| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 10/21/2021 |

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| SILVER BIRCH OF MICHIGAN CITY | 4400 EAST MICHIGAN BLVD<br>MICHIGAN CITY, IN 46360 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00364197.<br><br>Complaint IN00364197 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: 10/20 and 10/21/21<br><br>Facility number: 014052<br><br>Residential Census: 119<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 10/27/21. | R 0000 | | |
| R 0120<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(e)(1-3)<br>Personnel - Noncompliance<br>(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:<br>(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 | | | |

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

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| | personnel.<br>(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.<br>(3) Inservice records shall be maintained and shall indicate the following:<br>(A) The time, date, and location.<br>(B) The name of the instructor.<br>(C) The title of the instructor.<br>(D) The names of the participants.<br>(E) The program content of inservice.<br>The employee will acknowledge attendance by written signature. | | | |
| | Based on record review and interview, the facility failed to ensure the required personnel annual inservices, which included Resident Rights and Dementia Care, were completed for 3 of 5 staff members reviewed. (QMA 1, LPN 1, and the Activity Director (AD))<br><br>Findings include:<br><br>Review of the employee records was completed on 10/20/21 at 1:05 p.m..<br><br>1. QMA 1 was hired on 3/7/18. The QMA did not complete the required yearly Resident Rights training for the 2020 calendar year.<br><br>2. LPN 1 was hired on 2/26/19. The LPN did not complete the required yearly Resident Rights training for the 2020 calendar year. | R 0120 | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>No residents were affected by the deficient practice.<br>**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;**<br>Other residents could have been affected by deficient practice.<br>**What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;** | 12/13/2021 |

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| | 3. The AD was hired on 9/25/18. The AD did not complete any of the required yearly hours of Dementia or Resident Rights training for the 2020 calendar year.<br><br>Interview with the Human Resource Director on 10/20/21 at 1:00 p.m., indicated the above employees had not completed the required yearly hours of Dementia and/or Resident Rights training for the 2020 calendar year. | | 1. A 12-month calendar of monthly staff in-services has been created.<br>2. All staff will be in serviced on the importance of state required in-service education and required hours.<br>3. All staff will be in serviced on the company's online Relias training program.<br>4. Any staff member who has not completed their monthly Relias training course by the 20th of the month will be removed from the schedule until training has been completed.<br><br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur;**<br>The Executive Director or designee will audit the all employee training records monthly for a period of three months to ensure state requirements are being met.<br>**By what date will the systemic changes be completed;**<br>12/13/2021 | |
| R 0216<br><br>Bldg. 00 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br>(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:<br>(1) The resident ' s physical, cognitive, and mental status. | | | |

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| | (2) The resident ' s independence in the activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility.<br>Based on observation, record review, and interview, the facility failed to ensure medications were not left with residents who were not able to self administer their medications for 1 of 5 residents observed for medication administration. (Resident 11)<br><br>Finding includes:<br><br>On 10/21/21 at 8:28 a.m., QMA 2 was observed preparing medications for Resident #11. Nine pills were placed in the medication cup and 17 grams of Miralax (a laxative) powder was mixed in a cup of water. The QMA entered the resident's room and placed the cup of water mixed with Miralax and the cup of pills on the resident's table. The QMA spoke with the resident and then proceeded to leave the room. The resident did not take her medication while the QMA was present in the room.<br><br>Interview with the QMA at that time, indicated she left the medication in the resident's room and she would take the pills when she was ready.<br><br>The record for Resident 11 was reviewed on 10/21/21 at 9:15 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia without behavior disturbance, and major depressive disorder.<br><br>The Annual Self Administration of Medication | R 0216 | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>No other residents were affected by the deficient practice.<br>**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;**<br>Other residents could have been affected by the deficient practice.<br>**What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;**<br>For the resident that was affected, they were reassessed by the Director of Nursing and Wellness, and it was determined that they were capable of self-administering their own medications safety. Their Primary Care Physician was notified and wrote an order for resident to self-administer medication. Family was made aware of changes.<br>Nursing staff was in-serviced on | 12/13/2021 |

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| | assessment, dated 7/26/21, indicated the resident could not self administer her medications.<br><br>Interview with the Director of Nursing and Wellness on 10/21/21 at 1:35 p.m., indicated the QMA should have stayed with the resident while she took her medication based on her Self Administration of Medication assessment. | | Medication Evaluation i.e. self-administer medications.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur;**<br>The Director of Nursing and Wellness will audit 5 random residents per month for a period of 3 months for ability to self -administer medication.<br>**By what date will the systemic changes be completed;**<br>12/13/2021 | |
| R 0247<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(7)<br>Health Services - Deficiency<br>(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.<br>Based on observation, record review and interview, the facility failed to ensure medications were given as ordered related to antidepressants for 1 of 5 residents observed during medication administration. (Resident 11)<br><br>Finding includes:<br><br>On 10/21/21 at 8:28 a.m., QMA 2 was observed preparing medications for Resident 11. The medications were prepackaged and the medication label indicated the resident was to receive Citalopram (an antidepressant) 10 milligrams (mg) daily. The pill was placed into the medication cup, along with 8 other pills and taken into the resident's room. | R 0247 | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>No other residents were affected by the deficient practice.<br><br>**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;**<br>Other residents could be affected by deficient practice.<br>**What measures will be put into** | 12/13/2021 |

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|---|---|---|---|---|
| | The record for Resident 11 was reviewed on 10/21/21 at 9:15 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia without behavior disturbance, and major depressive disorder.<br><br>A Physician's Order, dated 10/15/21, indicated the Citalopram was to be discontinued.<br><br>A Physician's Order, dated 10/16/21, indicated the resident was to receive Sertraline (an antidepressant) 25 mg daily.<br><br>The October 2021 Medication Administration Record (MAR), indicated the Sertraline was signed out as being administered on 10/21/21. The Citalopram had been discontinued on the MAR.<br><br>Interview with LPN 2 on 10/21/21 at 1:34 p.m., indicated the medication packs were delivered for 2 week cycles. She indicated if a medication was changed within that 2 week cycle, a medication change label was to be placed on the packet. She also indicated the Sertraline was available and should have been given rather than the Citalopram. | | **place or what systemic changes will the facility make to ensure the deficient practice does not recur;**<br>Resident's physician and family were notified of deficient practice. Resident was monitored for any ill effects. Nursing staff was in-serviced on Medication Administration.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur;**<br>The Director of Nursing and Wellness or their designee will audit five residents per medication pass per month for a period 3 months.<br>**By what date will the systemic changes be completed;**<br>12/13/2021 | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, record review, and interview, the facility failed to store, serve and prepare food under sanitary conditions related to dirty food equipment, shelves, and countertops, expired leftover food in the reach in cooler, food | R 0273 | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** | 12/13/2021 |

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|---|---|---|---|---|
| | and debris on the floor of the walk-in freezer, transportation carts with dried food spillage and stains, adhered dirt on the floor near the baseboard, open and undated spices, and open containers of chicken and beef base for 1 of 1 kitchens observed. (The Main Kitchen)<br><br>Findings include:<br><br>1. During the full kitchen sanitation tour on 10/20/21 at 9:45 with Cook 1 the following was observed:<br><br>a. The inside doors, bottom trays and the drip pan all had a heavy accumulation of dried food spillage.<br><br>b. The grates on the grill had a heavy accumulation of burned food.<br><br>c. The sides of the fryer had a heavy accumulation of dried grease.<br><br>d. The stove top grates had an accumulation of burned food and the backsplash had a heavy accumulation of dried grease.<br><br>e. There was a heavy accumulation of adhered dirt along the base board throughout the entire kitchen and dish area.<br><br>f. There was dried food spillage on the floor grates and white pvc pipes under the dish machine and 3 compartment sink.<br><br>g. The ice scoop was observed inside the ice machine, laying in the ice itself.<br><br>h. The 3 tiered carts were dirty with food spillage noted. | | No residents were affected by the deficient practice.<br>**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;**<br>Other residents could have been affected by deficient practice.<br>**What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;**<br>Dietary staff was in-serviced on Kitchen Sanitation, a complete and through deep clean of the kitchen was conducted and a daily & weekly cleaning schedule was created. Staff was in serviced on cleaning schedule.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur;**<br>The Executive Director or designee will conduct a weekly audit of the kitchen for proper sanitation and cleanliness for a period of three months.<br>**By what date will the systemic changes be completed;**<br>12/13/2021 | |

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| | i. The countertop where the can opener was located had an accumulation of dried food spillage.<br><br>j. There was a container of leftover chicken salad in the reach in cooler with a date opened of 10/13/21. There was a large amount of food crumbs noted on the bottom of the reach in cooler and the door was sticky to touch.<br><br>Interview with Cook 1 at the time, indicated left overs were good for 3 days.<br><br>k. The salad bar doors were sticky to touch with food crumbs noted on the shelf below that housed clean pans.<br><br>l. The inside of the clean utensil drawer had a large amount of food crumbs noted.<br><br>m. The freezer floor had a large amount food debris and paper products on the floor.<br><br>n. The lids for the 4 containers of beef and chicken base were not secured in the dry food storage room.<br><br>o. The floor fan had a heavy accumulation of dust on the blades and screen.<br><br>p. Both garbage cans were uncovered with garbage noted inside.<br><br>q. There were 19 containers of open spices on a shelf. All of the spices had no date opened and the shelf was sticky touch.<br><br>Interview with the Culinary Chef on 10/21/21 at 10:30 a.m., indicated all of the above was in need | | | |

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| | of cleaning. | | | |
| R 0407<br><br>Bldg. 00 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance<br>(b) The facility must establish an infection control program that includes the following:<br>(1) A system that enables the facility to analyze patterns of known infectious symptoms.<br>(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.<br>(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.<br>(4) Reporting communicable disease to public health authorities.<br>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not wearing the appropriate eye protection and face coverings for health care professionals (HCP's). This had the potential to affect all 119 residents residing in the facility.<br><br>Findings include:<br><br>1. On 10/20/21 at 11:35 a.m., QMA 1 was observed preparing medications at her medication cart. She was wearing clear plastic safety glasses over her prescription glasses. There were gaps at the side as well as along the top. The QMA was observed entering and exiting a resident's room. 2. During a random observation on 10/20/21 at 9:05 a.m., the Administrator and the Director of Nursing and Wellness were observed standing in the front foyer. Both were wearing face masks, however not protective eyewear. There were residents observed in the area and within 6 feet. | R 0407 | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>No residents were affected by the deficient practice.<br>**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;**<br>Other residents could have been affected by deficient practice.<br>**What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur;**<br>Employees were in-serviced on correct eye protection and face coverings for HCPs. Correct eye | 12/13/2021 |

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| | 3. During a random observation on 10/20/21 at 9:30 a.m., Receptionist 1 was observed wearing a face mask over her mouth and nose, however she had no protective eyewear on. There were residents standing at the front desk within 6 feet of her.<br><br>Interview with the Director of Nursing and Wellness on 10/20/21 at 11:50 a.m., indicated she was unaware protective eyewear was mandatory at the present time.<br><br>The COVID-19 Infection Control Guidance in Long-term Care Facilities updated 9/27/21, indicated "HCP (Healthcare Professional) must wear face mask (medical) and eye protection, face shield /or goggles that cover top, bottom, sides of eyes with no gaps) as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status according to community transmission as follows: For substantial or high community transmission, then eye protection should be used by all HCP for all residents within 6 feet when delivering essential direct care regardless of COVID-19 status. In areas of substantial to high transmission in which healthcare personnel (HCP) are using eye protection for all resident encounters, extended use of eye protection may be considered as a conventional capacity strategy."<br><br>4. On 10/21/21 at 8:45 a.m., Receptionist 1 was observed wearing a cloth face mask over her mouth and nose.<br><br>At 11:10 a.m., the Activity Director was observed gathering residents to get into the community van to leave the facility. She was wearing a cloth face | | protection was ordered and distributed to employees.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur;**<br>The Director of Nursing and Wellness or their designee will monitor for compliance daily, for a period of 3 months.<br>**By what date will the systemic changes be completed;**<br>12/13/2021 | |

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| | mask over her mouth and nose. Receptionist 1 was also observed in the same area behind the desk still wearing her cloth face mask.<br><br>Interview with the Activity Director and Receptionist 1 at that at that time, indicated they were both unaware they could not wear the cloth face mask.<br><br>The COVID-19 Infection Control Guidance in Long-term Care Facilities updated 9/27/21, indicated "Direct and indirect care HCP should wear a medical procedure mask for the duration of their shifts." | | | |