STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/02/2026

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 the Investigation of Intake 465744. Intake 465744 - State deficiencies related to the allegations are cited at R0243. Survey date: February 2, 2026 Facility number: 013801 Residential Census: 112 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/6/26.	R 0000		
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:	R 0243	Affected residents: Residents B, C & D had no negative outcome from narcotics not being signed out on the MAR Potential be affected:	02/24/2026

	(A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure narcotic medications were signed out as being administered for 3 of 3 records reviewed. (Residents B, C, and D) Findings include: 1. The record for Resident B was reviewed on 2/2/26 at 1:05 p.m. Diagnoses included, but were not limited to, heart disease, acute pain, major depressive disorder, high blood pressure, and dementia. The current Service Plan, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 12/3/25, indicated Tylenol with codeine #3, take one tablet daily prn (as needed). The Medication Administration Record (MAR), for the month of 12/2025 indicated the Tylenol with codeine was not signed out		An audit has been completed for all residents with PRN narcotics to ensure PRN narcotics were signed off on the residents MAR. Systemic Change: Licensed Nurses and QMA's have been reeducated on facility Policy & Procedure related to the signing out of narcotics on the residents MAR and documentation related to the need to give a PRN narcotic medication as well as follow up of the effectiveness of the PRN narcotic. Monitoring: A Performance Improvement Tool has been developed that will monitor compliance with PRN narcotic documentation on the MAR and in the resident progress notes. The PI tool will be completed Monday through Friday by the DONW/Designee for 3 weeks, then weekly for 3 weeks, then monthly for 3 months with the results being forwarded to the QAPI committee for any further recoommendations and/or resolution.	

as being administered.

The Individual Resident Control Medication Record Sheet indicated the Tylenol with codeine was signed out as being administered on 12/5/25 at 6:00 p.m. and on 12/8/25 at 6:00 p.m.

The MAR for the month of 1/2026 indicated the Tylenol with codeine was administered on 1/28/26 at 8:29 p.m.

The Individual Resident Control Medication Record Sheet indicated the Tylenol with codeine was signed out as being administered on 1/9/26 at 6:00 p.m., 1/13/2 at 6:30 p.m., 1/15/26 at 6:00 p.m., and 1/18/26 at 10:00 p.m.

There was no documentation in nursing progress notes of why the medication was administered, nor was the medication signed out as being administered on the corresponding MARs.

During an interview on 2/2/26 at 4:30 p.m., the Director of Nursing indicated the medication should be signed out as being administered on the MAR. The facility had not policy for review.

2. During an interview on 2/2/26 at 11:07 a.m., Resident C indicated she had no issues

receiving pan medications, "the nurse just gives them to me."

The record for Resident C was reviewed on 2/2/26 at 1:35 p.m. Diagnoses included, but were not limited to, acute and chronic pain, and major depressive disorder.

A Physician's Order, dated 12/8/25, indicated Hydrocodone (an opioid medication) 7.5-325 milligrams (mg), give one tablet twice a day prn (as needed) for pain.

The Medication Administration Record (MAR) for the month of 12/2025 indicated the Norco was signed out as being administered six times.

The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered two times a day at 8:00 a.m. and 6:00 p.m. on 12/8-12/17/25 and 12/20-12/30/25.

The MAR for the month of 1/2026 indicated the prn Norco was signed out as being administered seven times to the resident.

The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered at 8:00 a.m. and 6:00 p.m. on 1/5-1/10/26. The Director of

Nursing (DON) was not able to find the other narcotic control record.

There was no documentation in nursing progress notes of why the medication was administered, nor was the medication signed out as being administered on the corresponding MARs.

During an interview on 2/2/26 at 3:45 p.m., the DON indicated she was unsure if the resident was asking for the pain medication or not, but there was no documentation in nursing progress notes of all the prn pain medications administered nor were they documented on the MARs.

During an interview on 2/2/26 at 4:37 p.m. with LPN 1, who was working as the floor nurse for the resident, indicated she administered the Norco to the resident every night regardless of if she asked for it or not. She did not wait for the resident to ask her if they need a pain pill and was aware the medication was ordered prn. She indicated "If I do not give it to her, she will become very aggressive and hostile." She had not informed the DON or the physician of the resident's behavior.. She indicated she was aware the medication needed to be signed out on the MAR as well as on the narcotic record. LPN 1

indicated she had administered a Norco to the resident during the evening pass today and she did not ask for it.

During an interview on 2/2/26 at 4:45 p.m., the DON indicated nursing staff were to sign the narcotic medications out on the MAR. She was not aware LPN 1 was just administering the medication on a scheduled basis rather than as needed, nor was she aware the resident had this sort of behavior.

3. During an interview on 2/2/26 at 11:13 a.m., Resident D indicated sometimes she had to ask for pain medications and sometimes "they will just give it to me."

The record for Resident D was reviewed on 2/2/26 at 1:50 p.m. Diagnoses included, but were not limited to, high blood pressure, stroke, anxiety, pain in the left knee, major depressive disorder, low back pain, and osteoarthritis.

A Physician's Order, dated 10/8/25, indicated Hydrocodone 5-325 milligrams (mg), give one tablet twice a day prn (as needed).

The Medication Administration Record (MAR) for the month of 10/2025 indicated the prn Norco was signed out two times.

	The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered 16 times at 6:00 p.m. in October 2025. The 11/2025 MAR indicated the prn Norco was signed out as being administered three times on 11/4, 11/17, and 11/21/25. The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered 47 times in November 2025 at 7:00 a.m., 8:00 a.m., and 6:00 p.m. The 12/2025 MAR indicated the prn Norco was signed as being administered three times to the resident on 12/1, 12/4, and 12/10/25. The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered 56 times at 6:00 a.m., 8:00 a.m., 4:00 p.m., and 6:00 p.m. The 1/2026 MAR, indicated the prn Norco was signed out as being administered to the resident three times on 1/7, 1/15, and 1/27/26. The Individual Resident Control Medication Record Sheet indicated the Norco was signed out as being administered 41 times through 1/23/26 at 7:00			

a.m., 8:00 a.m., 4:00 p.m., and 6:00 p.m. The Director of Nursing (DON) was not able to find the other narcotic control records for the rest of 1/2026 and 2/2026.

There was no documentation in the nursing notes of all the prn Norco administered to the resident, nor was there documentation of all the times the medication was given and signed on the corresponding MARs.

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This citation relates to Intake 465744.

Based on record review and interview, the facility failed to ensure narcotic medications were signed out as being administered for 3 of 3 records reviewed. (Residents B, C, and D)

Findings include:

1. The record for Resident B was reviewed on 2/2/26 at 1:05 p.m. Diagnoses included, but were not limited to, heart disease, acute pain, major depressive disorder, high blood pressure, and dementia.

The current Service Plan, indicated the resident was cognitively intact for daily decision making.

A Physician's Order, dated

12/3/25, indicated Tylenol with codeine #3, take one tablet daily prn (as needed).

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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 SIGNATURETeri Fallon	TITLERegional Director of Clinical Services	(X6) DATE02/24/2026