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	01/18/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 1/17/2024 and 1/18/2024 Facility number: 014260 Residential Census: 112 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/25/24.	R 0000		
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a weight was obtained semi-annually and failed to complete a self administration of medication assessment on admission for a resident who self administers medications for 2 of 7 residents whose clinical	R 0216	1 *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The*	02/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natasha L Dailey		02/12/2024

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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	records were reviewed. (Residents 2 and 3) Findings include: 1. A clinical record review was completed on 1/17/2024 at 2:30 P.M. Resident 2's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, congestive heart disease and morbid obesity. Resident 2's last documented weight was 2/11/2023. During an interview on 1/18/2024 at 12:24 P.M., the Wellness Director indicated weights should be done at least quarterly for residents and there should have been another weight for Resident 2 in the chart, but there was not. During an interview on 1/18/2024 at 4:19 P.M., the Executive Director indicated the resident had not had a weight checked after 2/11/2023 and she should have had one semi-annually. The resident had no documentation in her chart of refusing to have her weight taken. On 1/18/2024 at 4:05 P.M., the Executive Director provided a policy titled "Weight Monitoring Policy", dated 2/14/2020, and indicated this was the current policy used by the facility. The policy indicated " ...all residents will be weighed upon admission and at least semiannually thereafter ...."2. During an observation on 1/17/2024 at 2:15 P.M., Resident 3 had prescription bottles for metoprolol and losartan (antihypertensive medications) sitting on an end table in her room. During an interview on 1/17/2024 at 2:20 P.M., Resident 3 indicated she self-administered all her medications.		*plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents weight obtained, and medication assessment done on residents that had not been completed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficiency. All residents will receive an annual medication administration assessment annually and semi-annual weight. 1 What measures will be put into place or what systemic changes the facility will make to	

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	A record review was completed on 1/17/2024 at 3:30 P.M. A Physician's Order, dated 9/10/2020, indicated self-administer medications. Resident 3's last Self-Administration of Medication Assessment was dated 12/11/2021. An interview with the Director of Wellness (DOW) was completed on 1/18/2024 at 8:10 A.M. The DOW indicated a Self-Administration of Medication Assessments should be done annually for any resident who self-administers their own medications. The DOW indicated Resident 3 did not have a current Self-Administration of Medication Assessment, but should have had one. On 1/18/2024 at 10:10 A.M., the Administrator provided an undated policy titled, "Medication Management Program". The Administrator indicated it was the policy currently being used by the facility. The policy indicated, "...1. Self-Administration Program: If a prospective or current resident requests to independently manage medications, a Self-Assessment of Medication Administration is completed by a licensed nurse with the prospective or current resident to determine the individual's ability to safely self-administer medications. This Assessment is completed upon admission and thereafter on a routine basis and as needed...."		ensure that the deficient practice does not recur; All residents will be scheduled for an annual medication administration assessment through pcc and DONW or designee will audit to ensure completion of assessment. All residents will receive semi-annual weights, DONW or designee will audit and review to ensure completion. 1 How the corrective action(s) 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 audit and report compliance at QAPI meeting for six consecutive QAPI meetings or until compliance 95% noted for three consecutive QAPI meetings with semi-annual weights and medication administration assessments. Systematic changes will be in effect by _2/29/2024_____. This Community respectfully requests a paper compliance review.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure service plans were signed by the resident or their representative for 3 of 7 residents reviewed for service plans. (Residents 4, 5 and 6) Findings include: 1. A record review was completed on 1/17/2024 at 3:11 P.M. Resident 4's diagnoses included, but were not limited to diabetes, depression, chronic pain and hypertension. A Service Plan, dated 9/23/2023, lacked the	R 0217	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence*	02/29/2024

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	resident's signature and date. A Service Plan, dated 10/13/2023, lacked the resident's signature and date. 2. A record review was completed on 1/17/2024 at 2:58 P.M. Resident 5's diagnoses included, but were not limited to asthma, depression, diabetes, anxiety and hypertension. A Service Plan, dated 9/7/2023, lacked the resident's signature and date. 3. A record review was completed on 1/17/2024 at 3:54 P.M. Resident 6's diagnoses included, but were not limited to hypertension, depression, diabetes, and osteoarthritis. A Service Plan, dated 8/28/2023, lacked the resident's signature and date. During an interview on 1/18/2024 at 12:03 P.M., the Wellness Director indicated the service plans should be reviewed with the resident, have them sign it, and give a copy to the resident and place it in the chart. On 1/18/2024 at 10:20 A.M., the Wellness Director provided the policy titled,"Service Plans", dated 8/1/2018 with a revision date of 1/31/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...The Director of Health and Wellness or designee will review the service plan with the resident, make changes if needed, both parties will sign and date after review...."		*of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Service plans reviewed and signed by residents or designee that are current residents. 1 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by alleged deficiency. 1 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All service plans audited for signature compliance. DONW or designee to ensure service plans are reviewed per regulation and policy, signed by resident or designee semi-annually or as needed when changes occur. 1 How the corrective action(s)	

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			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 audit for completion and review in QAPI meeting for six consecutive meetings or until 95% compliance noted for three consecutive meetings. Systematic changes will be in effect by _2/29/2024_____. The facility respectfully requests a paper compliance review.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was labeled, dated and stored in a sanitary manner, failed to ensure foods outdated were discarded, and failed to ensure kitchen equipment was clean in 1 of 1 kitchens observed. (Main Kitchen) Findings include: 1. During an observation of the main kitchen, on 1/17/2024 at 9:37 A.M. with Cook 3, the following was observed: a. In the freezer was a bag of hoagie rolls not sealed tightly and no used by date. - 2 boxes on the floor. Cook 3 indicated they had received a delivery on Monday.	R 0273	1 *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation*	02/29/2024

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	- A package of fish that was not sealed tightly with a date prepared as 12/18/2023 and no use by date. - A bag of egg rolls that were not sealed appropriately. b. In the walk-in cooler: - A container of chicken salad with a prepared date of 1/4/2024 and no use by date. - A metal flat pan with sliced tomatoes, sliced onions and lettuce pieces with no use by date. - An open bag of tortilla shells not sealed tightly. - A opened bag of meat balls with a prepared date of 12/28/2023 and no use by date. - A container of hot fudge with a prepared date of 10/28/2023 and no use by date. - A plastic bag of chicken breasts with no opened date and or use by date. - A hamburger roll not sealed tightly and leaked juices into a box below. c. In the dry storage room the following was observed: - 4 boxes on the floor. - A opened box of corn meal with no use by date. - An opened bag of coconut flakes dated 10/9/2023 and no use by date. - An opened box of baking soda with no date opened. - 3 cans of sweetened condensed milk with the expiration date of 4/21/2023. d. In a liquid refrigerator the following was observed: - The refrigerator floor had a red sticky substance on it. - Opened and undated gallon of milk and juice. - The rubber seal on the refrigerator door was cracked and had black electrical tape on it.		*serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawka.* What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 2 No specific residents identified; all residents have the potential to be affected by the alleged deficiency 1 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficiency. Supervised cleaning of kitchen, coolers, and freezer done to ensure sanitization as well as ensure all items labeled appropriately. Seal on refrigerator replacement ordered and will be replaced. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Cleaning schedules updated and will be reviewed weekly by ED or	

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	During an interview on 1/17/2024 at 10:17 A.M., Cook 3 indicated the foods/liquids should be sealed tightly, dated when opened and used by date, no boxes should be on the floor and the refrigerator's seal should be fixed. 2. During a follow up kitchen observation on 1/18/2024 at 9:25 A.M. with Cook 4, the following was observed: - A 3 shelved metal cart, sitting next to a hand washing sink had 2 opened and undated bags of grits. - The bottom shelf was dirty with dried food substances and a yellow sticky substance. - An unsealed opened bag of confectioner's sugar with no use by date. - 3 skillets (1 small and 2 large) with missing Teflon on the skillet cooking area. - A microwave located on a shelve, above the meat slicer was noted to have dried food debris and splatters on the glass plate and along the inside walls. - The knife holder beside the microwave had dried food substance on the top where the knives are to be put in. - A mop pad under the steamer. - Utensil draw with dirty scoops and dried food substances. - Opened bottle of food coloring on a shelf with a date opened of 3/7/2019 and an expiration or used by date that was rubbed off. - An opened bottle of imitation maple syrup on a shelf with a used by date of 8/24/20. - Under the convection oven was dirty with food substances and the shelf had spills of a liquid on it. - The stove had dried black/rust looking area to the back splash. During an interview on 1/18/2024 at 9:57 A.M.,		designee. Kitchen, coolers, and freezer inspected weekly by ED or designee. All findings will be reviewed in QAPI meetings for compliance until 95% compliance noted for three consecutive QAPI meetings. Inservice completed by CM and ED on 2/5/2024 1 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Cleaning schedules audited once weekly by ED or designee and documented on audit form. Kitchen inspected once weekly and documented on audit form. All areas of concern reviewed during QAPI meetings until 95% compliance noted for three consecutive QAPI meetings. Systematic changes will be in effect by ____2/29/2024_____. The facility respectfully requests a paper compliance review.	

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	Cook 4 indicated the foods and liquids should have been dated, the cart should not be by the sink, the equipment should have been cleaned and the expired things should have been thrown out. A Weekly Culinary Cleaning Schedule (Cooks) form, dated December (no year), was provided by Cook 4 on 1/18/2024 at 9:58 A.M. For week 1 there were initials documented for: Deep clean the salad bar, empty old vegetables, label and date everything. Clean the wall behind the stove and fryer. Clean the Eloma oven , inside and out,and deep clean the fryer. The form lacked any further initials indicating the cleaning had been completed for the next 3 weeks. The remainder of the form was not completed for the rest of the kitchen areas. On 1/18/2024 at 10:55 A.M., the Administrator provided the policy titled,"Dietary Cleaning", dated 1/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated"...1. All equipment , food contact surfaces, and utensils shall be cleaned...7. Refrigerator units must be cleaned monthly. 8. Wall surfaces that become splattered during the food preparation process must be cleaned daily...11. Documentation of cleaning must be maintained...." On 1/18/2024 at 10:55 A.M., the Administrator provided the policy titled,"Dietary Food Safety", dated 5/2/2018, and indicate the policy was the one currently used by the facility. The policy indicated, "...To follow Department of Health Guidelines in the food service department to maintain compliance with local, state and federal regulations... A daily cleaning schedule will be followed...."			

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	On 1/18/2024 at 10:55 A.M., the Administrator provide the policy titled, "Dietary Storage Dry Food", dated 5/2/2018, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Food items that remain sealed from the supplier may be held until the expiration date if unopened. 2. All dry foods must be dated and stored in a temperature-controlled environment...." On 1/18/2024 at 10:55 A.M., the Administrator provided the policy titled," Food Storage", dated 12/20/2020, and indicated the policy was the one currently use by the facility. The policy indicated, "...All products should be dated upon receipt and when they are opened. Use "use-by-dates" on all food stored in refrigerators and use dates according to the timetable in the Dry, Refrigerated and Freezer Storage Chart... 55. The walls, ceiling, and floor should be maintained in good repair and regularly cleaned... 58. All foods should be stored away from the walls and off the floor... 60. Any opened products should be placed in seamless plastic or glass containers with tight fitting lids and labeled and dated."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to secure medications appropriately in a resident's room for 1 of 4 residents who were reviewed for self-administration of medication. (Resident 3) Finding includes:	R 0295	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and*	02/29/2024

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	During an observation, on 1/17/2024 at 2:15 P.M., Resident 3 had prescription bottles for metoprolol and losartan (antihypertensive medications) sitting on an end table. During an interview, on 1/17/2024 at 2:15 P.M., Resident 3 indicated she self-administers all her medications. Resident 3 indicated she didn't have a locked location in her room to keep her medications. A record review was completed, on 1/17/2024 at 3:30 P.M. Resident 3 had a Physician's Order to self-administer medications, dated 9/10/2020. An interview with the Director of Wellness (DOW) was completed on 1/18/2024 at 8:10 A.M. The DOW indicated any resident who self-administers medications should have their medications locked in a secure location within their room. The DOW indicated Resident 3 didn't have a secure location in her room to lock her medications, but she should have. On 1/18/2024 at 10:10 A.M., the Administrator provided an undated policy titled, "Medication Management Program". The Administrator indicated it was the policy currently being used by the facility. The policy indicated, "...1. Self-Administration Program: If a prospective or current resident requests to independently manage medications... c. Medication Storage: Residents who are independent with medications may store and use prescription and nonprescription medications in their apartment, however, all medications must be securely stored so that other residents and/or guests cannot feasibly access...."		*submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident had medication in her apartment behind locked apartment door. 1 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents that self-administer medication were reviewed and re-educated on medication storage policy. 1 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Audit lease	

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			agreement annually with residents for policy for storage of medication in apartment for residents that self-administer. 1 How the corrective action(s) 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 to bring audit results to QAPI meeting for three consecutive meetings or until 95% compliance noted. SySytematic changes will be in effect by __2/29/2024_____. The facility respectfully requests a paper compliance review.	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to store medications in a locked location for 1 of 2 medication storage rooms observed for medication storage. (Wellness Office) Finding includes: An observation of a medication storage room (Wellness Office) with LPN 2 was completed on 1/18/2024 at 9:24 A.M. The following was observed in an unlocked closet:	R 0304	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient*	02/29/2024

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	a. Five unopened bottles of lactulose (ammonia reducer) with resident medication labels. b. Three bottles of carbiopa-levo 25-100 (Parkinson's disease drug) with resident medication labels. c. Two boxes of albuterol sulfate (inhalation solution) with resident medication labels. d. One box of formoterol fumarate (inhalation solution) with resident medication label. An interview with LPN 2 was completed on 1/18/2024 at 9:30 A.M. LPN 2 indicated the medications in the closet were the residents' extra medications that didn't fit in the medication carts. LPN 2 indicated the closet door doesn't lock but the closet door should lock. On 1/18/2024 at 10:00 A.M., a copy of the facility's medication storage policy was requested from the Director of Wellness (DOW). The DOW indicated the facility only had a policy for the storage of narcotics and not for any other medication.		*documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents found to be affected, immediate action taken to ensure medications stored appropriately. 1 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by alleged deficiency. 1 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All medications to be stored properly in locked cabinet or cart. DONW or designee will monitor weekly for compliance x 3 months and then monthly thereafter. 1 How the corrective action(s) will be monitored to ensure the	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: 3rd party pharmacy will do an onsite audit quarterly for medication storage and report all findings to ED and DONW or designee. Systematic changes will be in effect by __2/29/2024_____. The facility respectfully requests a paper compliance review.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (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 record review and interview, the facility failed to ensure an infection control program was maintained related to not having an infection control log to monitor infections within the facility. This had the potential to affect all 112 residents residing in the facility. Finding includes: During an interview on 1/18/2024 at 9:04 A.M., the Wellness Director indicated a log of infections	R 0407	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient*	02/29/2024

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	was kept in a binder and mapped out per floor so that she could keep track of them and identify any trends in infections. A review of the facility infection control binder was completed on 1/18/2024 at 10:50 A.M. The binder lacked infection documentation or maps from February of 2023 thru October of 2023. During an interview on 1/18/2024 at 11:00 A.M., the Wellness Director indicated the infection control binder did not include any infection control documentation from February 2023 through October of 2023. She indicated there should have been an infection control audit done monthly. On 1/18/2024 at 1:30 P.M., the Wellness Director provided the policy titled "Infection Prevention and Control Program", dated 9/15/2023, and indicated the policy was the one currently used by the facility. The policy indicated " ...C. Infection Prevention and Control Monitoring (i) The monthly Infection Prevention and Control Log is utilized by the Director of Nursing and Wellness, or designee, to determine if there are any infectious disease patterns, themes, and/or trends in the Community ...."		*documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No specific residents identified to have been affected. 1 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by alleged non-compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DONW or designee will do weekly audits of infection control logs to ensure monitoring completed. 1 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place: DONW or designee will report findings in QAPI meetings for three consecutive meetings or until 95% compliance noted. Systematic changes will be in effect by __2/29/2024_____. The facility respectfully requests a paper compliance review.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure infection control measures were in place related to an annual health assessment not completed for 3 of 7 resident records reviewed. (Residents 2, 5, and 6) Findings include: 1. A clinical record review was completed, on 1/17/2024 at 2:30 P.M. Resident 2's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, congestive heart disease and morbid obesity. The Physician Orders, 3/11/2022, lacked a current health statement to indicate the resident was free from communicable diseases, including tuberculosis.2. A record review was completed on 1/17/2024 at 2:58 P.M. Resident 5's diagnoses	R 0409	1 *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance*	02/29/2024

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	included, but were not limited to asthma, depression, diabetes, anxiety and hypertension. Resident 5 was admitted on 9/23/2021. The residents record lacked the documentation of a current 2023 annual health statement to indicate Resident 5 being free from tuberculosis in an infectious state. 3. A record review was completed on 1/17/2024 at 3:54 P.M. Resident 6's diagnoses included, but were not limited to hypertension, depression, diabetes, and osteoarthritis. Resident 6 was admitted on 2/17/2021. The residents record lacked the documentation of current 2023 annual health statement to indicate Resident 6 being free from tuberculosis in an infections state. During an interview, on 1/18/2024 at 2:08 P.M., the Director of Nursing indicated there should have been an annual health statement On 1/18/2024 at 2:15 P.M., a policy was requested for Annual Health statements was requested, but one was not provided prior to the exit of the survey.		*by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Natasha Dailey, Executive Director, Silver Birch of Mishawaka.* What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Annual health screening obtained for 2 of three residents, third resident moved out of community. 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: Audit all resident charts for annual health screening and obtained for those that were noncompliant. 1 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DONW or designee will audit all new move in records for annual health screening completion and ensure that all annual health screenings are completed annually. 1 How the corrective action(s) 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 bring	

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			audits to QAPI meeting for three consecutive QAPI meetings or until 95% compliance noted. Systematic changes will be in effect by _2/29/2024_____. The facility respectfully requests a paper compliance review.	