STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MISHAWAKA	3630 HICKORY ROAD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00399165, IN00399126, IN00398640, IN00397632 and IN00395492. Complaint IN00399165- Unsubstantiated due to lack of evidence. Complaint IN00399126- Substantiated. State residential findings are cited at R039 Complaint IN00398640 - Unsubstantiated due to lack of evidence. Complaint IN00397632 - Unsubstantiated due to lack of evidence. Complaint IN00395492- Substantiated. No state residential findings related to the allegations were cited. Survey dates: January 23, 24, 25 and 26, 2023 Facility number: 014260 Residential Census: 112 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 2/3/23.	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 March 2,2023. We respectfully request a desk review and consideration for paper compliance of substantial compliance based on the POC.	
R 0039 Bldg. 00	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Stacy DeMeester | Executive Director | 02/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on interviews and record reviews the facility failed to investigate concerns related to medications on 2 of 4 residents with medication concerns. (Residents C and H). Findings include: 1. During an interview conducted with Resident C on 1/24/23 at 2:00 P.M., Resident C indicated she contacted her daughter because the nurse was attempting to give her pills and she knew the amount was incorrect. Resident C indicated the nurse told her this is what the doctor had ordered for you. Resident C indicated she refused to take the medication that's when the nurse went to the cart and obtained the correct medication. Resident C contacted her daughter and informed her about what happened. Resident C indicated she informed the DON and didn't hear anything .Resident C indicated after her daughter spoke to the DON, the DON give her a picture of her medications . Resident indicated at this time her medications have been correct. 2. The clinical record for Resident H was reviewed on 1/25/23 at 2:30 P.M. Resident H. had orders to receive Hydrocod-APAP 10-325 three times a day for chronic pain. The clinical record indicated the last dose documented as given was on January 17th at 1:00 P.M. During an interview, conducted with the DON on 1/25/23 at 3:10 P.M., she indicated they are now under a different pharmacy and are working to get the kinks out, she indicated they can only request	R 0039	**R039 – Residents' Rights – Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident C:** Concern regarding receiving wrong medications had been resolved prior to survey and no further issues to date. **Resident H:** Resident's medications have been available with no further issues to date **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 current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. All current employees will be re-educated on the grievance policy and process by 3/2/23. The Senior Clinical Advisor and Regional Support for Silver Birch Living will provide the re-education. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	03/02/2023

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	an emergency delivery for new admissions or drugs that their pharmacy can't provide in a timely manner. DON indicated she doesn't have the time to document all of the residents she comes into contact regarding their concerns she just tries to fix it. The facility grievance book as no mention of C or H concerns at this time, nor is there any documention of their concerns in their progress notes at this time. On 1/26/2023 at 11:25 A.M., the DON provided a Policy titled "Resident Grievance/or Concern Policy & Procedure" with an effective date of 8/7/2021. The policy indicated, "...Procedure:1. All community staff members will use the Grievance/Concern form to document verbal and/or written complaints from residents, families and/or responsible parties. 2. The complaint will be documented in the Grievance/Concern binder on the grievance log.3. The Grievance concern form shall be promptly completed.4. The Executive Director or designee will contact the complainant immediately to advise them that a formal investigation has been initiated and they will be notified of the outcome within 14 days. 5. The Executive Director or designee will conduct the investigation within 72 hours following the Protocol for performing a thorough investigation...." This State finding relates to complaint IN00399126.		**practice does not** recur. The Executive Director (ED) or designee will audit documentation and the grievance log every week for 3 months, then 1 time monthly for 3 months, then randomly for 3 months for appropriate documentation regarding grievance resolution and follow through. Any findings will be addressed at the time of discovery and recorded on the grievance log. **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 ED or designee will 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:** **3/2/23**	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure			

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	continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure at least every six months hold fire and disaster drill in conjunction with the local fire department. This has the potential to affect 112 Residents residing at the facility. Finding includes: On 1/25/2023 at 11:52 A.M., the Administrator indicated that they had an emergency disaster evacuation drill on 7/24/2022 with the fire Marshall and on 11/30/2022 the fire Marshall was invited but did not attend and indicated they should have rescheduled. On 1/26/2023 at 10:17 A.M., the Director of Nursing indicated they do not have a fire drill policy but follow the state guidelines.	R 0092	**- 092 Administration & Management non-compliance** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents identified. Environmental Service Manager (ESM) Conducted a fire drill in conjunction with the local Fire Marshall on 1/27/23. **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.	03/02/2023

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			All current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. ESM was re-educated on need to conduct fire and disaster drills every 6 months in conjunctions with the local fire department. Executive Director (ED) provided the re-education. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ESM will contact the local fire department every 6 months, before scheduling a TELS fire drill, to ensure the next fire drill will be scheduled in conjunction with the local fire department. Executive Director (ED) or designee will monitor TELS work order system for documentation of fire drills held in conjunction with the local fire department. **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 ED 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**	

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			changes will be completed: Changes will be completed by 3/2/23	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to ensure a yearly inspection was performed on the heating and ventilation system. This has the potential to affect 112 residents that reside at the facility. Finding includes: During an interview on 1/25/2023 at 11:00 A.M., the Environmental Service Manager indicated that he cleans and inspects the condenser coils and clean air filters, he provided a schedule the dates it was completed. No company was hired to come and do the yearly inspection.	R 0148	**R 148 Sanitation & Safety Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** No Residents identified **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;**	03/02/2023

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	On 1/25/2023 at 11:30 A.M., the Environmental Service Manager indicated that they have no policy on heating and ventilation that they follow the state regulations.		All current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. The HVAC systems in the facility have been scheduled for service by Herrman & Goetz Inc. on 3/21/23 A re-occurring work order has been assigned in TELS work order system to schedule yearly HVAC inspections. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Executive Director (ED) or designee will review TELS re-occurring work orders weekly for 3 months and then 1 time monthly for 3 months, then randomly for 3 months. **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 ED or designee will 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:** **3/2/23**	

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R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on observation, interview and record review, the facility failed to ensure a resident with oxygen had orders for 1 of 1 Residents reviewed for oxygen. Finding includes: During an observation on 1/24/2023 at 10:00 A.M., the resident had a concentrator in his room 2 medium size green e tank cylinders and a 6 pack of smaller e tanks. The resident indicated he uses the small tank when he leaves his room because he gets very short of breath but has not used the larger tanks. During an interview on 1/25/2023 at 11:00 A.M., the Executive Director indicated the Resident can have oxygen cylinders in his room if he has oxygen order in place for oxygen and supplies. During an interview on 1/25/2023 at 11:42 A.M., the Director of Nursing indicated he had no oxygen order and should have and was not aware he was using it. On 1/25/2023 at 11:16 A.M., the Executive Director provided a policy titled, "Oxygen Use & Storage Policy and Procedures", dated 6/15/18, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the policy of this community to ensure resident has access to oxygen as ordered by the physician	R 0153	**R153 Sanitation & Safety Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient** practice. No identifier: Received order for oxygen for resident on 1/25/23, as follow up to being questioned by a surveyor as to why oxygen was in the resident's apartment. Resident did not inform any community staff of having an order for oxygen. **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 current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. This resident was educated on informing staff of new orders promptly. All staff will be educated on reporting to the DONW or designee any new medical equipment or oxygen noted in a	03/02/2023

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	through vendor of choice, to ensure safe handling of compressed gases, oxygen delivery systems and equipment, and to assist resident with handling, storage and management of oxygen equipment. Procedure: A. The resident will have a current physician order for oxygen and supplies. The order will state rate, frequency, and delivery device...."		resident's apartment. A notice will be provided to each resident and their responsible party to report any new medication orders, new medical equipment they have acquired, and oxygen orders to the nurse upon return from their appointments. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not** recur. The Director of Nursing and Wellness (DONW) or designee will follow up on any staff reports of new medical equipment or oxygen in a resident's apartment and ensure orders are in place for the same. DONW or designee will audit new orders weekly x 3 weeks, then monthly x 3 months, then randomly for 3 months to ensure new orders are followed through. Any findings will be corrected at the time of discovery. **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 audit findings to the Quality Assurance (QA) Committee monthly until 100% compliance is met for 3 consecutive months,	

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			then quarterly until resolved as determined by the QA Committee. **What date the systemic changes will be completed:** **3/2/23**	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure the policy and procedure regarding the Qualified Medication Aides process for permission to administer as needed (PRN) medication was followed for 2 of 9 records reviewed. (Resident J and L) Findings include: 1. The clinical record for Resident J was reviewed on 1/26/2023 at 9:45 A.M. Resident had diagnosis, including but not limited to, diabetic mellitus with diabetic nephropathy and pain in the left foot. The current service plan for Resident J indicated the facility administered all of her medications except for a nasal spray, which she self administered. The current physician orders for medications,	R 0246	**R0246 – Health Services – Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient** practice. Resident J: looking at documentation. Resident L: looking at documentation. **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 current residents residing at Silver Birch of Evansville have the potential to be affected by the	03/02/2023

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	included an order for Tramadol, one tablet every 12 hours as needed for pain control. The current medication administration record for January 2023, indicated the resident was documented as having received the pain medication 9 times from Jan 1 - Jan 25, all administered by QMAs (Qualified Medication Assistant). Review of the nursing progress notes for January 2023 did not indicate any documentation regarding the resident's complaints of pain, location of any pain or authorization for the QMA to administer the medication. During an interview with the Director of Nursing, conducted on 1/26/2022 at 2:50 P.M. she pulled up the electronic Medication Record and indicated the staff were supposed to document specific information regarding the administration of the PRN medications, including from whom they had obtained permission to administer the medication. The DON went to a few of the 9 entries and confirmed there was no documentation regarding the required authorization information. 2. A clinical record for Resident L was reviewed on 1/26/2023 at 10:11 A.M Diagnoses included, but not limited to, type 2 diabetes, hypertension, chronic pain syndrome, and major depression disorder. Resident AL's Physician Orders, dated 1/20/2023, indicated he was receiving hydro-APP 5-325 - 1 tab take 1 tablet by mouth every 4-6 hours as needed for pain, indication for use tooth extraction. A Medication Administration Record dated 1/2023, indicated Resident L had received the pain		alleged deficient practice. Licensed nurses and Qualified Medication Aides will be re-educated by 3/2/23 regarding documenting resident's refusal of medications, watching residents take their medications, signing out medications at the time of administration, and contacting a licensed nurse for authorization prior to administering a prn medication and documenting the name of the nurse that gave authorization. The re-education will be provided by the Senior Clinical Advisor and Regional Support for Silver Birch Living and the Director of Nursing and Wellness for Silver Birch of Mishawaka. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not** recur. The Director of Nursing & Wellness (DONW) or designee will audit documentation every week for 3 months, then 1 time monthly for 3 months, then randomly for 3 months for appropriate documentation regarding medication administration. Any findings will be addressed at the time of discovery and recorded on an audit tool. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	medication on 1/23/2023 which was administered by a QMA (qualified medication aide). During an interview, on 1/26/2023 at 2:33 P.M., the Director of Nursing indicated the documentation would pop up under the Progress Notes for the QMA to document and for the nurse that authorized for the as needed narcotic, it was not present, and it should have been. She indicated that they do not have a policy they follow the QMA scope of practice. On 1/26/2023 at 2:02 P.M., the Executive Director provided a policy titled, "Qualified Medication Aide Scope of Practice", undated and indicated it was the one currently used by the facility. The scope of practice indicated "... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."		**recur, i.e., what quality assurance program will be put into** place. The DONW or designee will 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:** **3/2/23**	
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor			

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SILVER BIRCH OF MISHAWAKA	3630 HICKORY ROAD MISHAWAKA, IN 46545

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	competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on observation, record review and interviews, the facility failed to ensure food was prepared and served in a clean and sanitized manner in 1 of 1 kitchens. Finding includes:	R 0274	R0274 Food & Nutrition Services non-compliance **What corrective action will be accomplished for those residents found to have been affected by the deficient** practice.	03/02/2023

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	1. During the Kitchen sanitation tour, conducted on 1/24/2023 between 10:15 - 10:35 A.M., the following was noted: The large stand mixer and the meat slicer were observed to be uncovered. The meat slicer was stored on a metal food preparation counter. Dietary Cook, Employee was noted to be putting together enchiladas right next to the meat slicer. The stand mixer was located just adjacent to the same food preparation counter. During an interview with the Employee she indicated neither the stand mixer or the meat slicer had recently been utilized. The microwave, located on a shelf above the uncovered meat slicer was noted to have dried food splatters and a build up of grime on both the outside and inside. Staff were observed to utilize the microwave during the meal preparation process. The knife holder, which was affixed to the wall behind the same meal preparation counter was noted to be heavily soiled on the outside and the slotted top. 1 of 4 knives observed was noted to have a broken off tip. Two large plastic rolling white bins with clear plastic lids were noted pushed underneath the meal preparation counter. The bins were noted to be heavily soiled with food splatters, grime and crumbs. Employee indicated one bin contained flour and the other bin contained sugar. A open three shelf rolling cart, located in between the steam oven and the handwashing sink was heavily soiled with crumbs, spilled dry liquids and dust. The shelves were noted to have the following food items stored on them: oil, teriyaki		No residents were Identified. **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 current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. 1. A deep cleaning of the kitchen was completed on 2/9/23. Stand mixer and meat slicer covered when not in use and removed from food prep area. Microwave cleaned inside and out of food splatter, grime and build up. Knife holder cleaned of soil, knifes with broken tips have been replaced. Plastic flour and sugar bins have been labeled and cleaned of soil and food splatter. Rolling cart has been cleaned of soil, food splatter, and liquid spills. The grill has been cleaned of buildup and grime. The refrigerated serving unit and compartments have been cleaned of crumbs and liquid spills. The oven has been cleaned inside and out of buildup and grime. The convection over has been cleaned of soil and dust. All potholders have been washed. All Culinary staff have been reeducated on the cleaning checklist. 2. The cook, Employee 8, and all culinary staff have been	

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	sauce, paprika and an opened box of cream of wheat. There was a heavy build up of black grime on the open top grill and there was a greasy build up on the outside of the grill. The refrigerated cold food serving unit had crumbs and spilt liquids on the shelves in the bottom shelves and around the top compartments where food items were placed. The top, outside and inside of the oven were noted to be dirty with a heavy build up of greasy brown grime. There was a black build up of baked on grime. The top of the convection/steam oven was heavily soiled with dust. There were pot holders utilized by the facility noted on the dusty, dirty surface. The outside of the plate warmer was noted to be heavily soiled with dust, grime and dried food splatters. The floors and walls under, around and behind food service equipment was noted to be heavily soiled with a build up of grime, dust dried splatters of liquids, and dropped items such as food, papers and small kitchen items. 5 of 5 skillets, stored as clean, had peeling nonstick Teflon on the insides. During an interview with the FSS she indicated they "hardly ever" used the skillets. However, during the observation of the meal service, conducted on 1/24/2023 at 11:00 A.M., Employee was noted to prepare a grilled cheese sandwich one of the skillets with peeling Teflon on the inside surface.		re-educated on glove use in the kitchen. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not** recur. Executive Director (ED) or designee will conduct sanitization and glove use inspections 1 time weekly for 3 months and then 1 time monthly for 3 months, then randomly for 3 months. Any findings will be corrected at the time of discovery. **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 ED or designee will report inspection 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.	

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	2. During observation of the meal service, conducted on 1/24/2023 at 10:55 A.M. - 11:30 A.M., the following was noted: The cook, Employee 8, after washing her hands and donning a clean pair of gloves, touched the handle of a skillet, a lighter to manually light the burner under the skillet, the handle of the refrigerated unit, plastic wrap covering preprepared sandwiches and then picked up a prepared cheese sandwich with her contaminated gloved hand, held the sandwich in her gloved hand while she put butter on it before she placed it into the skillet. In addition, Employee 8 was observed preparing pans of enchiladas. After washing her hands and donning a clean pair of gloves, the cook was noted to put on oven mitts, pull an already prepared pan of enchiladas out of the steam/convection oven and place the pan onto the steam table, she then took a obtained a large plastic bag containing shredded cheese from the refrigerated serving unit and reached in with her contaminated gloved hand and grabbed handfuls of cheese and sprinkled over the pan of enchiladas she had just placed into the steam table. Finally, Employee 9 and the Food Service Supervisor were observed to have gloves on their hands. They were noted to be touching paper menu/meal tickets, the outside of Styrofoam meal containers, the outsides of cups and dishes, large round serving platters and then both employees reached into a large bag of potato chips with their contaminated gloved hands and then placed the handful of obtained chips onto a plate and served the chips to a resident.			

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R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure medications were available for a Resident who received narcotic pain medication for 1 of 3 residents reviewed for Medications. (Resident H) Finding includes: During an interview with Resident H, on 1/24/23 at 11:40 A.M., he indicated his pain medications have been out for a while and it occurs all of the time, he indicated he thinks he's been out since last Sunday. Resident H indicated that not having his pain mediation throws him off and he sometimes doesn't want to take any of his other medication. A Physician's Order, indicated Resident H was to Receive Hydrocodone-APAP (Vicodin/Tylenol)10-325mg (miligram) three times a day for chronic pain. Records indicated the last dose was given on January 17th at 1:00 P.M. During an interview with QMA 5, she indicated she notified the physician and pharmacy about Resident H's pain medication. QMA 5 indicated the facility is under a new pharmacy and is unsure how long it will take to fill prescriptions.	R 0297	**R0297 – Pharmaceutical Services – Non-compliance** **What corrective action will be accomplished for those residents found to have been affected by the deficient** practice. **Resident H:** all medications ordered in February have been received and administered, except for those refused by the resident. There are a few holes – can they be corrected? **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 current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. QMA 5: Re-educated on checking EDK, notifying pharmacy, and documenting efforts to obtain medication(s) not in current supply. Employee 7: Re-educated on	03/02/2023

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	During an interview with Employee 7 she indicated she entered the incorrect codes on the EMR (electronic medical record) on 1/19 and 1/21 and the hydrocodone is not avaliable. She indicated she coded it incorrectly. During an interview with the DON on 1/25/2023 at 3:10 P.M., she indicated the facility is under a different pharmacy and are working to get the kinks out, she indicated they can only request an emergency delivery for new admissions or drugs that their pharmacy can't provide in a timely manner. On 1/26/2023 at 1:19 P.M, the Executive Director provided a policy titled "Pharmacy Services Agreement for Diabetic Supplies and Consulting" and indicated it is the one currently being used by the facility. The agreement indicated "...Agreement... iv. Provide products in a prompt and timely manner, as specified herein...viii. provide drug information and consultation to the organization's licensed professional staff regarding products ordered for individual patients by members of the organization's professional staff....b. Delivery of Products. The pharmacy agrees to deliver products for patients to the facility, as mutually agreed by the parties..."		proper documentation of medications administered at the time of administration, including when a medication is not available. Licensed nurses and Qualified Medication Aides (QMA) will be re-educated by 3/2/23 regarding documenting resident's medications that need refilled and date & time of pharmacy notification. Re-education includes checking the emergency drug kit (EDK) to determine if the medication is available, contacting the pharmacy for narcotic authorization number that is to be included on the EDK log sheet and signed by 2 staff members to verify the correct narcotic was removed from the EDK and administered to the resident. Licensed Nurse or QMA should contact the pharmacy upon discovery of medications not available, follow the above procedure for checking the EDK, and document if the medication is available or will be sent by the pharmacy, including on what date & time. The resident's record is to include documentation of the findings. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not** recur. The Director of Nursing &	

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			Wellness (DONW) or designee will audit documentation every week for 3 months, then 1 time monthly for 3 months, then randomly for 3 months for appropriate documentation regarding medication administration. Any findings will be addressed at the time of discovery and recorded on an audit 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 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:** **3/2/23**	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well			

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	as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interviews, the facility failed to ensure the pharmacy completed medication reviews for 7 of 9 residents reviewed. (A, B, C, D, F, G and J) Findings include: Review of the clinical records for Residents A, B, C, D, F, G and J, completed during the survey on 1/24 - 1/26/2023 indicated there was no documentation provided regarding a pharmacist review of the resident's medications, except for 1 pharmacy review with recommendations in September 2022 for Resident A and B. During an interview with the Director of Nursing, conducted on 1/26/2023 at 10:30 A.M., she indicated the facility had recently switched pharmacy providers in December 2022. She indicated they had requested a copy of any pharmacy reviews completed in 2022 for Resident A, B, C, D, F, G and J, from their former pharmacy provider, but none had been provided. When queried regarding the facility policy and procedure regarding pharmacy medication reviews for residents, the Director of Nursing indicated the facility did not have a specific policy but just followed the State guidelines.	R 0298	**R0298 – Pharmaceutical Services – Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident A:** not identified **Resident B:** not identified **Resident C:** not identified **Resident D:** not identified **Resident F:** not identified **Resident G:** not identified **Resident J:** not identified **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 current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. The Director of Nursing & Wellness (DONW) or designee is working with the contracted pharmacist for their schedule of resident reviews during February, March and April of 2023	03/02/2023

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			What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Director of Nursing & Wellness (DONW) or designee will review the pharmacist schedule for completion of medication reviews every week for 3 months, then 1 time monthly for 3 months, then randomly for 3 months to ensure completion of residents' medication reviews every 60 days. Any findings or omissions will be addressed at the time of discovery and recorded on the schedule with corrective action implemented. **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 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:** **3/2/23**	
R 0356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance			

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Bldg. 00	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure that all required information was provided in the Emergency Information File for 7 out of 7 records reviewed. (Residents A, B, C, D, F, G, J) Finding includes: During a clinical record review on 1/24/2023 for the following residents A, B,C, D, F, G, J, the hospital preference was not listed in the Emergency Information File. During an interview on 1/25/2023 at 2:10 P.M., the Director of Nursing indicated it should be under other information and it is not and should have been. On 1/26/2023 at 9:00 A.M., the Director of Nursing indicated they do not have a policy on the	R 0356	**R0356 – Clinical Records – Non-compliance** **What corrective action will be accomplished for those residents found to have been affected by the deficient** practice. **Resident A:** not identified **Resident B:** not identified **Resident C:** not identified **Resident D:** not identified **Resident F:** not identified **Resident G:** not identified **Resident J:** not identified **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	03/02/2023

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	Emergency Information file they follow the state regulations.		**what corrective action will be** taken. All current residents residing at Silver Birch of Mishawaka have the potential to be affected by the alleged deficient practice. All residents that currently reside at Silver Birch of Mishawaka have the hospital of their choice indicated on their profile sheets. The Director of Nursing & Wellness (DONW) or the receptionist reviews the daily census for changes and updates. The emergency binders are kept at the front desk and are managed by the receptionist who checks the daily census in PCC no less than 3 times weekly. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not** recur. The Director of Nursing & Wellness (DONW) or designee will compare the daily census to the emergency binders every week for 3 months, then 1 time monthly for 3 months, then randomly for 3 months to ensure all current residents have a profile that includes the residents' hospital of choice in the emergency binders. Any findings or omissions will be addressed at the time of discovery. **How the corrective action will**	

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			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 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:** **3/2/23**	