

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 03/02/2023	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 3630 HICKORY ROAD, MISHAWAKA, , 46545					
(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 IN00401491, IN00402391, and IN00402722. Complaint IN00401491 - No State Residential Findings related to the allegations were cited. Complaint IN00402391 - State Residential Findings related to the allegations are cited at R0036. Complaint IN00402722 - State Residential Findings related to the allegations are cited at R0243. Survey date: March 1 & 2, 2023 Facility number: 014260 Residential Census: 114 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective April 3,2023. We respectfully request a desk review and consideration for paper compliance of substantial compliance based on the POC.				

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	3/8/2023.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview, observation, and medical record review, the facility failed to provide timely treatment for a urinary tract infection (Resident F) and removal of staples (Resident E) for 2 of 9 residents reviewed for quality of care. Findings include: 1. A clinical record review of Resident F was completed on 3/1/2023 at 10: 38 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, hypothyroidism, and depressive disorder. A Brief Interview for Mental Status (BIMS) on 9/21/2022,	R 0036	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> Resident F is deceased. Resident E Staples removed on 3/9/23. <u>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:</u> All current residents residing at Silver Birch of Mishawaka has a potential to be affected by the alleged deficient practice. All current employees will be educated on the Stop and Watch – Early warning tool. <u>What measures will be put into place or what systemic changes the facility will make</u>	04/03/2023

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indicated Resident F had moderate cognitive impairment. She was independent with toileting.

A Nurse's Note, on 12/27/2023, at 9:53 A.M., indicated Resident F was complaining of discomfort while urinating, and Resident F appeared more confused than usual.

A Physician Order, on 12/27/2023, indicated for staff to obtain a urinalysis with culture and sensitivity, if indicated.

On 12/28/2022, at 6:33 P.M., a Nurse's Note indicated, the urine sample was collected and taken to the laboratory.

A Nurse's Note, on 1/1/2023 at 1:50 P.M., indicated the daughter of Resident F was concerned about Resident F's behavior, and the response given of, "I don't know", to questions.

On 1/1/2023 at 6:04 P.M., a Nurse's Note indicated that Resident F continued to be confused including placing odd in things in odd places, standing in her room without pants on, and taking the bedding on and off the bed.

The urinalysis with culture and sensitivity was reported to the facility on 1/4/2023. The culture indicated Escherichia coli of greater than 100,000 colony

to ensure that the deficient practice does not recur;

Director of Nursing and Wellness (DONW) or designee will review Stop and Watch Tool daily and add to binder. Physician will be notified of any change and resident will be placed on the watch list.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

The DONW or designee will report findings to the quality assurance (QA) committee monthly until 100% compliance is met for 3 consecutive months, then quarterly until resolved as determined by the QA committee.

What date the systemic changes will be completed:

Changes will be completed by 4/3/2023

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forming units per milliliters. The Medical Director signed and dated the urinalysis with culture and sensitivity on 1/5/2023, and an order for levofloxacin 500 milligrams daily was obtained on 1/6/2023.

The Medication Administration Record indicated the first dose of levofloxacin was administered on 1/7/2023. at 8:00 A.M.

During an interview on 3/2/2023 at 10:01 A.M., the Senior Clinical Advisor indicated an abnormal lab would be sent to the physician, and the physician should be contacted the same day of the abnormal lab report. The Senior Clinical Advisor refused to answer questioning of the timeliness of treatment for a positive urinary tract infection.

A policy was request for treatment of urinary tract infections. On 3/2/2023 at 1:28 P.M., the Executive Director indicated a policy was not available for urinary tract infections.

2. A clinical record review of Resident E was completed on 3/1/2023 at 11:48 A.M. Diagnoses included, but were not limited to: multiple sclerosis, hypertension, depression, and alcohol abuse.

A Nurse's Note, on 2/15/2023, at 1:58 P.M., indicated Resident E was found on the floor with a

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gash on the right side of his head. Resident E believed he was sleep-walking and hit his head on the side of his wheelchair.

An AfterVisit Summary from a local hospital on 2/15/2023, indicated to follow up with hospital physician for staple removal around 2/22/2023. An appointment was made for 2/23/2023 at 11:00 A.M.

During an observation on 3/1/2023 at 1:33 P.M., Resident E was observed to have 3 staples to his right scalp above the ear.

On 3/2/2023 at 9:20 A.M., Resident E was observed to have 3 staples to his right scalp above the ear.

During an interview on 3/2/2023 at 10:01 A.M., the Senior Clinical Advisor indicated she was not sure if Resident E went to the scheduled appointment for suture removal. She indicated staple removal should occur within 10-14 days of placement.

On 3/2/2023 at 11:28 A.M., QMA 1 indicated while speaking with the Senior Clinical Advisor, she was not sure if the staples were still in place, or if Resident E went to the scheduled appointment. She indicated she would go check Resident E's head for the presence of

staples.

A telephone call was placed to the physician's office on 3/2/2023 at 11:38 A.M. The telephone attendant indicated Resident E did not attend the scheduled appointment.

A policy for staple care was request. The Executive Director indicated at 1:28 P.M., a policy was not available for staple care.

Based on interview, observation, and medical record review, the facility failed to provide timely treatment for a urinary tract infection (Resident F) and removal of staples (Resident E) for 2 of 9 residents reviewed for quality of care.

Findings include:

1. A clinical record review of Resident F was completed on 3/1/2023 at 10: 38 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, hypothyroidism, and depressive disorder.

A Brief Interview for Mental Status (BIMS) on 9/21/2022, indicated Resident F had moderate cognitive impairment. She was independent with toileting.

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On 1/1/2023 at 6:04 P.M., a Nurse's Note indicated that Resident F continued to be confused including placing odd in things in odd places, standing in her room without pants on, and taking the bedding on and off the bed.

The urinalysis with culture and sensitivity was reported to the facility on 1/4/2023. The culture indicated Escherichia coli of greater than 100,000 colony forming units per milliliters. The Medical Director signed and dated the urinalysis with culture and sensitivity on 1/5/2023, and an order for levofloxacin 500 milligrams daily was obtained on 1/6/2023.

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R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review the facility failed to administer insulin for 1 of 2 residents reviewed for medication administration and a resident was given a medication cup with a different room number on it for a resident reviewed for medication administration.	R 0243	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> Resident D -Residents insulin has been administered with no further issues to date. Resident C Not Identifiable <u>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;</u> All current residents residing at Silver Birch of Mishawaka has the potential to be affected	04/03/2023

(Resident D and C)

Findings include:

1. During an interview, on 3/1/2023 at 10:57 A.M., Resident D indicated he recently did not get his blood sugar taken and insulin given in the evening. He did not recall the exact date, but it was in February. His blood sugar was elevated during the night, and it was in the morning. He was down in the card room playing cards and they usually came down and gave it. When he returned to his floor, he spoke to someone and they indicated the person doing the insulin went home for the evening and there was no one working that could give it.

A clinical record review for Resident D on 3/1/2023 at 11:40 A.M. The diagnoses included, but limited to: diabetes type 2, and hypertension.

A Physician Order, dated 2/2023, Lantus SoloStar Solution Pen-injector 100 UNIT/ML 40 unit subcutaneously at bedtime related to type 2 diabetes.

Review of the Medication Administration Record (MAR), dated February 2023 indicted that on 2/19/2023 no entry of a blood sugar or Lantus administered at bedtime.

by this alleged deficient practice. All current nursing staff has been reeducated on the medication administration program and policy.

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

Director of Nursing and Wellness (DONW) will audit the medication administration documentation weekly for 3 months and then 1 time monthly for 3 months and then randomly for 3 months for appropriate documentation regarding medication administration. Any findings will be addressed at the time of discovery and recorded on auditing tool with corrective action.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

The DONW or designee will

Review of the electronic medical record for 2/20/2023 the morning blood sugar was 389.

During an interview, on 3/1/2023 at 2:00 P.M., the Qualified Medication Aide (QMA) 1 indicated if the box is blank in the MAR that means it was not given. She looked in the record and indicated that 2/19/2023 was still red in the electronic medical record which indicated the insulin and blood sugar was not signed for and no reason was marked for why it was not given.

During a phone interview, on 3/2/2023 at 11:00 A.M., QMA 4 indicated that Resident D complained last month that he did not get his insulin and that is why his blood sugar was so high in the morning. She reported this to the Director of Nursing. She did not recall the date, but it was not that long ago.

During a phone interview, on 3/2/2023 at 10:49 A.M., Agency Licence Practical Nurse (LPN) 7 indicated that when she works, she does the insulin cart. She was not home so did not know what days she worked the past month. If the schedule indicated, she worked she probably did. She indicated that when a medication is given to a resident you sign that it was given in the MAR. If it is blank that means it was not given. If a

report audit findings to the Quality Assurance (QA) Committee monthly until 100% compliance is met for 3 consecutive months, then quarterly until resolved as determined by the QA committee.

What date the systemic changes will be completed:

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resident is not available, she would put N/A.

On 3/2/2023 at 1:31 P.M., the Administrator provided a policy titled, "Medication Administration Program Policy", revised 6/15/18, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 3. Residents receiving medication assistance will have: b. Documentation of the medication name, dose, time, taken by resident. c. Documentation of refusals or inability to take medication according to the prescription...."

Based on observation, interview, and record review the facility failed to administer insulin for 1 of 2 residents reviewed for medication administration and a resident was given a medication cup with a different room number on it for a resident reviewed for medication administration. (Resident D and C)

Findings include:

1. During an interview, on 3/1/2023 at 10:57 A.M., Resident D indicated he recently did not get his blood sugar taken and insulin given in the evening. He did not recall the exact date, but it was in February. His blood sugar was elevated during the night, and it

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FORM APPROVED

OMB NO. 0938-0391

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	Documentation of the medication name, dose, time, taken by resident. c. Documentation of refusals or inability to take medication according to the prescription...."			
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