STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/14/2022

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 Complaints IN00377635 and IN00379510. Complaint IN00377635 - Unsubstantiated due to lack of evidence. Complaint IN00379510 - Substantiated. State deficiencies related to the allegations are cited at R0349. Survey date: September 14, 2022 Facility number: 013801 Residential Census: 115 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/16/22.	R 0000	September 27, 2022 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	

			September 14,2022 State Residential Licensure Survey (IN00379510) 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 27,2022. 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 27, 2022 serves as our allegation of compliance. The provider respectfully request a Desk Review on or after	

			October 7,2022. Should you have any question or concerns regarding the Plan of Corrections, please contact me. 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 related to the lack of documentation of a fall, an assessment of the resident, or a transfer to the hospital for 1 of 3 residents reviewed for falls. (Resident B) Finding includes:	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;**	10/07/2022

	The closed record for Resident B was reviewed on 9/14/22 at 11:00 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, stroke, vascular dementia, epilepsy, and chronic pain. A Service Plan, dated 12/19/20, indicated the resident had mobility deficits and was unable to use the stairs and exit the building without assistance. The resident would be able to use a rolling walker for ambulation. A Nurses' Note, dated 3/22/22, indicated the resident tested negative for COVID-19. The next documented Nurses' Note, was dated 4/13/22 at 1:35 p.m., which indicated the resident was currently admitted to a skilled nursing facility for rehabilitation. The writer had spoken with the daughter to discuss current status and possible return to the facility. There was no documentation as to what happened to the resident and why he was at a skilled nursing facility. On 9/14/22 at 1:30 p.m., the Director of Nursing (DON) and the Administrator were interviewed. The Administrator provided a copy of the stand up morning meeting notes, dated 3/29/22, which indicated the resident had		R#1 no longer reside in the facility. 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 audited clinical records related to falls and hospital transfers to ensure documentation is noted in clinical records. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 9/14/22 Nursing staff was	

	a fall and was sent to the hospital. The DON indicated the resident was sent out via 911 after the fall. There was no information in the resident's clinical record regarding the fall, an assessment of the resident at the time of fall, or a transfer to the hospital. This State Residential finding relates to Complaint IN00379510. Based on record review and interview, the facility failed to ensure clinical records were complete related to the lack of documentation of a fall, an assessment of the resident, or a transfer to the hospital for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: The closed record for Resident B was reviewed on 9/14/22 at 11:00 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, stroke, vascular dementia, epilepsy, and chronic pain. A Service Plan, dated 12/19/20, indicated the resident had mobility deficits and was unable to use the stairs and exit the building without assistance. The resident would be able to use a rolling walker for ambulation. A Nurses' Note, dated 3/22/22, indicated the resident tested		immediately re-educated regarding clinical record documentation related to falls, fall assessment and hospital transfer. In-service provided to all Nursing staff related to implementation of Fall observation statement form, Clinical record documentation related to falls, fall assessment and hospital transfer on 09/14/22 -.09/19/22 by the Director of Health and Wellness. 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 monitor clinical records for fall documentation, fall assessment s/p fall and hospital transfer documentation weekly for 3 months. 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	

	negative for COVID-19. The next documented Nurses' Note, was dated 4/13/22 at 1:35 p.m., which indicated the resident was currently admitted to a skilled nursing facility for rehabilitation. The writer had spoken with the daughter to discuss current status and possible return to the facility. There was no documentation as to what happened to the resident and why he was at a skilled nursing facility. On 9/14/22 at 1:30 p.m., the Director of Nursing (DON) and the Administrator were interviewed. The Administrator provided a copy of the stand up morning meeting notes, dated 3/29/22, which indicated the resident had a fall and was sent to the hospital. The DON indicated the resident was sent out via 911 after the fall. There was no information in the resident's clinical record regarding the fall, an assessment of the resident at the time of fall, or a transfer to the hospital. This State Residential finding relates to Complaint IN00379510.		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: 10/07/22**	

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