STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF HAMMOND	5620 SOHL AVENUE, HAMMOND, , 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 1 & 2, 2025 Facility number: 013801 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/6/25.	R 0000	October15, 2025 Suzanne Kuzemka, Director of Long-Term Care Indiana Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006 Dear Ms. Williams: Please reference the enclosed 2567L as “Plan of Correction” for the	

			October 2, 2025, Residential Licensure Survey (Q3V111) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools October 15, 2025. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on October 15, 2025, serves as our allegation of compliance. Should you have any questions or concerns regarding the Plan of Corrections, please contact me.	

			Respectfully, Neysa Holman Stewart, HFA	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's physician was notified of treatment refusals for 1 of 7 records reviewed. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety,	R 0036	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R 036** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R#2 was assessed no adverse reactions noted. MD notified of treatment refusal.	10/24/2025

	depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. A Physician's Order, dated 10/1/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Mupirocin 2% ointment (an ointment to treat skin infections), apply 1 gram to affected toes daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident refused the Mupirocin 2% ointment. There was no documentation the resident's physician was notified of the treatment refusals. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated the resident's physician should have been notified of the treatment refusals. Based on record review and interview, the facility failed to ensure the resident's physician was notified of treatment refusals for 1 of 7 records reviewed. (Resident 2) Finding includes:		Order received by MD on 10/7/25 to discontinue medication. No other residents were affected by the deficient practice. **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 residing in* the community are at risk for this alleged deficient practice. To identify other residents having the potential to be affected by the same deficient practice, DHW reviewed the Medication Administration audit report related to treatment refusal, any concerns found were addressed immediately / MD notification. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 10/03/25 -10/09/25 Nursing	

	The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. A Physician's Order, dated 10/1/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Mupirocin 2% ointment (an ointment to treat skin infections), apply 1 gram to affected toes daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident refused the Mupirocin 2% ointment. There was no documentation the resident's physician was notified of the treatment refusals. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated the resident's physician should have been notified of the treatment refusals.		staff was immediately re-educated regarding MD notification related to treatment refusal. Licensed nurse at the end of each shift will run the Medication Administration Report regarding missed medication to ensure all refusal of medication is addressed and MD notified. DHW will review the medication admin audit report weekly to ensure MD notification of refusal of treatments are in keeping with MD / Provider orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Health and Wellness or Designee will review medication admin audit report weekly for 3 months to ensure that any refusal of treatment are in keeping with MD / Provider orders and that the provider has been notified. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for QI committee will determine if continued auditing is necessary once 100%	

			compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 10/24/25**	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (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 observation, record review, and interview, the facility	R 0216	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R216** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	10/24/2025

	failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration of medications. (Residents 2, 5, 6, and 4) Findings include: 1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler.		Residents #2,#5,#6 & #4 self-administration of medication assessments updated, and MD orders related to self-administration of medication received. No other residents were affected by the deficient practice. **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 residing in* the community are at risk for this alleged deficient practice. To identify other residents having the potential to be affected by the same deficient practice, DHW or designee completed and audit of residents who self-administer medication to ensure self-administration assessment and MD orders are in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

	The resident did not have a physician's order to self-administer the above medications. A Self-Administration of Medication Assessment, dated 7/6/22, indicated the resident was safe to administer his insulin. There was no self-administration of medication assessment completed after 7/6/22. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication assessments were to be completed quarterly and upon a significant change. 2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a semiglutide) injection. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). The October 2025 Physician's Order Summary (POS) indicated the resident received		On 10/2/25 - 10/9/25 applicable nursing staff were immediately in-serviced regarding Self-administration of medication assessment updated / completed and MD order in place related to self-administration of medication. The DHW and/or designee will review the 24HR Report and Dashboard weekly to ensure Self-administration medication orders and self-administration medication assessments are reviewed / updated appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Health and Wellness or Designee will review 24HR Report & Dashboard weekly for 3 months to ensure resident's	

	Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN for wheezing. The resident was also receiving Ozempic 1 milligram (mg) subcutaneously every Friday. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic. A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been		Self-administration of medication assessment and MD orders are reviewed / updated appropriately. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan will be amended when indicated. **Date by which systemic corrections will be completed: 10/24/25** .	

	self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic. 3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure. The Medication Administration Record (MAR), dated 9/2025, indicated the resident self-administered the following medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and budesonide-formoterol inhaler. A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications. The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications.			

	The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications. The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications. During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins, nebulizer treatment, and inhalers. She provided an undated fax from the Physician that indicated the resident may self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated 8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications. 4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD).			

An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).

Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily, resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may self-administer.

The September and October Medication Administration Records (MARs) indicated the resident self-administered the Duoneb and Wixela.

A Self-Administration Assessment, dated 9/8/25, indicated the resident may not self-administer medications.

During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information.

Based on observation, record review, and interview, the facility failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration

of medications. (Residents 2, 5, 6, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily.

The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler.

The resident did not have a physician's order to self-administer the above medications.

A Self-Administration of Medication Assessment, dated

7/6/22, indicated the resident was safe to administer his insulin.

There was no self-administration of medication assessment completed after 7/6/22.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication assessments were to be completed quarterly and upon a significant change.

2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a semiglutide) injection.

The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD).

The October 2025 Physician's Order Summary (POS) indicated the resident received Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and

	Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN for wheezing. The resident was also receiving Ozempic 1 milligram (mg) subcutaneously every Friday. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic. A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic. 3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but			

were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure.

The Medication Administration Record (MAR), dated 9/2025, indicated the resident self-administered the following medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and budesonide-formoterol inhaler.

A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications.

The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications.

The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications.

The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications.

	During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins, nebulizer treatment, and inhalers. She provided an undated fax from the Physician that indicated the resident may self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated 8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications. 4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD). An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs). Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily,			

	resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may self-administer. The September and October Medication Administration Records (MARs) indicated the resident self-administered the Duoneb and Wixela. A Self-Administration Assessment, dated 9/8/25, indicated the resident may not self-administer medications. During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information. Based on observation, record review, and interview, the facility failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration of medications. (Residents 2, 5, 6, and 4) Findings include:			

	1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler. The resident did not have a physician's order to self-administer the above medications. A Self-Administration of Medication Assessment, dated 7/6/22, indicated the resident was safe to administer his insulin. There was no			

	self-administration of medication assessment completed after 7/6/22. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication assessments were to be completed quarterly and upon a significant change. 2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a semiglutide) injection. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). The October 2025 Physician's Order Summary (POS) indicated the resident received Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN for wheezing. The resident was			

also receiving Ozempic 1 milligram (mg) subcutaneously every Friday.

The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic.

A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic.

3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure.

The Medication Administration

	Record (MAR), dated 9/2025, indicated the resident self-administered the following medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and budesonide-formoterol inhaler. A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications. The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications. The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications. The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications. During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins, nebulizer treatment, and			

	inhalers. She provided an undated fax from the Physician that indicated the resident may self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated 8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications. 4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD). An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).			

	Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily, resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may self-administer. The September and October Medication Administration Records (MARs) indicated the resident self-administered the Duoneb and Wixela. A Self-Administration Assessment, dated 9/8/25, indicated the resident may not self-administer medications. During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information. Based on observation, record review, and interview, the facility failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration of medications. (Residents 2, 5, 6, and 4) Findings include: 1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included,			

	but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler. The resident did not have a physician's order to self-administer the above medications. A Self-Administration of Medication Assessment, dated 7/6/22, indicated the resident was safe to administer his insulin.			

	There was no self-administration of medication assessment completed after 7/6/22. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication assessments were to be completed quarterly and upon a significant change. 2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a semiglutide) injection. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). The October 2025 Physician's Order Summary (POS) indicated the resident received Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN			

for wheezing. The resident was also receiving Ozempic 1 milligram (mg) subcutaneously every Friday.

The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic.

A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic.

3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure.

	The Medication Administration Record (MAR), dated 9/2025, indicated the resident self-administered the following medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and budesonide-formoterol inhaler. A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications. The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications. The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications. The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications. During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins,			

	nebulizer treatment, and inhalers. She provided an undated fax from the Physician that indicated the resident may self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated 8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications. 4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD). An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs). Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily, resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may			

	self-administer. The September and October Medication Administration Records (MARs) indicated the resident self-administered the Duoneb and Wixela. A Self-Administration Assessment, dated 9/8/25, indicated the resident may not self-administer medications. During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information. Based on observation, record review, and interview, the facility failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration of medications. (Residents 2, 5, 6, and 4) Findings include: 1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.			

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily.

The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler.

The resident did not have a physician's order to self-administer the above medications.

A Self-Administration of Medication Assessment, dated 7/6/22, indicated the resident was safe to administer his insulin.

There was no self-administration of medication assessment completed after 7/6/22.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication

	assessments were to be completed quarterly and upon a significant change. 2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a semiglutide) injection. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). The October 2025 Physician's Order Summary (POS) indicated the resident received Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN for wheezing. The resident was also receiving Ozempic 1 milligram (mg) subcutaneously every Friday. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the			

	resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic. A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic. 3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure. The Medication Administration Record (MAR), dated 9/2025, indicated the resident self-administered the following medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and			

budesonide-formoterol inhaler.

A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications.

The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications.

The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications.

The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications.

During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins, nebulizer treatment, and inhalers. She provided an undated fax from the Physician that indicated the resident may self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated

8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications.

4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD).

An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).

Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily, resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may self-administer.

The September and October Medication Administration Records (MARs) indicated the resident self-administered the Duoneb and Wixela.

A Self-Administration

Assessment, dated 9/8/25, indicated the resident may not self-administer medications.

During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information.

Based on observation, record review, and interview, the facility failed to ensure self-administration of medication assessments were current and followed and that residents had orders to self-administer their medications for 4 of 7 residents reviewed for self-administration of medications. (Residents 2, 5, 6, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

Physician's Orders, listed on the October 2025 Physician's Order Summary (POS), indicated the resident received Ozempic (a semiglutide) 1.5 milligrams (mg) subcutaneously (sq) every Tuesday, Novolin 70/30 insulin via a flex pen, inject 120 units

	sq twice a day before meals, and Trelegy Elipta inhaler, inhale 1 puff daily. The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered his Ozempic, Novolin 70/30 insulin, and his Trelegy Elipta inhaler. The resident did not have a physician's order to self-administer the above medications. A Self-Administration of Medication Assessment, dated 7/6/22, indicated the resident was safe to administer his insulin. There was no self-administration of medication assessment completed after 7/6/22. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated self-administration of medication assessments were to be completed quarterly and upon a significant change. 2. During a random observation on 10/2/25 at 11:40 a.m., two inhalers were noted in Resident 5's room. During an interview at that time, the resident indicated she self-administered her inhalers, nebulizer treatment, and her Ozempic (a			

	semiglutide) injection. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). The October 2025 Physician's Order Summary (POS) indicated the resident received Azelastine 0.1% (a nasal spray), instill 2 sprays in each nostril twice a day as needed (PRN), Albuterol HFA 90 microgram (mcg) inhaler, inhale 2 puffs every 6 hours PRN for wheezing, and Ipratropium-Albuterol 0/5-3, use 1 vial per nebulizer (a breathing treatment) every 6 hours PRN for wheezing. The resident was also receiving Ozempic 1 milligram (mg) subcutaneously every Friday.			

	The Medication Administration Records (MARs) for the months of July 2025, August 2025, and September 2025 indicated the resident self-administered her Azelastine nasal spray, Albuterol inhaler, and her Ipratropium-Albuterol nebulizer treatments. The MARs also indicated the Ozempic was signed out weekly with a code of "9" which was to see nurse's notes. There was no documentation indicating the resident self-administered her Ozempic. A Self-Administration of Medication Assessment, dated 7/13/25, indicated the resident could not self-administer her medications. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated based on the assessment, the resident should not have been self-administering her nasal spray, inhaler, nebulizer treatments, and her Ozempic. 3. Resident 6's record was reviewed on 10/1/25 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, asthma, and congestive heart failure. The Medication Administration Record (MAR), dated 9/2025, indicated the resident self-administered the following			

	medications: Humulin insulin, Novolin insulin, Tresiba insulin, ipratropium-albuterol nebulizer treatment, Retacrit injection, and budesonide-formoterol inhaler. A Service Plan, dated 9/19/25, indicated the resident required assistance with ordering medications and would be supported to take all medications safely and as ordered. There was lack of documentation to indicate the resident self-administered any medications. The Medication Self Administration Safety Screens, dated 9/6/25, 6/10/25, and 3/12/25, indicated the resident may not self-administer medications. The Level of Service Assessment, dated 5/14/25, indicated the resident required caregiver administration of medications. The Physician's Order Summary, dated 10/2025, lacked any current orders for the self-administration of medications. During an interview on 10/2/25 at 1:02 p.m., the Director of Nursing indicated the resident self-administered her insulins, nebulizer treatment, and inhalers. She provided an undated fax from the Physician that indicated the resident may			

	self-administer insulins, nebulizer treatment, and inhalers. She also provided a Move-In Assessment, dated 8/30/22, that indicated the resident could self-administer insulin and nebulizer treatments. She was unsure why there were no current orders for self-administration or why the self-administration assessment indicated the resident was not to self-administer any medications. 4. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD). An admission assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs). Physician's Orders, dated 9/8/25, indicated Duoneb (an inhaled breathing medication), via nebulizer twice daily, resident may self-administer and Wixela (an inhaled breathing medication), one puff every 12 hours, resident may self-administer. The September and October Medication Administration			

	Records (MARs) indicated the resident self-administered the Duoneb and Wixela. A Self-Administration Assessment, dated 9/8/25, indicated the resident may not self-administer medications. During an interview on 10/2/25 at 11:05 a.m., when informed of the findings, the Director of Nursing (DON) offered no additional information.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 1 of 7 sampled residents. (Resident 2)	R 0246	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R 246** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R#2 was assessed no	10/24/2025

	Finding includes: The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. The October 2025 Physician's Order Summary (POS) indicated the resident was to receive Tylenol 500 milligrams (mg) three times a day as needed (PRN) for pain and Tramadol (a pain medication) 50 mg every 6 hours PRN for pain. The September 2025 Medication Administration Record (MAR) indicated QMAs administered the resident's PRN Tylenol on the following dates and times without prior authorization from a licensed nurse: - 9/1/25 at 5:04 p.m. - 9/2/25 at 6:28 p.m. - 9/7/25 at 4:25 p.m. - 9/11/25 at 4:57 p.m. - 9/12/25 at 5:12 p.m. - 9/15/25 at 5:23 p.m.		adverse reaction noted. The Nurse and QMA noted were immediately re-educated regarding prior authorization by license nurse by the Director of Nursing & Wellness on 10/2/25. No other residents were affected by the alleged deficient practice. **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 facility residents that staff administer medication have the potential to be affected by the same deficient practice. DONW reviewed the PRN medication audit report related to PRN medication to ensure QMAs received prior authorization from license nurse is noted. No other residents were affected by the alleged deficient practice. What measures will be put into	

	- 9/16/25 at 5:22 p.m. - 9/17/25 at 5:18 p.m. - 9/25/25 at 7:48 p.m. - 9/26/25 at 5:24 p.m. - 9/29/25 at 6:29 p.m. - 9/30/25 at 7:29 p.m. The September 2025 Medication Administration Record (MAR) indicated QMAs administered the resident's PRN Tramadol on the following dates and times without prior authorization from a licensed nurse: - 9/1/25 at 5:04 p.m. - 9/2/25 at 6:28 p.m. - 9/6/25 at 10:01 a.m. - 9/7/25 at 4:25 p.m. - 9/9/25 at 8:27 a.m. - 9/11/25 at 4:58 p.m. - 9/12/25 at 5:12 p.m. - 9/15/25 at 5:23 p.m. - 9/16/25 at 5:23 p.m. - 9/17/25 at 5:20 p.m. - 9/25/25 at 7:48 p.m. - 9/26/25 at 5:25 p.m.		place or what systemic changes will be made to ensure that the deficient practice does not recur; On 10/2/25-10/9/25 the DONW re-educated QMA's and licensed nurse related to QMA receiving prior approval by licensed nurse to administer PRN medication. Nursing staff educated on new PRN medication communication form implemented. The Director of Nursing and Wellness or designee will review the 24HR Report and PRN Medication Report 5 days a week for 3 months to ensure QMAs receive authorization from a licensed nurse prior to administering needed PRN medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Nursing and Wellness or designee will audit 24HR Report & PRN Medication Report 5 days a week for 3 months to ensure QMAs receive prior	

	- 9/29/25 at 6:30 p.m. - 9/30/25 at 7:29 p.m. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated the QMAs should have obtained prior authorization from the nurse before giving the Tylenol and Tramadol. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 1 of 7 sampled residents. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain. A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact. The October 2025 Physician's Order Summary (POS) indicated the resident was to receive Tylenol 500 milligrams (mg) three times a day as needed (PRN) for pain and Tramadol (a pain medication) 50 mg every 6 hours PRN for pain.		authorization from a licensed nurse prior to administering needed PRN medication. Any issues identified will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. **Date by which systemic corrections will be completed: 10/24/25**	

	The September 2025 Medication Administration Record (MAR) indicated QMAs administered the resident's PRN Tylenol on the following dates and times without prior authorization from a licensed nurse: - 9/1/25 at 5:04 p.m. - 9/2/25 at 6:28 p.m. - 9/7/25 at 4:25 p.m. - 9/11/25 at 4:57 p.m. - 9/12/25 at 5:12 p.m. - 9/15/25 at 5:23 p.m. - 9/16/25 at 5:22 p.m. - 9/17/25 at 5:18 p.m. - 9/25/25 at 7:48 p.m. - 9/26/25 at 5:24 p.m. - 9/29/25 at 6:29 p.m. - 9/30/25 at 7:29 p.m. The September 2025 Medication Administration Record (MAR) indicated QMAs administered the resident's PRN Tramadol on the following dates and times without prior authorization from a licensed nurse: - 9/1/25 at 5:04 p.m.			

	- 9/2/25 at 6:28 p.m. - 9/6/25 at 10:01 a.m. - 9/7/25 at 4:25 p.m. - 9/9/25 at 8:27 a.m. - 9/11/25 at 4:58 p.m. - 9/12/25 at 5:12 p.m. - 9/15/25 at 5:23 p.m. - 9/16/25 at 5:23 p.m. - 9/17/25 at 5:20 p.m. - 9/25/25 at 7:48 p.m. - 9/26/25 at 5:25 p.m. - 9/29/25 at 6:30 p.m. - 9/30/25 at 7:29 p.m. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated the QMAs should have obtained prior authorization from the nurse before giving the Tylenol and Tramadol.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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	R 0349	Silver Birch of Hammond Please accept the following as the facility's credible allegation of compliance. This plan of correction does not	10/24/2025

must be as follows:

(1) Complete.

(2) Accurately documented.

(3) Readily accessible.

(4) Systematically organized.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication administration, incomplete oxygen orders, and lack of post fall assessments for 3 of 7 residents reviewed. (Residents 2, 5, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

constitute an admission of guilt or liability by
the facility and is submitted only in response to the regulatory requirement.

R 349

**What
corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**

R#2, R#5, R#4
immediately assessed for adverse reaction, none noted. R#5 oxygen flow rate clarification
obtained by MD on 10/3/25 oxygen flow rate updated on POS. Resident#4 Post fall assessments updated. R#2 Medication availability verified. No other residents
were affected by the deficient practice.

**How the
facility will identify other residents having the potential to be affected by
the same deficient practice and what corrective action**

	A Physician's Order, dated 6/6/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Zolpidem (a hypnotic medication) 10 milligrams (mg) at bedtime, the medication required prior authorization. The September 2025 Medication Administration Record (MAR) indicated QMA 1 had documented the Zolpidem administration as "11" which indicated the medication was unavailable on the following dates: 9/1/25, 9/2/25, 9/3/25, 9/6/25, 9/7/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25, 9/20/25, 9/21/25, 9/24/25, 9/25/25, 9/26/25, 9/29/25 and 9/30/25. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated that she did not know why the QMA coded the medication as being unavailable when other staff documented the medication as being given. All the QMA had to do was ask the nurse for authorization. 2. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD). A Physician's Order, dated		**will be taken;** *All residents residing in* the community are at risk for this alleged deficient practice. To identify other residents having the potential to be affected by the same deficient practice, DONW audited clinical records related to available medication not administered / missed, post falls documentation, oxygen flow rates noted on POS to ensure documentation is noted in clinical records appropriately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; On 10/3-10/9/25 Nursing staff were immediately re-educated by the DONW related to administering medication when available, oxygen flow rate documented on POS as ordered by MD and post fall assessment documentation. The Director of Nursing and Wellness or designee will review 24HR Report for new oxygen orders to ensure flow rate is noted, review Medication Administration audit report related to missed medication	

	3/30/25 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to use oxygen by the way of a nasal cannula every day and evening shift for COPD. There was no documentation indicating what the flow rate was to be. During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated a clarification order needed to be obtained. 3. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD). An Admission Assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs). A Progress Note, dated 9/20/25 at 4:04 p.m., indicated the resident fell in her bathroom. The record lacked any post-fall assessment between 9/21/25 at 4:04 p.m. and 9/22/25 at 11:15 p.m. During an interview on 10/2/25 at 11:05 a.m., the Director of		and review incident report to ensure follow up documentation is noted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Director of Nursing and Wellness or Designee will monitor 24HR Report for new oxygen orders to ensure flow rate is noted, review Medication Administration audit report related to missed medication and review incident report to ensure follow up documentation is noted weekly for 3 months. Any issues will be addressed immediately. The audits will be discussed during our monthly QI meeting for trends, patterns and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.	

Nursing (DON) indicated the nurse should have documented a post-fall assessment once on day shift and once on evening shift for three days after a resident fell.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication administration, incomplete oxygen orders, and lack of post fall assessments for 3 of 7 residents reviewed. (Residents 2, 5, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

A Physician's Order, dated 6/6/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Zolpidem (a hypnotic medication) 10 milligrams (mg) at bedtime, the medication required prior authorization.

The September 2025 Medication Administration

Date by which systemic corrections will be completed: 10/24/25

Record (MAR) indicated QMA 1 had documented the Zolpidem administration as "11" which indicated the medication was unavailable on the following dates: 9/1/25, 9/2/25, 9/3/25, 9/6/25, 9/7/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25, 9/20/25, 9/21/25, 9/24/25, 9/25/25, 9/26/25, 9/29/25 and 9/30/25.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated that she did not know why the QMA coded the medication as being unavailable when other staff documented the medication as being given. All the QMA had to do was ask the nurse for authorization.

2. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD).

A Physician's Order, dated 3/30/25 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to use oxygen by the way of a nasal cannula every day and evening shift for COPD. There was no documentation indicating what the flow rate was to be.

During an interview on 10/2/25

at 1:15 p.m., the Director of Nursing indicated a clarification order needed to be obtained.

3. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD).

An Admission Assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).

A Progress Note, dated 9/20/25 at 4:04 p.m., indicated the resident fell in her bathroom.

The record lacked any post-fall assessment between 9/21/25 at 4:04 p.m. and 9/22/25 at 11:15 p.m.

During an interview on 10/2/25 at 11:05 a.m., the Director of Nursing (DON) indicated the nurse should have documented a post-fall assessment once on day shift and once on evening shift for three days after a resident fell.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to

medication administration, incomplete oxygen orders, and lack of post fall assessments for 3 of 7 residents reviewed. (Residents 2, 5, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

A Physician's Order, dated 6/6/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Zolpidem (a hypnotic medication) 10 milligrams (mg) at bedtime, the medication required prior authorization.

The September 2025 Medication Administration Record (MAR) indicated QMA 1 had documented the Zolpidem administration as "11" which indicated the medication was unavailable on the following dates: 9/1/25, 9/2/25, 9/3/25, 9/6/25, 9/7/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25, 9/20/25, 9/21/25, 9/24/25, 9/25/25, 9/26/25, 9/29/25 and 9/30/25.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated that she did not know why the QMA coded the medication as being unavailable when other staff documented the medication as being given. All the QMA had to do was ask the nurse for authorization.

2. The record for Resident 5 was reviewed on 10/1/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD).

A Physician's Order, dated 3/30/25 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to use oxygen by the way of a nasal cannula every day and evening shift for COPD. There was no documentation indicating what the flow rate was to be.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated a clarification order needed to be obtained.

3. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD).

An Admission Assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).

A Progress Note, dated 9/20/25 at 4:04 p.m., indicated the resident fell in her bathroom.

The record lacked any post-fall assessment between 9/21/25 at 4:04 p.m. and 9/22/25 at 11:15 p.m.

During an interview on 10/2/25 at 11:05 a.m., the Director of Nursing (DON) indicated the nurse should have documented a post-fall assessment once on day shift and once on evening shift for three days after a resident fell.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication administration, incomplete oxygen orders, and lack of post fall assessments for 3 of 7 residents reviewed. (Residents 2, 5, and 4)

Findings include:

1. The record for Resident 2 was reviewed on 10/1/25 at 1:00 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of

the skin, asthma, anxiety, depression, diabetes, and pain.

A Semi-Annual Assessment, dated 4/2025, indicated the resident was cognitively intact.

A Physician's Order, dated 6/6/24 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Zolpidem (a hypnotic medication) 10 milligrams (mg) at bedtime, the medication required prior authorization.

The September 2025 Medication Administration Record (MAR) indicated QMA 1 had documented the Zolpidem administration as "11" which indicated the medication was unavailable on the following dates: 9/1/25, 9/2/25, 9/3/25, 9/6/25, 9/7/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25, 9/20/25, 9/21/25, 9/24/25, 9/25/25, 9/26/25, 9/29/25 and 9/30/25.

During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated that she did not know why the QMA coded the medication as being unavailable when other staff documented the medication as being given. All the QMA had to do was ask the nurse for authorization.

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2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic obstructive pulmonary disease (COPD).

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During an interview on 10/2/25 at 1:15 p.m., the Director of Nursing indicated a clarification order needed to be obtained.

3. The record for Resident 4 was reviewed on 10/1/25 at 10:43 a.m. Diagnoses included, but were not limited to, ataxia (impaired coordination and balance) due to a stroke, and chronic obstructive pulmonary disease (COPD).

An Admission Assessment, dated 9/8/25, indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living (ADLs).

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	assessment between 9/21/25 at 4:04 p.m. and 9/22/25 at 11:15 p.m. During an interview on 10/2/25 at 11:05 a.m., the Director of Nursing (DON) indicated the nurse should have documented a post-fall assessment once on day shift and once on evening shift for three days after a resident fell.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURENeysa Holman-Stewart	TITLEExecutive Director	(X6) DATE10/15/2025