

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2022
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF MUNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 W KILGORE AVENUE, MUNCIE, , 47304			
(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: November 17 & 18, 2022 Facility number: 014034 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 22, 2022.	R 0000			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to	R 0144	Survey Event ID JQ1D11	01/02/2023	

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ensure a clean, safe environment on 2 of 3 floors during general observation walk-through. (Floors 2 and 3) Findings include: During a tour of the facility, on 11/17/22 at 10:21 a.m., the heating and air wall unit at the end of the hallway, outside of rooms 221 and 222, and 248 and 249, were observed to have black debris on and around the vent grates. On 11/17/22 at 10:26 a.m., the heating and air wall unit at the end of the hallway outside rooms 348 and 349, and 321 and 322, were observed to have black debris on and around the vent grates. The hallway carpet had multiple areas with debris and large stains. During a facility tour, on 11/18/22 at 11:45 a.m., the Administrator indicated the heating and air vent grates needed to be cleaned and the black, dust-like debris removed. The hallway on the 3rd floor had noticeable debris and stains on the carpet. She indicated she would ask that it be vacuumed and inquire about the reason it had not been completed. Based on observation and interview, the facility failed to ensure a clean, safe environment on 2 of 3 floors during general observation	Alleged deficiency - 4A10 IAC 16.2-5-1.5(a) Sanitation and Safety Standards – R144 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Floor 2: hallway carpets were professionally cleaned on (December 2, 2022) Vent grates were cleaned by community ES staff on (November 19, 2022) Floor 3: hallway carpets were professionally cleaned on (November 29, 2022) Vent grates were cleaned by community ES staff on (November 19, 2022)	
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walk-through. (Floors 2 and 3)

Findings include:

During a tour of the facility, on 11/17/22 at 10:21 a.m., the heating and air wall unit at the end of the hallway, outside of rooms 221 and 222, and 248 and 249, were observed to have black debris on and around the vent grates.

On 11/17/22 at 10:26 a.m., the heating and air wall unit at the end of the hallway outside rooms 348 and 349, and 321 and 322, were observed to have black debris on and around the vent grates. The hallway carpet had multiple areas with debris and large stains.

During a facility tour, on 11/18/22 at 11:45 a.m., the Administrator indicated the heating and air vent grates needed to be cleaned and the black, dust-like debris removed. The hallway on the 3rd floor had noticeable debris and stains on the carpet. She indicated she would ask that it be vacuumed and inquire about the reason it had not been completed.

**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 have the potential to be affected by the alleged deficient practice.

All housekeeping and maintenance personnel were re-educated by the Executive Director (ED) on scheduled maintenance and the need to follow the maintenance schedule in common areas, including reacting with corrective measures to clean up spills on carpets, and vacuuming carpets routinely and as needed.

**What
measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**

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The Executive Director (ED) or designee will ensure cleaning and maintenance schedules are in place and department staff follow the schedules. The ED or designee will audit the common areas and hallways, including the vent grates and carpets 2 times weekly for 2 months, and ongoing if needed. Any findings will be corrected at the time of discovery and recorded on an audit tool.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

The Executive Director or designee will report audit findings to the Quality Assurance Committee monthly until 100% compliance has been met for three (3) consecutive months, then ongoing quarterly until the Quality Assurance Committee determines there is a resolution to the alleged issue.

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			By what date the systemic changes will be completed? January 2, 2022	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to assure an employee was properly trained to administer insulin and to follow physician orders regarding insulin dosage for 1 of 1 residents observed for insulin administration. (Resident 88) Findings include: On 11/17/22 at 10:28 a.m., a medication observation was completed with QMA 2. Upon entering Resident 88's room, the resident informed QMA 2 she had not received her insulin at bedtime the night before (11/16/22). QMA 2 indicated she would look into it and let the Director of Nursing (DON) know. 1. A review of Resident 88's Electronic Medication Administration Record (eMAR) was completed on 11/17/22 at 2:00 p.m. Diagnoses included,	R 0240	Survey Event ID JQ1D11 Alleged deficiency 410 IAC 16.2-5-4(d) Health Services - R240 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 88: Director of Nursing & Wellness (DONW) or designee notified resident's physician of alleged deficiencies with insulin administration and continues to monitor compliance with medications, including insulin, per physician's orders. How the facility will identify other residents having the potential to be affected by the	01/02/2023

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but were not limited to, diabetes mellitus, heart failure, and chronic kidney disease stage III.

Current physician's orders and the eMAR record included the following:

A current physician's order, dated 11/5/22, for Humalog (insulin) Kwik Pen, to inject 4 units two times a day at 8:00 a.m. and 12:00 p.m.

On 11/15/22, the eMAR indicated the insulin was not administered and no blood sugar result was obtained due to the resident being asleep.

A current physician's order, dated 11/4/22, for Humalog Kwik Pen, to inject 10 units daily at 4:00 p.m.

On 11/5/22, 11/6/22, 11/7/22, 11/9/22, 11/10/22, and 11/15/22, the record indicated the insulin was not administered by the QMA due to the blood sugar being outside of parameters for administration. The order lacked parameters and the clinical record lacked notification of the licensed nurse on duty/call or the physician regarding hold parameters and lack of administration.

same deficient practice and what corrective action will be taken:

Current residents residing at Silver Birch of Muncie who receive insulin have the potential to be affected by the alleged deficient practice.

The Director of Nursing & Wellness or designee has re-educated nurses and QMAs on the rights of medication administration, and the insulin administration policy and procedure.

What measures will be put in place, or what systemic changes the facility will make to ensure that the deficient practice does not recur:

The Director of Nursing & Wellness or designee will watch a QMA administer insulin 5

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On 11/8/22, 11/11/22, and 11/12/22, the record indicated the insulin was not administered by the QMA due to the resident being asleep.

A current physician's order, dated 9/20/22, for Humalog Kwik Pen, to inject as per sliding scale: If blood sugar was between 200 and 250, administer 2 units; if between 250-300, administer 3 units, and if between 301 and 500, administer 4 units, three times daily at 8:00 a.m., 12:00 p.m., and 4:00 p.m.

On 11/8/22 and 11/15/22, the record indicated the insulin was not administered and no blood sugar result was obtained by the QMA due to the resident being asleep.

A current physician's order, dated 11/4/22, for Lantus (long acting insulin to treat diabetes) SoloStar Pen, to inject 22 units at bedtime.

On 11/16/22, the eMAR indicated the insulin was not administered and no blood sugar result was obtained by the QMA due to the blood sugar being outside of parameters. The order parameters and the clinical record lacked notification of the licensed nurse on duty/call, or the physician regarding lack of administration.

During an interview, on 11/18/22

days a week for 4 weeks and then weekly for 4 weeks. Any variance in policy in medication administration will be addressed at the time of discovery and any remediation given to a QMA will be documented by the Director of Nursing & Wellness or designee and placed in the QMA's personnel record.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Director of Nursing & Wellness will report findings of the QMA administration observations to the Quality Assurance Committee monthly until 100% compliance has been met for three (3) consecutive months, then ongoing quarterly until the Quality Assurance Committee determines resolution.

By what date the systemic changes will be completed?
January 2,

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at 11:45 a.m., the Director of Nursing (DON) indicated the physician's orders regarding insulin administration should be followed and if a staff member was unsure about administration, they should contact the licensed nurse on duty or on call. The medication should not be held due to a resident sleeping.

2. During the medication administration observation, QMA 2 unlocked the resident's medication cabinet and obtained the resident's blood sugar. She applied a new needle to the Humalog Kwik Pen and dialed a dose of seven units. She prepared to administer the insulin. During an interview, at the time of the administration observation, QMA 2 indicated she had forgotten to prime the new insulin needle by dialing a 2 unit dose and checking for a drop at the end of the needle to assure a full ordered dose was administered.

QMA 2 primed the insulin needle and dialed a dose of seven units to administer. She inserted the needle into the resident's abdomen and pushed the plunger to administer the insulin, holding the pen in place for 2 seconds. Upon pulling the needle away from the resident's abdomen, several drops of liquid were observed running

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down her abdomen. QMA 2 wiped the drops with the used alcohol pad.

During an interview following observation, QMA 2 indicated she was aware of the drops of medication that were observed following the insulin administration. She indicated she should hold the pen in place for 5-10 seconds following injection, but realized she had withdrawn the pen in less than 5 seconds.

A current facility policy, dated 3/2/2020, titled, "Insulin Administration Program and Policy," included in the entrance documentation provided by the DON on 11/17/22 at 10:30 a.m., included the following:

"PROCEDURE:...6. Instructions for using prefilled pens are as follows:...To avoid air and to ensure proper dose, you will need to prime the syringe each time...After injecting, the needle should remain in the skin for at least 6 seconds...."

Based on observation, interview, and record review, the facility failed to assure an employee was properly trained to administer insulin and to follow physician orders regarding insulin dosage for 1 of 1 residents observed for insulin administration. (Resident 88)

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Findings include:

On 11/17/22 at 10:28 a.m., a medication observation was completed with QMA 2. Upon entering Resident 88's room, the resident informed QMA 2 she had not received her insulin at bedtime the night before (11/16/22). QMA 2 indicated she would look into it and let the Director of Nursing (DON) know.

1. A review of Resident 88's Electronic Medication Administration Record (eMAR) was completed on 11/17/22 at 2:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, heart failure, and chronic kidney disease stage III.

Current physician's orders and the eMAR record included the following:

A current physician's order, dated 11/5/22, for Humalog (insulin) Kwik Pen, to inject 4 units two times a day at 8:00 a.m. and 12:00 p.m.

On 11/15/22, the eMAR indicated the insulin was not administered and no blood sugar result was obtained due to the resident being asleep.

A current physician's order, dated 11/4/22, for Humalog Kwik Pen, to inject 10 units daily at 4:00 p.m.

On 11/5/22, 11/6/22, 11/7/22,

11/9/22, 11/10/22, and 11/15/22, the record indicated the insulin was not administered by the QMA due to the blood sugar being outside of parameters for administration. The order lacked parameters and the clinical record lacked notification of the licensed nurse on duty/call or the physician regarding hold parameters and lack of administration.

On 11/8/22, 11/11/22, and 11/12/22, the record indicated the insulin was not administered by the QMA due to the resident being asleep.

A current physician's order, dated 9/20/22, for Humalog Kwik Pen, to inject as per sliding scale: If blood sugar was between 200 and 250, administer 2 units; if between 250-300, administer 3 units, and if between 301 and 500, administer 4 units, three times daily at 8:00 a.m., 12:00 p.m., and 4:00 p.m.

On 11/8/22 and 11/15/22, the record indicated the insulin was not administered and no blood sugar result was obtained by the QMA due to the resident being asleep.

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On 11/16/22, the eMAR indicated the insulin was not administered and no blood sugar result was obtained by the QMA due to the blood sugar being outside of parameters. The order parameters and the clinical record lacked notification of the licensed nurse on duty/call, or the physician regarding lack of administration.

During an interview, on 11/18/22 at 11:45 a.m., the Director of Nursing (DON) indicated the physician's orders regarding insulin administration should be followed and if a staff member was unsure about administration, they should contact the licensed nurse on duty or on call. The medication should not be held due to a resident sleeping.

2. During the medication administration observation, QMA 2 unlocked the resident's medication cabinet and obtained the resident's blood sugar. She applied a new needle to the Humalog Kwik Pen and dialed a dose of seven units. She prepared to administer the insulin. During an interview, at the time of the administration observation, QMA 2 indicated she had forgotten to prime the new insulin needle by dialing a 2 unit dose and checking for a drop at the end of the needle to assure a full ordered dose was

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administered.

QMA 2 primed the insulin needle and dialed a dose of seven units to administer. She inserted the needle into the resident's abdomen and pushed the plunger to administer the insulin, holding the pen in place for 2 seconds. Upon pulling the needle away from the resident's abdomen, several drops of liquid were observed running down her abdomen. QMA 2 wiped the drops with the used alcohol pad.

During an interview following observation, QMA 2 indicated she was aware of the drops of medication that were observed following the insulin administration. She indicated she should hold the pen in place for 5-10 seconds following injection, but realized she had withdrawn the pen in less than 5 seconds.

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"PROCEDURE:...6. Instructions for using prefilled pens are as follows:...To avoid air and to ensure proper dose, you will need to prime the syringe each time...After injecting, the needle

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	should remain in the skin for at least 6 seconds...."			
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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 SIGNATURE	TITLE	(X6) DATE
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