STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED		
			B. WI	NG _		06/20/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				AST MICHIGAN BLVD		
SILVER E	BIRCH OF MICHIGA	AN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
Diag. 00	This visit was for a	State Residential Licensure	R 00	000			
		ncluded the Investigation of	K U	000			
	Complaint IN00435	_					
		5.,,					
	Complaint IN00435	347 - No deficiencies related to					
	the allegations are c						
	Survey dates: June	19 and 20, 2024					
	Facility number: 01	14052					
	Desidential Commune	120					
	Residential Census:	120					
	These State Residen	ntial Findings are cited in					
	accordance with 410	_					
	Quality review com	pleted June 21,2024.					
50454							
R 0154	410 IAC 16.2-5-1.	• •					
Dida 00		fety Standards - Deficiency					
Bldg. 00	, ,	ıll keep all kitchens,					
		nmon dining areas,					
		ensils clean, free from litter maintained in good repair in					
	accordance with 4						
		on and interview, the facility	R 01	5.4	R154		07/01/2024
		kitchen was clean related to	K U	. 34	What corrective action (s) will		07/01/2024
		oris under the dish machine			be accomplished for those	,,	
		ind the dish machine for 1 of 1			residents found to have been	,	
	kitchens. (The Main				affected by the deficient	·	
		,			practice:		
	Findings include:				No residents were affected by	the	
					deficient practice.		
	-	chen tour on 6/19/24 at 9:17			How will the facility identify		
	-	anager (DM), indicated the			other residents having the		
	following was obser	rved:			potential to be affected by the	е	
					same deficient practice and		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Rebecca Arthur

TITLE

(X6) DATE 07/05/2024

Any defiency statement 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 disclosed.

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 disclodays 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.

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 1 of 10

Executive Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/20/2024	
	PROVIDER OR SUPPLIER		4400 E	ADDRESS, CITY, STATE, ZIP COD EAST MICHIGAN BLVD GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	a. There was a large and debris under the dirty fork on the tile. b. There was a heav spillage on the white machine. During an interview all of the above was had not figured out they could clean unressidents currently food prepared in the	e amount of adhered dirt, rust, e dish machine as well as a e floor. y accumulation of dried food e back splash behind the dish at that time, the DM indicated in need of cleaning and they to move the dish machine so der it. She indicated all residing in the facility ate e kitchen.	TAU	what corrective action will taken: Other residents could have be affected by deficient practice. What measures will be put place or what systemic changes will the facility mate to ensure the deficient practice. The plumbing under the dish machine was reconfigured by installer on 6/20/24 allowing greater access for cleaning under the machine. The Dietary staff have been serviced on 410 IAC 16.2-5-5 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement which staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement has been implement by the staff have been in serviced on 410 IAC 16.2-5-6 A Daily, and Weekly, cleaning schedule has been implement	een into ke tice y the inder in 5.1 (f). g nted, viced e gnee if the liness r leted period
R 0217	410 IAC 16.2-5-2(Evaluation - Defic	, , ,			

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> C			OMPLETED	
		B. WI		2024			
				_			
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
OILVED BIROLLOE MIGHIOAN OITV				AST MICHIGAN BLVD			
SILVER	BIRCH OF MICHIGA	AN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	(e) Following com	pletion of an evaluation, the					
	facility, using appr	opriately trained staff					
	members, shall id	entify and document the					
		vided by the facility, as					
	follows:	•					
	(1) The services o	ffered to the individual					
	resident shall be a	appropriate to the:					
	(A) scope;						
	(B) frequency;						
	(C) need; and						
	(D) preference;						
	of the resident.						
	(2) The services of	ffered shall be reviewed and					
	revised as approp	riate and discussed by the					
	resident and facilit	ty as needs or desires					
	change. Either the	e facility or the resident may					
	request a service	plan review.					
	(3) The agreed up	on service plan shall be					
	signed and dated	by the resident, and a copy					
	of the service plan	n shall be given to the					
	resident upon requ						
	(4) No identification	on and documentation of					
	services provided	is needed if evaluations					
	subsequent to the	initial evaluation indicate					
	no need for a cha	nge in services.					
	(5) If administratio	on of medications or the					
	provision of reside	ential nursing services, or					
	both, is needed, a	licensed nurse shall be					
		cation and documentation of					
	the services to be	•					
		view and interview, the facility	R 02	217	R217		07/01/2024
		service plan was revised and			What corrective action (s) wi	II	
		to the resident's change in			be accomplished for those		
	-	residents reviewed for service			residents found to have been	1	
	plans. (Resident 5)				affected by the deficient		
					practice:		
	Finding includes:				No residents were affected by	the	
					deficient practice.		
		dent 5 was reviewed on 6/19/24			How will the facility identify		
	at 1:55 p.m. Diagno	oses included, but were not			other residents having the		

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. WING 06/20/2024				2024
				_	_		
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					AST MICHIGAN BLVD		
SILVER E	BIRCH OF MICHIG	AN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDED'S DEAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION DD FFIY (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	limited to, diabetes.	, high blood pressure, pain,			potential to be affected by th	ie	
	urine retention, and	benign prostatic hyperplasia			same deficient practice and		
	1	te that was not cancerous).			what corrective action will be	e	
		,			taken:	-	
	A Nurses' Note, dat	ted 6/5/24 at 6:40 a.m.,			Other residents could have be	en	
		ent reported that he had urinary			affected by deficient practice.		
		and requested to go to the ER			What measures will be put in	nto	
	(emergency room)	-			place or what systemic		
					changes will the facility mak	e	
	A Nurses' Note, dat	ted 6/5/24 at 4:58 p.m.,			to ensure the deficient practi		
		ent returned from the ER with			does not reoccur:		
		catheter (a catheter used to			Resident 5's Service Plan was	3	
		tions where you can't urinate			updated to reflect catheter on		
		ew physician's order was			6/21/24. The DONW or design	nee	
		a home health agency for care			will update resident's Service		
	of the foley cathete				Plans within 72 hours of a cha	inge	
					in condition.		
	The Service Plan, d	lated 12/28/23, and signed by			How will the corrective		
	the resident, indicat				action(s) be monitored to		
	documentation rega	arding the foley catheter or the			ensure the deficient practice		
	new home health se				will not reoccur:		
					The DONW, Executive Director	or or	
	During an interviev	v on 6/20/24 at 10:30 a.m., the			designee will audit 10 current		
	Director of Nursing	g indicated the foley catheter			resident's Service Plans a wee	ek	
	nor the start of the	home health services were on			for a period of 12 weeks for		
	his service plan.				accuracy, to ensure all resider	nts	
					Service Plans have been revie		
					Then randomly audit 10 reside	ent's	
					Service Plans a month for a p		
					of six months.		
					By what date will the system	ic	
					changes be completed:		
					7/1/2024		
R 0247	410 IAC 16.2-5-4((e)(7)					
	Health Services -	Deficiency					
Bldg. 00	(7) Any error in m	edication administration					
	shall be noted in t	he resident 's record. The					
	physician shall be	notified of any error in					

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 4 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				LETED
			B. WING 06/20/2024				
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			AST MICHIGAN BLVD		
SILVER I	BIRCH OF MICHIG	AN CITY			GAN CITY, IN 46360		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		istration when there are any					
	I	detrimental effects to the					
	resident.	view and interview the facility	D O	247	B247		07/01/2024
		view and interview, the facility od pressure medication was	R 02	2 4 /	R247	:11	07/01/2024
		od pressure medication was atside of the physician-ordered			What corrective action (s) wi be accomplished for those	Ш	
		8 residents reviewed for			residents found to have been	n	
	medications. (Resid				affected by the deficient		
	inculcations. (IXESIC	ioni <i>3 j</i>			practice:		
	Finding includes:				No residents were affected by	the	
	i manig meraces.				deficient practice.	aic	
	The record for Resi	dent 3 was reviewed on 6/19/24			How will the facility identify		
		noses included, but were not			other residents having the		
	limited to, heart dis			potential to be affected by the		ie	
					same deficient practice and		
	Physician's Orders,	dated 2/23/24, indicated		what corrective action will be		е	
	1 -	ac medication) 25 milligrams			taken:		
		let twice a day and hold if the			Other residents could have be	en	
		sure (top number) was less			affected by deficient practice.		
	than 100.				What measures will be put ir	nto	
					place or what systemic		
		ministration Record (MAR) for			changes will the facility mak	е	
		ne Metoprolol was administered			to ensure the deficient pract	ice	
	outside of the paran	neters on the following days:			does not reoccur:		
					Resident 3's physician was		
		ood pressure was 99/53			contacted and a review of said	b	
		ood pressure was 96/53			medication was conducted wh		
	-4/29/24 and the blo	ood pressure was 88/48			resulted in the medication being	ng	
					discontinued on 6/21/24.		
	5/2024 MAR:				DONW or designee will review		
	5/0/04	1			blood pressure readings 5 tim		
		od pressure was 96/44			week for 1 month then weekly	tor	
		ood pressure was 92/62			4 months for resident 3.		
		ood pressure was 93/55			How will the corrective		
	-5/30/24 and the blo	ood pressure was 96/61			action(s) be monitored to		
	6/2024 MAD.				ensure the deficient practice)	
	6/2024 MAR:				will not reoccur:	mals r	
	6/7/21 and the blace	nd pressure was 05/60			DONW or designee will rando	-	
		od pressure was 95/69 od pressure was 78/53			audit 5 residents a week for 3		
	ı -0/2/24 anu ine nio	ou diessule was 10/33			a monus marnave blood bress		

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 5 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPLETED		
			B. W	B. WING 06/20/2				
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	8			AST MICHIGAN BLVD			
SII VED E	BIRCH OF MICHIG	ANI CITY			SAN CITY, IN 46360			
OLVER BIROTTOT WHOTHOAN OFF			WIIOTIIC					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	-6/12/24 and the blo	ood pressure was 85/50			parameters, then 1 resident a			
					week for an additional 3 month	ns.		
	During an interview	on 6/20/24 at 10:30 a.m., the			By what date will the system	ic		
	Director of Nursing	indicated the blood pressure			changes be completed:			
	medication should h	nave been held when the			7/1/2024			
	resident's systolic b	lood pressure was less than						
	100.							
R 0273	410 IAC 16.2-5-5.	* *						
		nal Services - Deficiency						
Bldg. 00		ation and serving areas						
		n residents ' units) are						
	maintained in accordance with state and							
	local sanitation and safe food handling standards, including 410 IAC 7-24.							
		on and interview, the facility	R 0	273	R273	07/01/2024		
	-	prepare food under sanitary			What corrective action (s) wi			
		o dirty and greasy food			be accomplished for those			
		rty reach in cooler for 1 of 1			residents found to have been	1		
	kitchens. (The Mair	n Kitchen)		affected by the deficient				
					practice:			
	Findings include:				No residents were affected by	the		
					deficient practice.			
	_	kitchen tour on 6/19/24 at 9:17			How will the facility identify			
		anager (DM) indicated the			other residents having the			
	following was obse	rved:			potential to be affected by th	e		
	TTI OL 1	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			same deficient practice and			
		lls behind the food prep			what corrective action will be)		
	equipment were dir	ty and greasy.			taken:			
	1 701 1 6	11.1			Other residents could have be	en		
		which was not used that e accumulation of grease on			affected by deficient practice.			
	_	e accumulation of grease on			What measures will be put in	ito		
	both sides.				place or what systemic	_		
	a There was a been	y accumulation of grease on			changes will the facility make			
		in cooler next to the deep			to ensure the deficient practi	Ce		
		i in cooler heat to the deep			does not reoccur:	on		
	fryer.				Dietary have been in serviced			
	d The book anload	on the stove was stained with			410 IAC 16.2-5-5.1 (f). A Daily			
	_	nd both sides of the stove had			and Weekly, cleaning schedul			
	a viack substance at	na bom sides of the stove had			has been implemented, which	Stall		

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMP			COMPL	ETED
			B. WING 06/20/202				
			<u> </u>		_		-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
011.1/55.5		ANI OLTY			AST MICHIGAN BLVD		
SILVER	BIRCH OF MICHIGA	AN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
	a large amount of gr	rease.			have been in serviced on also		
					How will the corrective		
	e. There was a large	amount of dried burned food			action(s) be monitored to		
		he grates on the grill. During			ensure the deficient practice		
		time, the DM indicated they			will not reoccur:		
	rarely used the grill.	-			The Culinary Director or design	nee	
					conduct a daily walk thru of the		
	f. Both sides of the	griddle had a large amount of			kitchen area to ensure cleanlir		
	grease with a dried	food substance noted.			and the Executive Director or		
					designee will audit the comple	ted	
	g. There was dried f	food spillage on the top and			cleaning forms weekly for a pe		
	bottom shelves in th	ne reach in cooler located next			of six months to ensure state		
	to the steam table.				requirements are being met.		
					By what date will the system	ic	
	During an interview	at that time, the DM indicated			changes be completed:		
	all of the above was	in need of cleaning. She			7/1/2024		
	indicated 120 of 120	0 residents residing in the					
	facility ate food pre	pared in the kitchen.					
R 0295	410 IAC 16.2-5-6(
	Pharmaceutical Se	ervices - Noncompliance					
Bldg. 00	(a) Residents who	self-medicate may keep					
	· · · · · · · · · · · · · · · · · · ·	on and nonprescription					
	medications in the	ir unit as long as they keep					
	them secured from						
		on, record review, and	R 02	.95	R295		07/01/2024
		ty failed to ensure medications			What corrective action (s) wi	11	
		dent rooms for those who self			be accomplished for those		
		own medications for 1 of 2			residents found to have been	1	
		for self administration of			affected by the deficient		
	medication. (Reside	ent 4)			practice:		
					No residents were affected by	the	
	Finding includes:				deficient practice.		
					How will the facility identify		
	•	oservation on 6/19/24 at 1:30			other residents having the		
	•	oom door was unlocked, and			potential to be affected by the	е	
		in his room. At that time, the			same deficient practice and		
		ns were observed on a table			what corrective action will be	;	
		medications were not secured			taken:		
	or in a locked drawe	er.			Other residents could have be	en	

State Form Event ID: EHG811 Facility ID: 014052 If continuation sheet Page 7 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	. }		ADDRESS, CITY, STATE, ZIP COD	
				EAST MICHIGAN BLVD	
SILVER BIRCH OF MICHIGAN CITY			MICHI	IGAN CITY, IN 46360	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		C/0.0 /0.4 0. TO		affected by deficient practice	I
	_	on 6/20/24 at 8:50 a.m., the		What measures will be put i	nto
		e was at dialysis yesterday		place or what systemic	
		oor unlocked because he come in and look at his air		changes will the facility mal	
		I leave my medications on this		to ensure the deficient prac	tice
	_	put some of them inside the		does not reoccur: Resident 4 and all other curre	ant .
		ndicated he usually locked his		residents that self-administer	
		left the facility, however, when		medications will be reeducate	
	_	to eat meals in the dining		the importance of locking the	
		ve his apartment unlocked.		private apartments when the	
	room, ne would lea	ve ms aparament amounted.		not present.	y arc
	The record for Resi	dent 4 was reviewed on 6/19/24		Resident 4 and all other curre	ent
		oses included, but were not		residents that self-administer	
		lure, renal dialysis, high blood		ed	
	pressure, benign pro	ostatic hyperplasia (an		from	
		at was not cancerous), and		the facility it is their responsit	I
	anxiety.			to ensure their medications a	•
				always stored safely and it is	
		on the current 6/2024		highly encouraged to keep th	eir
		mmary (POS), indicated the		medications in a locked area	
	resident could self-	administer his own		within their private apartment	s.
	medications.			How will the corrective	
				action(s) be monitored to	
	_	ications were listed on the		ensure the deficient practic	e
	6/2024 POS:			will not reoccur:	
	T4h ' / d			The Executive Director or	
		yroid medication) 150		designee will conduct 5 rando	I
	micrograms (mcg)	eation used to treat low blood		audits a week for 3 months o	Ī
	pressure)10 milligra			apartments of residents that	ono
		dication used to treat high		self-administer their medicati to verify that their apartments	
	cholesterol) 40 mg	dication used to treat mgn		locked if they are not present	
		a potassium supplement) 20		Then the Executive Director	
	milliequivalent (me			designee will conduct 1 rando	
	Certavite multi vita			audit a week for an additiona	
		ation used to treat chronic		months.	
	kidney disease) 500			By what date will the syster	nic
	Tylenol 500 mg 2 ta	-		changes be completed:	•
	, , , , , , , , , , , , , , , , , , , ,			7/1/2024	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2024
	PROVIDER OR SUPPLIER		4400 E	ADDRESS, CITY, STATE, ZIP COD AST MICHIGAN BLVD GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0349	resident may self-ad During an interview Director of Nursing	. , . ,			
Bldg. 00	(a) The facility mu on each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately dod (3) Readily access (4) Systematically Based on observation interview, the facility records were completed documentation of a to drain urine in sitt on your own) and residents reviewed. Finding includes: During an interview resident indicated he three times a week. had a foley catheter At that time, he lifted drainage bag was to the record for Resident 1:18 p.m. Diagnol limited to, heart fail	Ist maintain clinical records These records must be the supervision of an acility designated with that e records must be as cumented. sible. organized. on, record review, and ty failed to ensure clinical lete related to the foley catheter (a catheter used uations where you can't urinate enal dialysis for 1 of 8	R 0349	R349 What corrective action (s) w be accomplished for those residents found to have bee affected by the deficient practice: No 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: Other residents could have be affected by deficient practice. What measures will be put in place or what systemic changes will the facility make to ensure the deficient practices.	n the e e e e e e e e e e e e e e e e e e

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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						0	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG _		06/20	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	₹			AST MICHIGAN BLVD		
SII VER F	BIRCH OF MICHIG	AN CITY			SAN CITY, IN 46360		
GIEVER BIROTTOT WHOTHOAR GITT					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nat was not cancerous), and			DONW added dialysis and		
	anxiety.				treatment to resident 4's POS	S on	
					6/21/24. DONW performed a	n	
		mentation on the 6/2024			audit of all current resident's	POS	
	-	Summary (POS), to indicate the			and add added dialysis where	е	
	resident had a foley	catheter or went to renal			applicable.		
	dialysis three times	a week.					
					How will the corrective		
	During an interview	v on 6/20/24 at 10:30 a.m., the			action(s) be monitored to		
	Director of Nursing	g indicated there was no			ensure the deficient practice	е	
	documentation on t	he 6/2024 POS regarding the			will not reoccur:		
	foley catheter or the	e renal dialysis.			The DONW, Executive Direct	tor or	
	•	•			designee will audit 10 current		
					resident's Service Plans a we		
					for a period of 12 weeks for		
					accuracy, to ensure all reside	ents	
					Service Plans have been revi		
					Then randomly audit 10 resid		
					Service Plans a month for a p		
					of six months.	Joriou	
					By what date will the systen	nic	
					changes be completed:	IIIC	
					7/1/2024		
					1/1/2024		

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