STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF HAMMOND	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 Intake IN00460317. Intake IN00460317 - State deficiency related to the allegations is cited at R0217. Survey date: September 2, 2025 Facility number: 013801 Residential Census: 105 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/8/25.	R 0000	September 12, 2025 Suzanne Williams, Director of Long-Term Care Indiana Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006 Dear Ms. Williams:	

			Please reference the enclosed 2567L as “Plan of Correction” for the September 2, 2025 Complaint Survey (IN00460317) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools September 12, 2025. 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 September 12, 2025 serves as our allegation of compliance. Should you have any questions	

			or concerns regarding the Plan of Corrections, please contact me. Respectfully, Neysa Holman Stewart, HFA	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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. (3) The agreed upon service plan shall be signed and dated by the	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 B, C Service Plans were reviewed and	09/19/2025

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 record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 2 of 4 resident records reviewed. (Residents B and C)

Findings include:

1. The record for Resident B was reviewed on 9/2/25 at 9:55 a.m. Diagnoses included, but were not limited to, heart failure, dementia, and depression.

A Fall Risk assessment, dated 3/22/24 and completed upon admission, indicated the resident was a high fall risk.

A Service Plan, dated 6/26/25, indicated the resident made safe judgements and would function appropriately in social situations. The resident needed

revised as appropriate / updated related to fall
prevention and safety precautions.

Nursing staff was immediately re-educated regarding the importance of reviewing and updating Fall Service Plan after each event to reflect fall prevention and safety precautions
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 completed and audit of residents with falls in the last 90 days to ensure a Service Plans related to falls were in place, reviewed

	occasional assistance to get in/out of bed, chair or car. A Progress Note, dated 8/22/25 at 3:24 a.m., indicated the resident had a fall on the night shift. A CNA 24 Hour Report, dated 8/22/25, indicated the resident had an unwitnessed fall and slid out of her wheelchair onto the floor. Two CNA's attempted to get the resident off the floor and were unable. A 911 call was placed to help assist getting Resident B off the floor. The Service Plan lacked any fall prevention or safety precautions and was not updated after a fall on 8/22/25. During an interview on 9/2/25 at 1:57 p.m., the Director of Nursing (DON) indicated she understood the concern and had no additional information to provide. 2. The record for Resident C was reviewed on 9/2/25 at 12:26 p.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension (high blood pressure), diabetes, and dependence on renal dialysis. A Fall Risk assessment, dated 6/30/25 and completed upon admission indicated the resident was a high fall risk		and updated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 9/02/25 -9/03/25 applicable nursing staff were immediately in-serviced regarding reviewing / updating Fall Service Plan after each event to reflect fall prevention or safety precaution. The DHW and/or designee will review the 24HR Report and Accident Report weekly to ensure Service Plans related to falls are reviewed / updated appropriately. 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 Report & Accident Report weekly	

A Service Plan. dated 6/30/25, indicated the resident was oriented and able to recall and retain information, and needed one-person physical assist with bathing / showering.

A Progress Note, dated 8/2/25, indicated the resident had an unwitnessed fall and was found sitting on the floor in front of the 2nd floor elevator. The resident was assessed for injuries and assisted off the floor to his rollator. The resident denied hitting his head and indicated he had no pain or discomfort.

The Service Plan lacked any fall prevention or safety precautions and was not updated after a fall on 8/2/25.

During an interview on 9/2/25 at 12:44 p.m., the Director of Nursing (DON) indicated they should have had the resident listed as a fall risk in his service plan since on admission his fall assessment indicated he was high risk.

The "Fall Prevention and Management " policy, received as current from the DON on 9/2/25 at 12:55 p.m. indicated, " ... 1. The resident's individualized service plan is reviewed and updated by the Community's licensed nurse, as needed, biannually, post fall event, and/or with significant change of condition..."

for 3 months to ensure resident’s Service Plans are reviewed / updated and implemented related to falls. 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 will be amended when indicated.

Date by which systemic corrections will be completed: 9/19/25

This citation relates to Intake IN00460317.

Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 2 of 4 resident records reviewed. (Residents B and C)

Findings include:

1. The record for Resident B was reviewed on 9/2/25 at 9:55 a.m. Diagnoses included, but were not limited to, heart failure, dementia, and depression.

A Fall Risk assessment, dated 3/22/24 and completed upon admission, indicated the resident was a high fall risk.

A Service Plan, dated 6/26/25, indicated the resident made safe judgements and would function appropriately in social situations. The resident needed occasional assistance to get in/out of bed, chair or car.

A Progress Note, dated 8/22/25 at 3:24 a.m., indicated the resident had a fall on the night shift.

A CNA 24 Hour Report, dated 8/22/25, indicated the resident had an unwitnessed fall and slid out of her wheelchair onto the floor. Two CNA's attempted to get the resident off the floor and were unable. A 911 call was

placed to help assist getting Resident B off the floor.

The Service Plan lacked any fall prevention or safety precautions and was not updated after a fall on 8/22/25.

During an interview on 9/2/25 at 1:57 p.m., the Director of Nursing (DON) indicated she understood the concern and had no additional information to provide.

2. The record for Resident C was reviewed on 9/2/25 at 12:26 p.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension (high blood pressure), diabetes, and dependence on renal dialysis.

A Fall Risk assessment, dated 6/30/25 and completed upon admission indicated the resident was a high fall risk

A Service Plan. dated 6/30/25, indicated the resident was oriented and able to recall and retain information, and needed one-person physical assist with bathing / showering.

A Progress Note, dated 8/2/25, indicated the resident had an unwitnessed fall and was found sitting on the floor in front of the 2nd floor elevator. The resident was assessed for injuries and assisted off the floor to his rollator. The resident denied

	hitting his head and indicated he had no pain or discomfort. The Service Plan lacked any fall prevention or safety precautions and was not updated after a fall on 8/2/25. During an interview on 9/2/25 at 12:44 p.m., the Director of Nursing (DON) indicated they should have had the resident listed as a fall risk in his service plan since on admission his fall assessment indicated he was high risk. The "Fall Prevention and Management " policy, received as current from the DON on 9/2/25 at 12:55 p.m. indicated, " ... 1. The resident's individualized service plan is reviewed and updated by the Community's licensed nurse, as needed, biannually, post fall event, and/or with significant change of condition..." This citation relates to Intake IN00460317.			

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