27/24 at 1:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes, hypertension, history of diabetic foot ulcer, and psoriasis (a skin disease). A Physician's Order, dated 1/9/24 and listed as current on the 8/2024 Physician's Order Summary (POS), indicated the resident was to receive Mounjaro (an antidiabetic medication) 2.5 milligrams (mg) per 0.5 milliliters (ml), inject 2.5 mg	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 0349** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R#D Physician immediately contacted to regarding clarification insulin orders, topical medication specific affected location and parameters for PRN blood	09/27/2024

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	weekly on Thursday. The Medication Administration Records (MARs), dated 4/2024 through 8/2024, indicated the resident had not received the medication weekly as ordered. During an interview on 8/28/24 at 11:00 a.m., the Director of Nursing (DON) indicated the Mounjaro was not covered by insurance and the medication was discontinued. The order should have been removed from the MAR. A Physician's Order, dated 2/19/24 and listed as current on the 8/2024 POS, indicated the resident was to receive Novolog insulin three times a day per sliding scale. A Physician's Order, dated 3/26/24 and listed as current on the 8/2024 POS, indicated the resident was to receive Humalog insulin three times a day per sliding scale. The 3/2024 MAR indicated QMA 3 had initialed the administration box on the following dates and times for both the Novolog and Humalog insulin, the administration box was coded as "9" which indicated to see nurses' notes. - 3/27/24 at 12:00 p.m. - 3/28/24 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. - 3/30/24 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. - 3/31/24 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Nurses' Notes for the above dates indicated a medication administration note was completed, and the only information documented was the medication order. There was no documentation indicating how much insulin was given and who administered the insulin.		pressure medication. Non-insulin certified QMA was re-educated regarding leaving MAR open for nurse to sign medication administration record for insulin. No adverse reaction noted for R#D. No other residents were affected by the alleged 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 audited clinical records related to the following: topical medication orders to ensure specific affected area locations are noted; review PRN blood pressure medication parameters to ensure that parameters were included in the order for reference by applicable clinical staff; consulted with pharmacy / physician regarding noted isolated incident of medication not being available (due to insurance barrier, resident aware). No other residents or incidents were noted in the review of all resident orders and the medication administration records by the DHW. What measures will be put into	

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		A. BUILDING 00 B. WING	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	During an interview on 8/28/24 at 2:25 p.m., the DON indicated the nurse administered the insulin, not the QMA. The QMA should not have documented her initials on the MAR. A Physician's Order, dated 6/4/24, indicated the resident was to receive Nystatin (an antifungal medication) 100,000 units/gram cream twice daily to affected areas. A Physician's Order, dated 8/1/24, indicated the resident was to receive Midodrine (a medication used to treat low blood pressure) 5 mg, take a 1/2 tablet three times a day as needed (PRN). During an interview on 8/28/24 at 11:00 a.m., the DON indicated the Nystatin order should have indicated where the cream was to be applied and the Midodrine order should have indicated what parameters warranted the medication being given.		place or what systemic changes will be made to ensure that the deficient practice does not recur; On 8/28/24-8/29/24 Nursing staff was immediately re-educated regarding the following by the DHW: complete and accurate clinical records documentation related topical medication specific affected area location, PRN blood pressure medication parameters, and non-Insulin QMAs to leave MAR open for nurse to sign for insulin medication. The DHW or designee will audit applicable Reports including the Order Summary Report (review of any new orders to include affected area(s) as applicable, PRN parameters as applicable) and Medication Administration Report (review to ensure complete and accurate reflection of medication administration). 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 DHW or designee will audit applicable Reports including the Order Summary Report (review of any new orders to include affected area(s) as applicable, PRN parameters as applicable) and Medication Administration Report (review to ensure complete and accurate reflection of medication administration) weekly x12 weeks. Any issues will be addressed	

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			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: 09/27/24**	