STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/08/2021

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 the Investigation of Complaint IN00365646. Complaint IN00365646 - Substantiated. State deficiencies related to the allegations are cited at R0029 and R00240. Survey date: November 8, 2021 Facility number: 014316 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 8, 2021	R 0000		
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and	R 0029	R_0029 What corrective action will be accomplished for those residents found to have been affected by the deficient practice;Resident V was assessed for injuries, abrasions	12/01/2021

	individuality. Based on interview and record review the facility failed to ensure residnets were treated with dignity and respect for 1 of 3 residents reviewed. (Resident V) Findings include: On 11-8-21, during a confidential interview, the interviewee indicated Resident V had been pushed down by Resident Y when she was outside returning from dialysis, but they could not remember the exact day this had happened. They indicated Resident V fell to the ground, but was unharmed. Resident V was unavailable for comment. A review of an investigation dated 10-22-21 indicated Resident Y had addressed Resident V as "grandma" and Resident V had responded that she was not his grandma. After being addressed as "grandma" again, Resident V obtained her cane, then Resident Y pushed her down. Resident V had abrasions, and was treated. Resident Y was seen by the physician and treatment was changed. This State citation is related to Complaint IN00365646.		noted to left hand and left knee. X-ray was obtained and no evidence of fracture or sprains. Resident V was also monitored for pain. Resident Y was assessed by Psych services after incident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.Residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. No other residents were affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.Resident rights and Resident Rules and Regulations will be reviewed in resident council on 11/16/2021. A copy of resident rights and Resident Rules and Regulations will be placed in each resident mailbox. An emergency newsletter will be delivered to all residents on "Resident Rules and Regulations" highlighting resident conduct. Facility working with Resident X's AAA case manager to find placement that better meets the needs. 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.Resident Rights and Resident Rules and Regulations	

	Based on interview and record review the facility failed to ensure residnets were treated with dignity and respect for 1 of 3 residents reviewed. (Resident V) Findings include: On 11-8-21, during a confidential interview, the interviewee indicated Resident V had been pushed down by Resident Y when she was outside returning from dialysis, but they could not remember the exact day this had happened. They indicated Resident V fell to the ground, but was unharmed. Resident V was unavailable for comment. A review of an investigation dated 10-22-21 indicated Resident Y had addressed Resident V as "grandma" and Resident V had responded that she was not his grandma. After being addressed as "grandma" again, Resident V obtained her cane, then Resident Y pushed her down. Resident V had abrasions, and was treated. Resident Y was seen by the physician and treatment was changed. This State citation is related to Complaint IN00365646.		shall be reviewed during each resident council meeting. Any resident issues brought forward during resident council regarding resident rights and/or resident rules and regulations shall be reviewed in monthly QAPI meeting for 6 months by the Executive Director, or designee.	
R 0240	Health Services - Deficiency	R 0240	R_0029	12/01/2021

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 ensure medications were given according to individual needs. (Resident V and Resident W)

Findings include:

In an interview on 11-8-21, Resident Z indicated medications are sometimes late, not given at all, or are left sitting at the bedside.

A review of Resident V's Physician orders dated 7-23-21 indicated to give Aricept (a medication for memory) 10 mg daily, Cardura (a medication for high blood pressure) 4 mg daily, Dialyvite (a supplement) 1 tablet daily and Ploglitazone 15 mg (to manage blood sugars) 1 tablet daily.

A review of Resident V's Medication Administration Record (MAR) indicated On 10-3 and 10-4, she did not receive Proglitazone, or Dialyvite, and on 10-21 and 10-29 she did not recieve Cardura or Aricept.

A reivew of Resident W's physician orders dated 7-14-21

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;Resident V and Resident W - medications to be administered as ordered by physician.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.Residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. DONW, or designee, will audit the Medication Administration Record to ensure medications are given as prescribed.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.DOWN, or designee will audit MAR's 5 days per week for two weeks then 3 days per week for 2 weeks, and then once a week for 2 weeks. Staff members not in compliance will be educated on Silver Birch's Medication Administration Policy.

	indicated to give Voltaren (an analgesic) pain gel to the knees twice daily. A review of Residnet W's MAR dated October 2021 indicated on 10-2 and 10-3 at 8 PM, the Voltaren pain gel had not been given. In an interview on 11-8-21 at 10:15 AM, the Director of Nursing indicated residents were to receive theri medications as ordered. This State citation is related to Complaint IN00365646. Based on interview and record review, the facility failed to ensure medications were given according to individual needs. (Resident V and Resident W) Findings include: In an interview on 11-8-21, Resident Z indicated medications are sometimes late, not given at all, or are left sitting at the bedside. A review of Resident V's Physician orders dated 7-23-21 indicated to give Aricept (a medication for memory) 10 mg daily, Cardura (a medication for high blood pressure) 4 mg daily, Dialyvite (a supplement) 1 tablet daily and Ploglitazone 15 mg (to manage blood sugars) 1 tablet daily.		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. DONW, or designee will review results of audit and report findings during monthly QAPI meeting and will make further recommendations as needed monthly for the next 6 months, or until 100% compliance is reached.	

	A review of Resident V's Medication Administration Record (MAR) indicated On 10-3 and 10-4, she did not receive Proglitazone, or Dialyvite, and on 10-21 and 10-29 she did not recieve Cardura or Aricept. A reivew of Resident W's physician orders dated 7-14-21 indicated to give Voltaren (an analgesic) pain gel to the knees twice daily. A review of Residnet W's MAR dated October 2021 indicated on 10-2 and 10-3 at 8 PM, the Voltaren pain gel had not been given. In an interview on 11-8-21 at 10:15 AM, the Director of Nursing indicated residents were to receive theri medications as ordered. This State citation is related to Complaint IN00365646.			

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