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	06/20/2024

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 IN00435347. Complaint IN00435347 - No deficiencies related to the allegations are cited. Survey dates: June 19 and 20, 2024 Facility number: 014052 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 21,2024.	R 0000		
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was clean related to adhered dirt and debris under the dish machine and on the wall behind the dish machine for 1 of 1 kitchens. (The Main Kitchen) Findings include: During the main kitchen tour on 6/19/24 at 9:17 a.m., the Dietary Manager (DM), indicated the following was observed:	R 0154	**R154** **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**	07/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Arthur	Executive Director	07/05/2024

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	a. There was a large amount of adhered dirt, rust, and debris under the dish machine as well as a dirty fork on the tile floor. b. There was a heavy accumulation of dried food spillage on the white back splash behind the dish machine. During an interview at that time, the DM indicated all of the above was in need of cleaning and they had not figured out to move the dish machine so they could clean under it. She indicated all ressidents currently residing in the facility ate food prepared in the kitchen.		**what corrective action will be taken:** Other residents could have been 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 reoccur:** The plumbing under the dish machine was reconfigured by the installer on 6/20/24 allowing greater access for cleaning under the machine. The Dietary staff have been in serviced on 410 IAC 16.2-5-5.1 (f). A Daily, and Weekly, cleaning schedule has been implemented, which staff have been in serviced on also. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** The Culinary Director or designee conduct a weekly walk thru of the kitchen area to ensure cleanliness and the Executive Director or designee will audit the completed cleaning forms weekly for a period of six months to ensure state requirements are being met. **By what date will the systemic changes be completed:** 7/1/2024	
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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Bldg. 00	(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; 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 the service plan was revised and updated according to the resident's change in condition for 1 of 8 residents reviewed for service plans. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 6/19/24 at 1:55 p.m. Diagnoses included, but were not	R 0217	**R217** **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**	07/01/2024

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	limited to, diabetes, high blood pressure, pain, urine retention, and benign prostatic hyperplasia (an enlarged prostate that was not cancerous). A Nurses' Note, dated 6/5/24 at 6:40 a.m., indicated the resident reported that he had urinary retention with pain and requested to go to the ER (emergency room) for an evaluation. A Nurses' Note, dated 6/5/24 at 4:58 p.m., indicated the resident returned from the ER with an indwelling foley catheter (a catheter used to drain urine in situations where you can't urinate on your own). A new physician's order was received to consult a home health agency for care of the foley catheter. The Service Plan, dated 12/28/23, and signed by the resident, indicated there was no documentation regarding the foley catheter or the new home health services. During an interview on 6/20/24 at 10:30 a.m., the Director of Nursing indicated the foley catheter nor the start of the home health services were on his service plan.		**potential to be affected by the same deficient practice and what corrective action will be taken:** Other residents could have been 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 reoccur:** Resident 5's Service Plan was updated to reflect catheter on 6/21/24. The DONW or designee will update resident's Service Plans within 72 hours of a change in condition. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** The DONW, Executive Director or designee will audit 10 current resident's Service Plans a week for a period of 12 weeks for accuracy, to ensure all residents Service Plans have been reviewed. Then randomly audit 10 resident's Service Plans a month for a period of six months. **By what date will the systemic changes be completed:** 7/1/2024	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in			

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	medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure blood pressure medication was not administered outside of the physician-ordered parameters for 1 of 8 residents reviewed for medications. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 6/19/24 at 10:00 a.m. Diagnoses included, but were not limited to, heart disease. Physician's Orders, dated 2/23/24, indicated Metoprolol (a cardiac medication) 25 milligrams (mg), take a 1/2 tablet twice a day and hold if the systolic blood pressure (top number) was less than 100. The Medication Administration Record (MAR) for 4/2024, indicated the Metoprolol was administered outside of the parameters on the following days: -4/19/24 and the blood pressure was 99/53 -4/23/24 and the blood pressure was 96/53 -4/29/24 and the blood pressure was 88/48 5/2024 MAR: -5/3/24 and the blood pressure was 96/44 -5/25/24 and the blood pressure was 92/62 -5/28/24 and the blood pressure was 93/55 -5/30/24 and the blood pressure was 96/61 6/2024 MAR: -6/7/24 and the blood pressure was 95/69 -6/9/24 and the blood pressure was 78/53	R 0247	**R247** **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:** Other residents could have been 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 reoccur:** Resident 3's physician was contacted and a review of said medication was conducted which resulted in the medication being discontinued on 6/21/24. DONW or designee will review blood pressure readings 5 times a week for 1 month then weekly for 4 months for resident 3. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** DONW or designee will randomly audit 5 residents a week for 3 months that have blood pressure	07/01/2024

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	-6/12/24 and the blood pressure was 85/50 During an interview on 6/20/24 at 10:30 a.m., the Director of Nursing indicated the blood pressure medication should have been held when the resident's systolic blood pressure was less than 100.		parameters, then 1 resident a week for an additional 3 months. **By what date will the systemic changes be completed:** 7/1/2024	
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 and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty and greasy food equipment and a dirty reach in cooler for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. During the main kitchen tour on 6/19/24 at 9:17 a.m., the Dietary Manager (DM) indicated the following was observed: a. The floor and walls behind the food prep equipment were dirty and greasy. b. The deep fryer, which was not used that morning, had a large accumulation of grease on both sides. c. There was a heavy accumulation of grease on the side of the reach in cooler next to the deep fryer. d. The back splash on the stove was stained with a black substance and both sides of the stove had	R 0273	**R273** **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:** Other residents could have been 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 reoccur:** Dietary have been in serviced on 410 IAC 16.2-5-5.1 (f). A Daily, and Weekly, cleaning schedule has been implemented, which staff	07/01/2024

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	a large amount of grease. e. There was a large amount of dried burned food on and in between the grates on the grill. During an interview at that time, the DM indicated they rarely used the grill. f. Both sides of the griddle had a large amount of grease with a dried food substance noted. g. There was dried food spillage on the top and bottom shelves in the reach in cooler located next to the steam table. During an interview at that time, the DM indicated all of the above was in need of cleaning. She indicated 120 of 120 residents residing in the facility ate food prepared in the kitchen.		have been in serviced on also. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** The Culinary Director or designee conduct a daily walk thru of the kitchen area to ensure cleanliness and the Executive Director or designee will audit the completed cleaning forms weekly for a period of six months to ensure state requirements are being met. **By what date will the systemic changes be completed:** 7/1/2024	
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, record review, and interview, the facility failed to ensure medications were secured in resident rooms for those who self administered their own medications for 1 of 2 residents reviewed for self administration of medication. (Resident 4) Finding includes: During a random observation on 6/19/24 at 1:30 p.m., Resident 4's room door was unlocked, and the resident was not in his room. At that time, the resident's medications were observed on a table by the window. The medications were not secured or in a locked drawer.	R 0295	**R295** **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:** Other residents could have been	07/01/2024

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	During an interview on 6/20/24 at 8:50 a.m., the resident indicated he was at dialysis yesterday and left his room door unlocked because he needed someone to come in and look at his air conditioning unit. "I leave my medications on this desk and I will also put some of them inside the desk drawer." He indicated he usually locked his apartment when he left the facility, however, when he went downstairs to eat meals in the dining room, he would leave his apartment unlocked. The record for Resident 4 was reviewed on 6/19/24 at 1:18 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, high blood pressure, benign prostatic hyperplasia (an enlarged prostate that was not cancerous), and anxiety. Physician's Orders, on the current 6/2024 Physician Order Summary (POS), indicated the resident could self-administer his own medications. The following medications were listed on the 6/2024 POS: Levothyroxine (a thyroid medication) 150 micrograms (mcg) Midodrine (a medication used to treat low blood pressure)10 milligrams (mg) Atorvastatin (a medication used to treat high cholesterol) 40 mg Potassium CL ER (a potassium supplement) 20 milliequivalent (meq) Certavite multi vitamin 1 Velphoro (a medication used to treat chronic kidney disease) 500 mg Tylenol 500 mg 2 tablets		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 reoccur:** Resident 4 and all other current residents that self-administer their medications will be reeducated on the importance of locking their private apartments when they are not present. Resident 4 and all other current residents that self-administer their medications will be encouraged thru written correspondence from the facility it is their responsibility to ensure their medications are always stored safely and it is highly encouraged to keep their medications in a locked area within their private apartments. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** The Executive Director or designee will conduct 5 random audits a week for 3 months of apartments of residents that self-administer their medications to verify that their apartments are locked if they are not present. Then the Executive Director or designee will conduct 1 random audit a week for an additional 3 months. **By what date will the systemic changes be completed:** 7/1/2024	

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	A Service Plan, dated 11/29/24, indicated the resident may self-administer his own medications. During an interview on 6/20/24 at 10:30 a.m., the Director of Nursing indicated the resident should have locked his door when he left the room.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete related to the documentation of a foley catheter (a catheter used to drain urine in situations where you can't urinate on your own) and renal dialysis for 1 of 8 residents reviewed. (Resident 4) Finding includes: During an interview on 6/20/24 at 8:50 a.m., the resident indicated he drove himself to dialysis three times a week. The resident also indicated he had a foley catheter that he took care of himself. At that time, he lifted his shirt and the urinary drainage bag was tucked inside his pants. The record for Resident 4 was reviewed on 6/19/24 at 1:18 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, high blood pressure, benign prostatic hyperplasia (an	R 0349	**R349** **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:** Other residents could have been 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 reoccur:**	07/01/2024

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	enlarged prostate that was not cancerous), and anxiety. There was no documentation on the 6/2024 Physician's Order Summary (POS), to indicate the resident had a foley catheter or went to renal dialysis three times a week. During an interview on 6/20/24 at 10:30 a.m., the Director of Nursing indicated there was no documentation on the 6/2024 POS regarding the foley catheter or the renal dialysis.		DONW added dialysis and treatment to resident 4's POS on 6/21/24. DONW performed an audit of all current resident's POS and add added dialysis where applicable. **How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur:** The DONW, Executive Director or designee will audit 10 current resident's Service Plans a week for a period of 12 weeks for accuracy, to ensure all residents Service Plans have been reviewed. Then randomly audit 10 resident's Service Plans a month for a period of six months. **By what date will the systemic changes be completed:** 7/1/2024	