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	06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MICHIGAN CITY	4400 EAST MICHIGAN BLVD MICHIGAN CITY, IN 46360

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00293838. Complaint IN00293838 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 17 and 18, 2019 Facility number: 014052 Residential Census: 118 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/20/19.	R 0000		
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or			

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

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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	discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge.			

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	(C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.			
	Based on record review and interview, the facility failed to ensure each resident who was transferred and/ or discharged from the facility received, in writing, the reason for the transfer and information regarding the Ombudsman, State agency, and	R 0045	R045 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient**	07/01/2019

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	appeal process for 1 of 8 records reviewed. (Resident 3) Findings include: The record for Resident 3 was reviewed on 6/18/19 at 9:45 p.m. Diagnoses included, but were not limited to, hypertensive heart disease without failure, cardiomyopathy, dementia with behavioral disturbance, and major depressive disorder. A transfer/discharge notice, dated 5/3/19, indicated the resident was transferred to a neuropsychiatry hospital for physical aggression. A Physician's emergency order for transfer was obtained on 5/3/19. On 6/17/19 the resident was transferred to another psychiatric hospital. There was no documentation to indicate the resident was provided with the State Transfer and Discharge form. Interview with the Director of Nursing on 6/18/19 at 10:30 a.m., indicated they do not send the State Transfer and Discharge form with residents at the time of discharges or unplanned transfers.		**practice;** State Form 49669 has been sent as of 7/2/2019 to all applicable parties. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Nursing staff will be in-serviced by 6/28/2019 on the mandatory use of state form 49669 “Notice of Transfer or Discharge.” **What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;** The facilities use of “Transfer” form that was created in-house has ceased as of 6/25/2019 and has been replaced with the state form 49669. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur;** All transfers/discharges will be reviewed/audited by the Director of Nursing or their designee using the “Transfer/Discharge Audit Form” (please see attached) to ensure the correct form and all individuals have been notified per state regulation 410 IAC 16.2-5-4. Audits will be performed within 36 hours of discharge/transfer. Audits will be preformed for a period of three months.	

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			By what date will the systemic changes be completed; 7/1/2019	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.			

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	(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure 6 hours of dementia training was completed within the first 6 months of hire for 3 of 5 employees reviewed for dementia training. Finding includes: The Dementia Training Logs for the year of 2018 were reviewed on 6/18/19 at 2:00 p.m. and indicated the following: a. The Culinary Manager, hired on 1/2/18, had only 4 hours of dementia training for 2018. b. CNA 1, hired on 8/6/18, had only 2 and 1/2 hours of dementia training for 2018. c. HA 1, hired on 12/6/18, had only 2 hours of dementia training for 2018. Interview with the Business Office Manager on 6/18/19 at 2:30 p.m., indicated she was unable to find the remaining dementia training hours for the above employees.	R 0120	R120 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents could have been affected by the deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;** All employees will complete 6 hours of Dementia Training with-in 2 weeks of start date, using in-house in-services and Relias online training. A certificate of completion (please see attached) will be awarded and will be housed in employee's personnel file. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur;** The Executive Director or their designee will audit all new	07/19/2019

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			employee personnel records monthly for a period of three months to ensure state requirements are being met. **By what date will the systemic changes be completed;** 7/19/2019	
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation and record review, the facility failed to maintain an effective Pest Control program related to continuing occurrences of bed bugs observed in resident rooms on the 4th floor. Finding includes: The following was observed on 6/18/19 at 12:30 p.m. during Environmental Tour with the Maintenance Director: a. Room 437 - there were many live bed bugs noted on the computer chair in the resident's bathroom, crawling on the ceiling, under the mattress and in the recliner chair. There were also numerous dead bed bugs under the recliner chair and under the mattress and box springs. Room 435 - there was a live bed bug crawling on the resident's bed sheet on her mattress. There were also numerous dead bed bugs under the mattress and box springs. Interview with the pest control company employee, at that time, indicated he was finding numerous live and dead bugs under the mattress and on the furniture.	R 0149	R149 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** Weekly treatments from Pest Control vendor until pest are eliminated. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents could be affected by deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;** **E**xecutive Director and Environmental Services Director will meet with resident of apartment #437 and explain the need to have all bags examined	07/03/2019

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	Room 422 - there were two dead bed bugs under the mattress. Room 407 - there were bed bug feces noted all over the box springs along the edges Interview with the Administrator on 6/18/19 at 10:30 a.m., indicated the bed bug problem had been going on since December 2018 for Room 437. The final treatment was 1/11/19, at which time no further bed bugs were seen until 4/10/19. At that time, Rooms 437 and 435 had bed bugs, both dead live. Treatments continued weekly for both rooms until 5/10/19 when another room, Room 422, was noted with bed bugs. On 5/24/19, Room 407 was observed with bed bugs and treatments continued weekly until there were no further signs of live bed bugs. The last treatment for room 407 was on 6/7/19 and that was the last time any rooms were treated for bed bugs. The Administrator indicated the resident in room 407 has a car and leaves the facility to buy items from the Goodwill. The resident also visits the resident in room 435 quite often.		before being brought into the building. The resident will also be informed of the facilities need to inspect the apartment weekly after treatment has ended to ensure the apartment remains free of pests. An all-staff meeting will be held on 7/3/2019 to inform staff of current plans treatment plans and ongoing plans to keep apartment and building pest free. A pest demonstration will be conducted and review of the chain of events that must be followed if suspicion of a bed bug occurs. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur;** Environmental Services director or designee will audit apartment weekly for a period of three months. **By what date will the systemic changes be completed;** **7/3/2029**	
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 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;			

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	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 and revised as needed for 2 of 8 Service Plans reviewed. (Residents 6 and 3) Findings include: 1. The record for Resident 6 was reviewed on 6/17/19 at 11:32 a.m. The resident was admitted to the facility on 6/11/19. Diagnoses included, but were not limited to, myocardial infarction, atherosclerotic heart disease, chronic ischemic heart disease, type 2 diabetes, hyperlipidemia, gastrointestinal hemorrhage, anxiety disorder, depressive episodes, hypertension, heart failure and iron deficiency anemia secondary to blood loss. The Initial Service Plan, dated 6/11/19, was signed by the Director of Nursing but not signed by the resident.	R 0217	R217 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** The resident's identified during survey have been signed Service Plans. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All resident's Service Plans were audited on 6/29/2019 and no other residents were affected by deficient practice. **What measures will be put into**	07/05/2019

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	Interview with the Director of Nursing on 6/18/19 at 11:00 a.m., indicated the Service Plan should have been signed by the resident. 2. The record for Resident 3 was reviewed on 6/18/19 at 9:45 p.m. Diagnoses included, but were not limited to, hypertensive heart disease without failure, cardiomyopathy, dementia with behavioral disturbance, and major depressive disorder. A Physician's Order, dated 4/9/19, indicated Seroquel 12.5 milligrams (mg) 1 at night time. On 6/12/19 another Physician's Order was obtained which indicated to increase the Seroquel 25 mg to three times a day. Nurse's Notes, dated 4/19/19 at 8:23 a.m., indicated the resident was upset regarding her breakfast meal and threw the plate and food across the room. Nurse's Notes, dated 5/2/19 at 2:17 p.m., indicated the resident became verbally aggressive towards two other residents. A transfer/discharge notice, dated 5/3/19, indicated the resident was transferred to a neuropsychiatry hospital for physical aggression. A Physician's emergency order for transfer was obtained on 5/3/19. Nurse's Notes, dated 6/16/19 at 6:26 p.m., indicated the resident became agitated during dinner. She grabbed another resident by the face and scratched her several times and pushed the resident to the floor. A service plan, dated 4/9/19 and signed by the resident on that date, indicated the resident needed psychiatry to evaluate and treat, needed		**place or what systemic changes will the facility make to ensure the deficient practice does not recur;** Nursing staff will be in-serviced. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur;** The Director of Nursing or designee will audit all updated Resident Services Plans for a period of three months. **By what date will the systemic changes be completed;** 7/5/2019	

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	assistance with bathing, meal time reminders, and medication assist. There was no information regarding the resident's current behaviors of physical and verbal aggression, pushing and threatening other residents. There was no information the resident was started on the antipsychotic medication of Seroquel. Interview with the Director of Nursing on 6/18/19 at 11:00 a.m., indicated those behaviors and the resident's medication were not addressed on the service plan.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (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 record review and interview, the facility failed to ensure hospital preferences were listed on the emergency information file for 1 of 8 records reviewed. (Resident 6)	R 0356	R356 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient**	07/03/2019

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	Finding includes: The record for Resident 6 was reviewed on 6/17/19 at 11:32 a.m. The resident was admitted to the facility on 6/11/19. Diagnoses included, but were not limited to, myocardial infarction, atherosclerotic heart disease, chronic ischemic heart disease, type 2 diabetes, hyperlipidemia, gastrointestinal hemorrhage, anxiety disorder, depressive episodes, hypertension, heart failure and iron deficiency anemia secondary to blood loss. The resident's emergency information file indicated no documentation of the resident's hospital preference. Interview with the Director of Nursing on 6/18/19 at 11:05 a.m., indicated the resident's hospital preference should have been listed on the emergency information file.		**practice;** An audit of all resident's Face Sheets/Emergency packets was conducted on 6/24/2019 concluding that no other residents were affected by deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit of all resident's Face Sheets/Emergency Packets was conducted on 6/24/2019 concluding that no other residents were affected by deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;** All nurses will be in-serviced on required resident information per state regulation 410 IAC 16.2-5-8. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur;** The Director of Nursing or their designee will audit all new resident's Face Sheets/Emergency Packets with-in 24 hours of move in to ensure all required information is listed. Audits will be preformed for a period of three months. **By what date will the systemic changes be completed;** 7/3/2019	

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