STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF FORT WAYNE	7125 S HANNA STREET, FORT WAYNE, , 46816

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00376259, IN00376274, IN00377203, IN00377218, IN00377315, IN00377631, IN00377880, IN00378802 and IN00379362. Complaint IN00376259 - Substantiated, No deficiencies related to the allegations are cited. Complaint IN00376274 - Substantiated, No deficiencies related to the allegations are cited. Complaint IN00377203 - Substantiated, No deficiencies related to the allegations are cited. Complaint IN00377218 - Unsubstantiated due to lack of evidence. Complaint IN00377315 -	R 0000	I respectfully request a desk review of the following plan of correction to the survey conducted at Silver Birch Fort Wayne on May 10, 2022. Silver Birch of Fort Wayne desires this plan of correction to be considered the facility'sAllegation of Compliance effective June 12, 2022.	

	Unsubstantiated due to lack of evidence. Complaint IN00377631 - Unsubstantiated due to lack of evidence. Complaint IN00377880 - Substantiated, No deficiencies related to the allegations are cited. Complaint IN00378802 - Unsubstantiated due to lack of evidence. Complaint IN00379362 - Substantiated. State deficiencies related to the allegations are cited at R0240 Survey dates: May 4, 5, 6, 9, and 10, 2022 Facility number: 014316 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 11, 2022			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in	R 0042	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	06/12/2022

	effect with respect to the facility, and any subsequent surveys. Based on observation, interview and record review, the facility failed to ensure Indiana State Survey Reports and the facility's Plan of Correction (POC) were available for review by the residents or their families. There were 102 residents residing in the facility. Findings include: On 5/4/2022 at 10:30 a.m., observed a wall mounted rack by the receptionist desk was labeled and the rack contained a binder labeled, Indiana State Surveys. During a review of the facility's Indiana State Survey binder on 5/9/2022 at 1:40 PM., was found a survey report filed in the binder was dated 12/22/2021, which was for a Residential COVID-19 Quality Assurance Walk Through Survey. Survey Reports were not filed in the State Survey binder for 2 surveys which were conducted in 2022. The missing survey reports were both for complaint investigations completed on 1/21/2022 and 3/4/2022. The facility also failed to file the POC for the deficiencies cited on the 3/4/2022 for a complaint survey. These survey reports were not available for review by the residents or their families		Survey report binder has been updated to include complaint surveys on 1/22/22, 3/3/22, and complaint/annual survey of 5/10/22. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents of the community were affected. The survey report binder will be updated so community residents have access to review surveys. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Executive Director (ED) or designee will check binder monthly to ensure that no survey documents are missing. ED will ensure documents are in place or correct immediately. **How will the corrective action be monitored to ensure the**	

	without asking for the reports. An interview with the Executive Director on 5/9/2022 at 3:33 PM, indicated the facility did not have a specific policy, but should follow the State Regulations for keeping the State Survey Reports Binder updated with all survey reports. An interview with the Executive Director on 5/10/2022 at 12:20 PM, the Executive Director indicated their State Survey Reports were currently up-to-date with all survey reports filed in the binder. Based on observation, interview and record review, the facility failed to ensure Indiana State Survey Reports and the facility's Plan of Correction (POC) were available for review by the residents or their families. There were 102 residents residing in the facility. Findings include: On 5/4/2022 at 10:30 a.m., observed a wall mounted rack by the receptionist desk was labeled and the rack contained a binder labeled, Indiana State Surveys. During a review of the facility's Indiana State Survey binder on 5/9/2022 at 1:40 PM., was found a survey report filed in the		**deficient practice will not recur?** Binder audit checklist will be reviewed by QA committee monthly for six months or until 100% compliance is reached. Systemic changes will be completed by: June 12, 2022	

	binder was dated 12/22/2021, which was for a Residential COVID-19 Quality Assurance Walk Through Survey. Survey Reports were not filed in the State Survey binder for 2 surveys which were conducted in 2022. The missing survey reports were both for complaint investigations completed on 1/21/2022 and 3/4/2022. The facility also failed to file the POC for the deficiencies cited on the 3/4/2022 for a complaint survey. These survey reports were not available for review by the residents or their families without asking for the reports. An interview with the Executive Director on 5/9/2022 at 3:33 PM, indicated the facility did not have a specific policy, but should follow the State Regulations for keeping the State Survey Reports Binder updated with all survey reports. An interview with the Executive Director on 5/10/2022 at 12:20 PM, the Executive Director indicated their State Survey Reports were currently up-to-date with all survey reports filed in the binder.			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h)	R 0151	**What corrective actions will be accomplished for those residents found to have been affected by the deficient**	06/12/2022

	(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure 4 of 4 pets living with residents in the facility had required annual veterinary examinations and required immunizations. There were 102 residents and 4 pets residing in the facility. (Resident 27, Resident 29, Resident 65 and Resident 70) Findings include: The facility's pet records were provided by the Executive Director (ED) on 5/5/2022 at 10:30 AM. During an interview at that time, the ED indicated currently all pet records were not available and the residents were requested to obtain their current pet records from their veterinarian. Review of the facility's pet records on 5/5/2022 at 10:30 AM indicated the facility listed 4 residents with pets and all of the residents had cats. The Facility's documentation indicated 2 of the 4 cats were past due for vaccinations. Review of facility's pet list indicated the following: Resident 27 had a cat and the		**practice?** Residents who did not have an Assistance Animal Lease Addendum on file will sign the Addendum. Residents who did not have current vaccination information for their support animals will be notified and required to provide updated vaccination records to the community. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Assistance animal policies and application procedures will be reviewed at the time of lease signing with all residents by the Eligibility Coordinator or designee. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Eligibility Coordinator will track dates that updated	

	cat's vaccinations were due on 4/2023. The facility's pet file was lacking a veterinary examination and vaccination records from the veterinarian for Resident 27's cat. Resident 29 had a cat and their cat's vaccinations were due on 3/2023. The facility's pet file was lacking veterinary examination and vaccination records from the veterinarian for Resident 29's cat. Resident 65 had a cat and their cat's vaccinations were due on 1/7/2021. Resident 65 had pet records, dated 12/11/2020, for an annual physical exam, toe nail trim and administration of a 1 year rabies vaccination. Resident 70 had a cat and their cat's vaccinations were due on 12/11/2021. Resident 70's pet records, dated 1/7/2021 was for a cat neuter (castration/sterilization), 1 year rabies vaccine, microchip, penicillin injection (post operation to prevent infection) and nail trim. During an interview with the ED on 5/9/2022 at 10:40 AM, indicated no additional pet records were provided by the residents with pets. During an interview with the ED on 5/9/2022 at 4:03 PM, indicated only 2 of the 4 residents had signed the		vaccinations are due and send notifications to residents by letter to ensure that pet vaccinations are completed timely. **How will the corrective action be monitored to ensure the deficient practice will not recur?** Vaccination audit checklist will be reviewed by QA committee monthly for six months or until 100% compliance is reached. Systemic changes will be completed by: June 12, 2022	

	facility's Assistance Animal Lease Addendum. The ED provided the Assistance Animal Lease Addendums for Resident 65, which was dated 5/19/2021 and Resident 70 was dated on 2-15-2021. The ED indicated Resident 27 and Resident 29 did not have a signed Assistance Animal Lease Addendum on file. Review of the current facility's policy provided by the ED on 5-9-2022 at 10:40 AM, titled, Assistance Animal Policy, with a revision date 2-1-2020, indicated, "...Silver Birch's policy is to provide a Resident with an Assistance Animal with equal opportunity to access to the premises of Silver Birch...Programs, and activities provided that Residents with Assistance Animals comply with the Resident Requirements under the Assistance Animal Lease Addendum...Residents with Service Animals may maintain the Service Animal on the Premises, as long as the Resident complies with the requirements of the Assistance Animal Lease Addendum...Resident seeking to maintain a Emotional Support Animal may request the Owner make a reasonable accommodation to the "no pet policy" on the bases of a Disability. Such request for accommodation shall include items: 1. Verification; 2.			

	Evidence of all immunizations and vaccinations required by Paragraph 5b of the Assistance Animal Lease Addendum...Assistance Animal Resident's Responsibilities...Resident with Assistance Animal are responsible for complying with the following: Signing the Assistance Animal Lease Addendum...Maintaining continuous compliance with Resident's responsibilities stated in the Assistance Animal Lease Addendum...." Review of the facility's Assistance Animal Lease Addendum, dated 11/4/2018, was provided by the ED on 5/9/2022 at 4:03 PM, indicated. "...Requirements of Resident to Retain Assistance Animal...The Resident must demonstrate the Resident is capable of meeting all of the following requirements to retain the Assistance Animal...5. Vaccinations, Maintenance, Grooming and Food-The resident is responsible to ensure that each of the following maintenance responsibilities are maintained at all time...b. The Resident must ensure the animal is immunized against disease common to that type of animal...All vaccinations must be current...." Based on interview and record review, the facility failed to			

ensure 4 of 4 pets living with residents in the facility had required annual veterinary examinations and required immunizations. There were 102 residents and 4 pets residing in the facility. (Resident 27, Resident 29, Resident 65 and Resident 70)

Findings include:

The facility's pet records were provided by the Executive Director (ED) on 5/5/2022 at 10:30 AM. During an interview at that time, the ED indicated currently all pet records were not available and the residents were requested to obtain their current pet records from their veterinarian.

Review of the facility's pet records on 5/5/2022 at 10:30 AM indicated the facility listed 4 residents with pets and all of the residents had cats. The Facility's documentation indicated 2 of the 4 cats were past due for vaccinations.

Review of facility's pet list indicated the following:

Resident 27 had a cat and the cat's vaccinations were due on 4/2023. The facility's pet file was lacking a veterinary examination and vaccination records from the veterinarian for Resident 27's cat.

Resident 29 had a cat and their

	cat's vaccinations were due on 3/2023. The facility's pet file was lacking veterinary examination and vaccination records from the veterinarian for Resident 29's cat. Resident 65 had a cat and their cat's vaccinations were due on 1/7/2021. Resident 65 had pet records, dated 12/11/2020, for an annual physical exam, toe nail trim and administration of a 1 year rabies vaccination. Resident 70 had a cat and their cat's vaccinations were due on 12/11/2021. Resident 70's pet records, dated 1/7/2021 was for a cat neuter (castration/sterilization), 1 year rabies vaccine, microchip, penicillin injection (post operation to prevent infection) and nail trim. During an interview with the ED on 5/9/2022 at 10:40 AM, indicated no additional pet records were provided by the residents with pets. During an interview with the ED on 5/9/2022 at 4:03 PM, indicated only 2 of the 4 residents had signed the facility's Assistance Animal Lease Addendum. The ED provided the Assistance Animal Lease Addendums for Resident 65, which was dated 5/19/2021 and Resident 70 was dated on 2-15-2021. The ED indicated			

	Resident 27 and Resident 29 did not have a signed Assistance Animal Lease Addendum on file. Review of the current facility's policy provided by the ED on 5-9-2022 at 10:40 AM, titled, Assistance Animal Policy, with a revision date 2-1-2020, indicated, "...Silver Birch's policy is to provide a Resident with an Assistance Animal with equal opportunity to access to the premises of Silver Birch...Programs, and activities provided that Residents with Assistance Animals comply with the Resident Requirements under the Assistance Animal Lease Addendum...Residents with Service Animals may maintain the Service Animal on the Premises, as long as the Resident complies with the requirements of the Assistance Animal Lease Addendum...Resident seeking to maintain a Emotional Support Animal may request the Owner make a reasonable accommodation to the "no pet policy" on the bases of a Disability. Such request for accommodation shall include items: 1. Verification; 2. Evidence of all immunizations and vaccinations required by Paragraph 5b of the Assistance Animal Lease Addendum...Assistance Animal Resident's Responsibilities...Resident with			

	Assistance Animal are responsible for complying with the following: Signing the Assistance Animal Lease Addendum...Maintaining continuous compliance with Resident's responsibilities stated in the Assistance Animal Lease Addendum...." Review of the facility's Assistance Animal Lease Addendum, dated 11/4/2018, was provided by the ED on 5/9/2022 at 4:03 PM, indicated. "...Requirements of Resident to Retain Assistance Animal...The Resident must demonstrate the Resident is capable of meeting all of the following requirements to retain the Assistance Animal...5. Vaccinations, Maintenance, Grooming and Food-The resident is responsible to ensure that each of the following maintenance responsibilities are maintained at all time...b. The Resident must ensure the animal is immunized against disease common to that type of animal...All vaccinations must be current...."			

R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review the facility failed to follow physician order for 1 of 7 residents reviewed (Resident A). Findings include: A resident roster was provided by the Executive Director (ED) on 5/4/22 at 12:21 PM, which indicated Resident A was interviewable. Resident A was interviewed on 5/5/22 at 10:34 AM. Resident A indicated staff were not checking her blood pressure prior to administration of blood pressure medication. A record review was completed on 5/6/22 at 10:30 AM for Resident A. An order, dated 4/26/22, for Metoprolol Tartrate tablet 25 mg give 12.5 mg by mouth two times a day for beta blocker. Give ½ tab POI BID. Hold for BP <100/60. Resident A's Medication Administration Record (MAR) indicated the medication was given on 4/27/22-5/4/22 and 5/7/22-5/8/22 on 1st shift, and	R 0240	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents who are on medications with a need for blood pressure prior to giving medication will have parameters listed in EMAR and documented blood pressures as needed. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Director of Nursing and Wellness will review Resident Orders for Blood Pressure medication to determine Residents who require blood pressure prior to providing medication and correct EMAR. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Facility updated PCC to	06/12/2022

	4/27/22-5/8/22 on 2nd shift. Documentation was lacking that blood pressure was taken prior to the administration of the medication. QMA 2 was interviewed on 5/5/22 at 1:48 PM. QMA 2 indicated she took Resident A's blood pressure prior to administration of medication. QMA 2 indicated she would only document her blood pressure if it was <100. QMA 7 was interviewed on 5/5/22 at 2:30 PM. QMA 7 indicated she took Resident A's blood pressure prior to administration of medication. QMA 7 indicated she would document this on paper due to no place to document in the electronic chart. QMA 7 indicated other residents with a similar order have an automatic pop up requiring the blood pressure to be enter prior to administration of medication, but Resident A did not. The Director of Nursing (DON) was interviewed on 5/6/22 at 2:51 PM. The DON indicated if a resident had an order that included parameters of when medication could be given or not, the documentation would be on the MAR. The Regional Nurse Consultant was interviewed on 5/9/22 at 10:52 AM. The Regional Nurse		include a parameter box to require staff to input the blood pressure readings before blood pressure medication is given when a blood is required. **How will the corrective action be monitored to ensure the deficient practice will not recur?** PointClickCare (PCC) report will be ran weekly to ensure that parameters are followed and education will be provided by the DONW or designee as needed. Reports will be reviewed monthly in QA committee for six months or until 100% compliance is reached. Systemic changes will be completed by: June 12, 2022	

	Consultant indicated the facility did not have a specific policy but followed Indiana Department of Health guidance. This finding relates to Complaint IN00379362 Based on interview and record review the facility failed to follow physician order for 1 of 7 residents reviewed (Resident A). Findings include: A resident roster was provided by the Executive Director (ED) on 5/4/22 at 12:21 PM, which indicated Resident A was interviewable. Resident A was interviewed on 5/5/22 at 10:34 AM. Resident A indicated staff were not checking her blood pressure prior to administration of blood pressure medication. A record review was completed on 5/6/22 at 10:30 AM for Resident A. An order, dated 4/26/22, for Metoprolol Tartrate tablet 25 mg give 12.5 mg by mouth two times a day for beta blocker. Give ½ tab POI BID. Hold for BP <100/60. Resident A's Medication Administration Record (MAR) indicated the medication was given on 4/27/22-5/4/22 and 5/7/22-5/8/22 on 1st shift, and 4/27/22-5/8/22 on 2nd shift.			

	Documentation was lacking that blood pressure was taken prior to the administration of the medication. QMA 2 was interviewed on 5/5/22 at 1:48 PM. QMA 2 indicated she took Resident A's blood pressure prior to administration of medication. QMA 2 indicated she would only document her blood pressure if it was <100. QMA 7 was interviewed on 5/5/22 at 2:30 PM. QMA 7 indicated she took Resident A's blood pressure prior to administration of medication. QMA 7 indicated she would document this on paper due to no place to document in the electronic chart. QMA 7 indicated other residents with a similar order have an automatic pop up requiring the blood pressure to be enter prior to administration of medication, but Resident A did not. The Director of Nursing (DON) was interviewed on 5/6/22 at 2:51 PM. The DON indicated if a resident had an order that included parameters of when medication could be given or not, the documentation would be on the MAR. The Regional Nurse Consultant was interviewed on 5/9/22 at 10:52 AM. The Regional Nurse Consultant indicated the facility			

	did not have a specific policy but followed Indiana Department of Health guidance. This finding relates to Complaint IN00379362			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to ensure staff wore masks that covered their nose and mouth. This affected 102 of 102 residents who reside in the facility and ate their meals from the kitchen (Chef 3, Dietary 4, Dietary 5, Dietary 6, Dietary 8). Findings include:	R 0407	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** On May 10 and May 12, all staff were educated on infection control regarding mask use and current masking guidelines. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Staff not following masking guidelines will be educated immediately by a leadership team member or designee. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?**	06/12/2022

	An observation was made on 5/4/22 at 9:40 AM. Chef 3, Dietary 4 and Dietary 8 were not wearing masks in the kitchen. Chef 3 was interviewed on 5/4/22 at 9:45 AM. Chef 3 indicated a mask is not required due to vaccination status. An observation was made in the dining room on 5/4/22 at 11:40 AM. Dietary 4 and Dietary 5 were wearing their mask under their nose. Chef 3 had pulled his mask down to talk to residents. An observation was made on 5/5/22 from 11:23 AM - 11:42 AM in the dining room. Dietary 5 had his mask pulled down around his chin. Dietary 5 was interviewed on 5/5/22 at 11:38 AM, Dietary 5 indicated he should not have his mask down around his chin. An observation was made on 5/5/22 at 1:45 PM. Dietary 4 had pulled her mask down to talk to residents. The Executive Director (ED) was interviewed on 5/5/22 at 1:56 PM. The ED indicated staff should wear mask appropriately. An observation was made on 5/6/22 at 12:21 PM in the dining room. Dietary 6 had her mask pulled down around her chin around residents.		Daily tours of the community to ensure employees are following current masking guidelines will be completed by ED, DONW, or their designee and any concerns will be addressed immediately. **How will the corrective action be monitored to ensure the deficient practice will not recur?** Regulatory status will be discussed in monthly QA committee meetings and any concerns will be addressed immediately by ED or DONW. QA will review mask audits monthly for six months or until 80% compliance is reached. Systemic changes will be completed by: June 12, 2022	

Dietary 6 was interviewed on 5/6/22 at 12:26 PM. Dietary 6 indicated she should not pull her mask down around residents.

The ED was interviewed on 5/4/22 at 1:40 PM. The Administrator indicated the facility did not have a specific policy regarding mask but followed the Indiana Department of Health guidance.

Based on observation and interview, the facility failed to ensure staff wore masks that covered their nose and mouth. This affected 102 of 102 residents who reside in the facility and ate their meals from the kitchen (Chef 3, Dietary 4, Dietary 5, Dietary 6, Dietary 8).

Findings include:

An observation was made on 5/4/22 at 9:40 AM. Chef 3, Dietary 4 and Dietary 8 were not wearing masks in the kitchen.

Chef 3 was interviewed on 5/4/22 at 9:45 AM. Chef 3 indicated a mask is not required due to vaccination status.

An observation was made in the dining room on 5/4/22 at 11:40 AM. Dietary 4 and Dietary 5 were wearing their mask under their nose. Chef 3 had pulled his mask down to talk to residents.

An observation was made on 5/5/22 from 11:23 AM - 11:42

AM in the dining room. Dietary 5 had his mask pulled down around his chin.

Dietary 5 was interviewed on 5/5/22 at 11:38 AM, Dietary 5 indicated he should not have his mask down around his chin.

An observation was made on 5/5/22 at 1:45 PM. Dietary 4 had pulled her mask down to talk to residents.

The Executive Director (ED) was interviewed on 5/5/22 at 1:56 PM. The ED indicated staff should wear mask appropriately.

An observation was made on 5/6/22 at 12:21 PM in the dining room. Dietary 6 had her mask pulled down around her chin around residents.

Dietary 6 was interviewed on 5/6/22 at 12:26 PM. Dietary 6 indicated she should not pull her mask down around residents.

The ED was interviewed on 5/4/22 at 1:40 PM. The Administrator indicated the facility did not have a specific policy regarding mask but followed the Indiana Department of Health guidance.