

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/22/2024	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF HAMMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 5620 SOHL AVENUE, HAMMOND, , 46320					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00426989. Complaint IN00426989 - State deficiency related to the allegations is cited at R0349. Survey date: February 22, 2024 Facility number: 013801 Residential Census: 117 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/26/24.	R 0000	March 7, 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				

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February 22, 2024 State Residential Licensure Complaint Survey (IN00426989) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools March 7, 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 continuing to better our Elders in our community.

The Plan of Correction submitted on March 7, 2024 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Corrections, please contact me.

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			Respectfully, Neysa Holman Stewart, HFA	
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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 record review and interview, the facility failed to ensure clinical records were complete and accurately documented, related to follow up documentation after incidents between other residents with or without injury, for 2 of 3 residents reviewed for altercations. (Residents B and C) Findings include: 1. The closed record for Resident B was reviewed on 2/22/24 at 9:30 a.m. Diagnoses	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; Resident B and Resident C were not noted to experience any adverse health related outcomes as a result of the alleged incidents	03/14/2024

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FORM APPROVED

OMB NO. 0938-0391

included, but were not limited to, type 2 diabetes, heart failure, anxiety disorder, and high blood pressure.

The Service Plan indicated the resident was cognitively intact.

A State Reportable, dated 12/11/23 at 5:30 p.m., indicated the resident was out in the community and saw another resident who lived in the facility. The other resident asked him if he could purchase some cigarettes for him, as he was not allowed in the store anymore. Resident B agreed to buy the cigarettes for the resident. When Resident B came out of the store, the other resident was agitated because the resident took so long in the store, and punched him in the face. Both residents returned to the facility and were separated and sent to their apartments. The police were called and a report was filed, however, neither resident wanted to press charges.

A Nurses' Note, dated 12/11/23 at 5:54 p.m., indicated the resident continued on antibiotic therapy and had no complaints of pain or discomfort.

A Nurses Note, dated 12/12/23 at 8:37 a.m., indicated the resident was alert and responsive and was in his apartment.

A Nurses' Note, dated 12/12/23

under review; the incidents under review were reported to occur outside of the Community. Resident B and Resident C no longer reside in the Community. 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, DONW or designee audited clinical records related to resident-to-resident incidents with or without injury.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;

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at 12:45 p.m., indicated the nurse went in to speak and check on the resident, however, he was unavailable and was out in the community.

A Nurses' Note, dated 12/12/23 at 6:03 p.m., indicated the resident called and informed the facility he was going to the emergency department because he had a migraine.

The Medication Administration Record for the month of 12/2023 indicated the resident received all of his medications on 12/12/23.

There was no documentation in the resident's clinical record regarding the altercation with the other resident as well as his well-being and how he was feeling and if there were any other injuries.

During an interview on 2/22/24 at 11:00 a.m. the Administrator indicated the Director of Nursing was off, however, she was available by phone. She was under the impression nursing staff had charted on the resident after the incident. She indicated she knew nursing staff had checked up on him when he was in the building, however, there was no documentation in his record to reflect that.

2. The closed record for Resident C was reviewed on 2/22/24 at 10:30 a.m.

On 02/26/24 Nursing staff was immediately re-educated regarding accurately documenting in clinical records related to incidents between residents with or without injury by the Director of Nursing & Wellness. Residents involved in incidents between residents will be put on 72-hour observation / charting for any adverse effects related to the incident. The DONW or Designee will review all resident incidents with or without injury documentation to ensure nursing staff is accurately documenting in the clinical records.

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 Nursing and Wellness or Designee will monitor clinical records for accurate documentation for resident-to-resident incidents to ensure residents involved are being observed for any adverse reactions related to incidents with or without injury on a weekly basis for 12 weeks. Any issues will be addressed

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Diagnoses included, but were not limited to, hernia, heart failure, chronic pain, nicotine dependence, high blood pressure, and major depressive disorder.

The Service Plan indicated the resident was cognitively intact.

A Nurses' Note, dated 12/8/23 at 3:16 p.m., indicated he was involved in an incident that happened off of the property.

A Nurses' Note, dated 12/8/23 at 5:10 p.m., indicated the resident was observed in his apartment with a black eye to the left eye, a pink abrasion on the nose, and a lacerated scabbed lip. The resident indicated he was assaulted by 4 young men outside of the facility. The resident did not want the nurse to call his daughter, and he did not want to go to the hospital. The resident's vital signs were checked.

The next documented entry in Nurses' Notes was on 12/9/23 7:03 p.m., which indicated the hospital had called to inform the facility the resident would be admitted for fractured ribs.

The resident returned on 12/11/23.

The Medication Administration Record for the month of 12/2023 indicated the resident

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: 3/14/24**

received all of his medications on 12/9/23.

There was no documentation or follow up assessment of the resident and the injuries post the incident outside of the facility.

During an interview on 2/22/24 at 11:00 a.m. the Administrator indicated the nurses should have documented how the resident was doing the next day, and before the end of the shift on 12/8/23. There was no nurse who worked during the midnight shift.

This citation relates to Complaint IN00426989.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented, related to follow up documentation after incidents between other residents with or without injury, for 2 of 3 residents reviewed for altercations. (Residents B and C)

Findings include:

1. The closed record for Resident B was reviewed on 2/22/24 at 9:30 a.m. Diagnoses included, but were not limited to, type 2 diabetes, heart failure, anxiety disorder, and high blood pressure.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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