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 MICHIGAN CITY	4400 EAST MICHIGAN BLVD, MICHIGAN CITY, , 46360

(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. This visit included the Investigation of Intake IN00463770. Intake IN00463770 - No deficiencies related to the allegations are cited. Survey dates: October 1 and 2, 2025 Facility number: 014052 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/6/25.	R 0000		
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	R 0216	**Prefix Tag # R216**	11/06/2025

	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 record review and interview, the facility failed to ensure semi-annual weights and semi-annual evaluations were completed for 2 of 8 residents reviewed. (Residents 4 and 8) Findings include: 1. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus. The resident's weight on 8/22/24 was 297.4 pounds (lbs). On 6/12/25, the resident weighed 269.8 lbs. On 8/21/25, the resident weighed 284.0 lbs.		**410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 – weight was obtained on 10.04.2025 Resident #8 – expired on 7.22.2025 2 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: An audit has been completed to ensure all weights are current and documented in the residents medical Record.	

	There were no weights recorded between 8/22/24 and 6/12/25. During an interview on 10/1/25 at 3:32 p.m., the Director of Nursing indicated the resident was not weighed between 8/22/24 and 6/12/25. 2. Resident 8's record was reviewed on 10/2/25 at 10:15 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and heart failure. The resident admitted to the facility on 6/7/22. The Level of Service Assessment/Evaluation was completed on 6/3/24 and 12/3/24. There were no documented semi-annual evaluations completed since 12/3/24. During an interview on 10/2/25 at 2:15 p.m., the Director of Nursing indicated there were no other semi-annual evaluations completed for the resident. Based on record review and interview, the facility failed to ensure semi-annual weights and semi-annual evaluations were completed for 2 of 8 residents reviewed. (Residents 4 and 8) Findings include: 1. Resident 4's record was reviewed on 10/1/25 at 11:31		An audit has been completed to ensure all service plans are accurate and up to date. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur. The clinical staff will be in-serviced by a DONW or designee by: 11/6/2025 Regulation R216 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation Silver Birch Policies: Weight Monitoring Policy Service Plans 4 How the corrective action(s) will be	

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			By what date the systemic changes will be completed: 11.6.2025	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident	R 0217	**Prefix Tag # R217** **41 IAC** **16.2-5-2(e)(1-5) Evaluation** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 – The service plan has updated and is accurate. Resident #3 – The service plan has updated and is accurate. Resident #5 – The service plan has updated and is accurate. 2	11/06/2025

	upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 2. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus. A therapy report provided by the facility indicated the resident had received PT and OT services since July 2025. A Service Plan, updated and signed by the resident on 3/5/25, did not include any Physical (PT) or Occupational Therapy (OT) Services. On 10/2/25 at 9:30 a.m., Resident 3 was observed sitting in a recliner in her apartment. She was completing therapy services with an outside provider therapy member. During an interview on 10/2/25 at 9:48 a.m., the DON indicated		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: An audit has been completed and Service Plans updated to reflect any outside services needed 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur. The clinical staff will be in-serviced by a DONW or designee by: 11/6/2025 410C Regulation C 16.2-5-2(e)(1-5) Evaluation Silver Birch Policies: Service Plans	

	the resident was currently on therapy services and the Service Plan was not updated to include the therapy services. 3. Resident 5's record was reviewed on 10/2/25 at 9:08 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, depression, and anxiety disorder. Per a list provided by the Director of Nursing on 10/1/25, Resident 5 self-administered medications, received injections, and received oxygen. The Service Plan, signed on 3/6/25, indicated the resident was independent for dressing and eating and used a rollator or walker for safe transfers and used a powerchair for long distances. The Level of Service Assessment/Evaluation, dated 9/9/25, indicated the resident was cognitively intact. The Medication Self-Administration Safety Screen, dated 9/12/25 at 2:43 p.m., indicated the resident was able to self-administer medications unsupervised.		4 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 DONW, Executive Director or designee will audit ten (10) current resident semi-annual evaluations for accuracy for a period of twelve (12) weeks. The DONW, Executive Director or designee will randomly audit ten resident semi-annual evaluations per month for a period of six (6) months. 5 By what date the systemic changes will be completed: 11.6.2025	

	The October 2025 Physician's Order Summary (POS) indicated Humalog (insulin) 100 unit/milliliter 10 units twice daily. There were no physician's orders in the record for oxygen therapy. A Progress Note, dated 7/3/25 at 6:28 a.m., indicated a note was received from therapy that the resident had been evaluated for physical therapy. A Progress Note, dated 9/18/25 at 7:33 a.m., indicated a note was received from behavioral health (psychiatric services) for services on 9/8/25. Behavioral services were to continue. The Service Plan was not updated to reflect the use of oxygen, self-administration of medications, insulin injections, psychiatric services, or physical therapy services. During an interview on 10/2/25 at 10:02 a.m., the Director of Nursing indicated the resident was on continuous oxygen therapy which should have been in the POS and also on the service plan. The service plan needed to be updated. A facility policy titled, "Service Plans," and noted as current, indicated, "...A. The Director of Nursing and Wellness [DONW] or designee will complete the initial Level of Service			

	Assessment/Evaluation within 24 hours of admission. B. The DONW or designee will complete the Service Plan within seven days of completion of Level of Service Assessment/Evaluation based on services triggered by the assessment. C. The DONW or designee will review the Service Plan biannually and upon significant change in condition. D. Service plan shall include coordination and inclusion of services being delivered to a resident by an outside entity...F. DONW or designee will meet with residents and review their service plans at least annually and if changes are warranted. If both parties agree on the service plan it is to be signed and dated by the resident and DONW or designee..." Based on observation, record review and interview, the facility failed to ensure Service Plans were updated and accurate related to psychiatric services, physical and occupational therapy, oxygen, injections and self medication administration for 3 of 8 resident records reviewed. (Residents 2, 3 and 5) Findings include: 1. On 10/1/25 at 2:30 p.m., Resident 2 was observed walking in the hall with a Physical Therapist.			

Resident 2's record was reviewed on 10/1/25 at 10:30 a.m. Diagnoses included, but were not limited to, angina pectoris, diabetes mellitus and bipolar disorder.

An initial psychiatric Diagnostic Evaluation was completed on 2/10/25. A Behavioral Health Note, dated 8/18/25, indicated the resident had been seen related to depression and Behavioral Health services were to continue.

A Home Health Plan of Care, dated 8/18/25, indicated the resident would begin receiving physical therapy once a week for eight weeks for fall prevention, pain, balance and gait training.

A Service Plan, dated 1/29/25, did not include updates for psychiatric services or physical therapy.

During an interview on 10/2/25 at 11:21 a.m., the Director of Nursing (DON) indicated she was aware the service plans were not updated and they were being corrected.

2. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

	A therapy report provided by the facility indicated the resident had received PT and OT services since July 2025. A Service Plan, updated and signed by the resident on 3/5/25, did not include any Physical (PT) or Occupational Therapy (OT) Services. On 10/2/25 at 9:30 a.m., Resident 3 was observed sitting in a recliner in her apartment. She was completing therapy services with an outside provider therapy member. During an interview on 10/2/25 at 9:48 a.m., the DON indicated the resident was currently on therapy services and the Service Plan was not updated to include the therapy services. 3. Resident 5's record was reviewed on 10/2/25 at 9:08 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, depression, and anxiety disorder. Per a list provided by the Director of Nursing on 10/1/25, Resident 5 self-administered medications, received injections, and received oxygen. The Service Plan, signed on 3/6/25, indicated the resident was independent for dressing and eating and used a rollator			

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Based on observation, record review and interview, the facility failed to ensure Service Plans were updated and accurate related to psychiatric services, physical and occupational therapy, oxygen, injections and self medication administration for 3 of 8 resident records reviewed. (Residents 2, 3 and 5)

Findings include:

1. On 10/1/25 at 2:30 p.m., Resident 2 was observed walking in the hall with a Physical Therapist.

Resident 2's record was reviewed on 10/1/25 at 10:30 a.m. Diagnoses included, but were not limited to, angina pectoris, diabetes mellitus and bipolar disorder.

An initial psychiatric Diagnostic Evaluation was completed on 2/10/25. A Behavioral Health Note, dated 8/18/25, indicated the resident had been seen related to depression and Behavioral Health services were to continue.

A Home Health Plan of Care, dated 8/18/25, indicated the resident would begin receiving physical therapy once a week for eight weeks for fall prevention, pain, balance and

gait training.

A Service Plan, dated 1/29/25, did not include updates for psychiatric services or physical therapy.

During an interview on 10/2/25 at 11:21 a.m., the Director of Nursing (DON) indicated she was aware the service plans were not updated and they were being corrected.

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A therapy report provided by the facility indicated the resident had received PT and OT services since July 2025.

A Service Plan, updated and signed by the resident on 3/5/25, did not include any Physical (PT) or Occupational Therapy (OT) Services.

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A Service Plan, dated 1/29/25, did not include updates for psychiatric services or physical therapy.

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Per a list provided by the Director of Nursing on 10/1/25, Resident 5 self-administered medications, received injections, and received oxygen.

The Service Plan, signed on 3/6/25, indicated the resident was independent for dressing and eating and used a rollator or walker for safe transfers and used a powerchair for long distances.

The Level of Service Assessment/Evaluation, dated 9/9/25, indicated the resident was cognitively intact.

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The Medication Self-Administration Safety Screen, dated 9/12/25 at 2:43 p.m., indicated the resident was

	able to self-administer medications unsupervised. The October 2025 Physician's Order Summary (POS) indicated Humalog (insulin) 100 unit/milliliter 10 units twice daily. There were no physician's orders in the record for oxygen therapy. A Progress Note, dated 7/3/25 at 6:28 a.m., indicated a note was received from therapy that the resident had been evaluated for physical therapy. A Progress Note, dated 9/18/25 at 7:33 a.m., indicated a note was received from behavioral health (psychiatric services) for services on 9/8/25. Behavioral services were to continue. The Service Plan was not updated to reflect the use of oxygen, self-administration of medications, insulin injections, psychiatric services, or physical therapy services. During an interview on 10/2/25 at 10:02 a.m., the Director of Nursing indicated the resident was on continuous oxygen therapy which should have been in the POS and also on the service plan. The service plan needed to be updated. A facility policy titled, "Service Plans," and noted as current, indicated, "...A. The Director of			

	Nursing and Wellness [DONW] or designee will complete the initial Level of Service Assessment/Evaluation within 24 hours of admission. B. The DONW or designee will complete the Service Plan within seven days of completion of Level of Service Assessment/Evaluation based on services triggered by the assessment. C. The DONW or designee will review the Service Plan biannually and upon significant change in condition. D. Service plan shall include coordination and inclusion of services being delivered to a resident by an outside entity...F. DONW or designee will meet with residents and review their service plans at least annually and if changes are warranted. If both parties agree on the service plan it is to be signed and dated by the resident and DONW or designee..." Based on observation, record review and interview, the facility failed to ensure Service Plans were updated and accurate related to psychiatric services, physical and occupational therapy, oxygen, injections and self medication administration for 3 of 8 resident records reviewed. (Residents 2, 3 and 5) Findings include: 1. On 10/1/25 at 2:30 p.m., Resident 2 was observed			

	walking in the hall with a Physical Therapist. Resident 2's record was reviewed on 10/1/25 at 10:30 a.m. Diagnoses included, but were not limited to, angina pectoris, diabetes mellitus and bipolar disorder. An initial psychiatric Diagnostic Evaluation was completed on 2/10/25. A Behavioral Health Note, dated 8/18/25, indicated the resident had been seen related to depression and Behavioral Health services were to continue. A Home Health Plan of Care, dated 8/18/25, indicated the resident would begin receiving physical therapy once a week for eight weeks for fall prevention, pain, balance and gait training. A Service Plan, dated 1/29/25, did not include updates for psychiatric services or physical therapy. During an interview on 10/2/25 at 11:21 a.m., the Director of Nursing (DON) indicated she was aware the service plans were not updated and they were being corrected.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1)	R 0241	**Prefix Tag # R241**	11/06/2025

	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. 2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside. The Service Plan, signed on 9/5/25, indicated the resident's medications were to be administered by staff. The October 2025 MAR indicated the resident was self-administering the Miralax,		**41 IAC** **16.2-5-4(e)(1) Health Services** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 – The physician order has been updated and reviewed. The service plan has been revised to reflect that staff will administer all medications. Medication assessment has been updated to reflect the same. Resident #4 – The physician order has been updated and reviewed. The service plan has been revised to reflect that staff will administer all medications. Medication assessment has been updated to reflect the same. Resident #7 – The physician order has been updated and reviewed. The service plan has been revised to reflect that staff will	

albuterol inhaler, and nitroglycerin tablet.

The Medication Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his chair. He had a Fluticasone

administer all medications. Medication assessment has been updated to reflect the same.

2
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:

An audit has been completed of Medication Administration assessments and service plans to ensure both are accurate.

3
What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur.

The clinical staff will be in-serviced by a DONW or designee by: 11/6/2025

	nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave. During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays. The record was reviewed for Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder. A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications. The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff and the resident would be supported to take medications safely and as ordered. The resident had behaviors and reported suicidal ideation and frequent thoughts of death. The resident received behavioral		410 IAC Regulation 16.2-5-4(e)(1) Silver Birch Policies: Medication Administration 4 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 DONW, Executive Director or designee will audit all residents physician medication orders to ensure that the residents' medication administration status reflects the same. Audit the care plan, the medication assistance record and the level of service evaluation to ensure compliance.	

	health services. There were no physician orders for the three nasal sprays found in the resident's room. Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside. Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the bedside. The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September. The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September. The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September. The 9/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc		5 By what date the systemic changes will be completed: 11.6.2025	

supplement were signed out as self-administered for the month of September.

During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside.

A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."

Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for self-administration of

medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications.

A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications.

The October 2025 Physician's Order Summary (POS) indicated an order for:

- nystatin powder (antifungal medication) applied to affected areas twice a day.

The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin powder twice daily all month.

During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.

2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside.

The Service Plan, signed on 9/5/25, indicated the resident's medications were to be administered by staff.

The October 2025 MAR indicated the resident was

self-administering the Miralax, albuterol inhaler, and nitroglycerin tablet.

The Medication Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his

chair. He had a Fluticasone nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave.

During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays.

The record was reviewed for Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder.

A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications.

The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff and the resident would be supported to take medications safely and as ordered. The resident had behaviors and reported suicidal ideation and frequent thoughts of death. The

resident received behavioral health services.

There were no physician orders for the three nasal sprays found in the resident's room.

Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside.

Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the bedside.

The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 9/2025 MAR indicated the Multivitamin and

Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside.

A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."

Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for

self-administration of medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications.

A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications.

The October 2025 Physician's Order Summary (POS) indicated an order for:

- nystatin powder (antifungal medication) applied to affected areas twice a day.

The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin

powder twice daily all month.

During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.

2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside.

The Service Plan, signed on 9/5/25, indicated the resident's medications were to be administered by staff.

The October 2025 MAR indicated the resident was self-administering the Miralax, albuterol inhaler, and nitroglycerin tablet.

The Medication

Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his chair. He had a Fluticasone nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's

multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave.

During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays.

The record was reviewed for Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder.

A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications.

The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff and the resident would be supported to take medications safely and as ordered. The resident had behaviors and reported suicidal ideation and frequent thoughts of death. The resident received behavioral health services.

There were no physician orders for the three nasal sprays found in the resident's room.

Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside.

Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the bedside.

The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 9/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month

	of September. During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside. A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."			

Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for self-administration of medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications.

A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications.

The October 2025 Physician's Order Summary (POS) indicated an order for:

- nystatin powder (antifungal

medication) applied to affected areas twice a day.

The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin powder twice daily all month.

During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.

2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside.

The Service Plan, signed on 9/5/25, indicated the resident's medications were to be administered by staff.

The October 2025 MAR indicated the resident was self-administering the Miralax, albuterol inhaler, and nitroglycerin tablet.

The Medication Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the

assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his chair. He had a Fluticasone nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave.

During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays.

The record was reviewed for Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder.

A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications.

The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff

and the resident would be supported to take medications safely and as ordered. The resident had behaviors and reported suicidal ideation and frequent thoughts of death. The resident received behavioral health services.

There were no physician orders for the three nasal sprays found in the resident's room.

Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside.

Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the bedside.

The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc

supplement were signed out as self-administered for the month of September.

The 9/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside.

A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."

Based on observation, record review, and interview, the facility

failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for self-administration of medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications.

A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications.

The October 2025 Physician's Order Summary (POS) indicated an order for:

- nystatin powder (antifungal medication) applied to affected areas twice a day.

The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin powder twice daily all month.

During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.

2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside.

The Service Plan, signed on 9/5/25, indicated the resident's medications were to be

administered by staff.

The October 2025 MAR indicated the resident was self-administering the Miralax, albuterol inhaler, and nitroglycerin tablet.

The Medication Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his chair. He had a Fluticasone nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave.

During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays.

The record was reviewed for Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder.

A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications.

The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff and the resident would be supported to take medications safely and as ordered. The

resident had behaviors and reported suicidal ideation and frequent thoughts of death. The resident received behavioral health services.

There were no physician orders for the three nasal sprays found in the resident's room.

Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside.

Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the bedside.

The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

	The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September. The 9/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September. During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside.			

A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."

Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for self-administration of medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease

and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications.

A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications.

The October 2025 Physician's Order Summary (POS) indicated an order for:

- nystatin powder (antifungal medication) applied to affected areas twice a day.

The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin powder twice daily all month.

During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.

2. Resident 4's record was reviewed on 10/1/25 at 11:31 a.m. Diagnoses included, but

were not limited to, major depressive disorder, type 2 diabetes mellitus, and chronic obstructive pulmonary disease.

The current October 2025 Physician's Order Summary (POS) indicated the following: polyethylene glycol 3350 powder (Miralax, laxative) 17 grams in 4-8 ounces of liquid daily resident to self-administer, albuterol 90 micrograms inhaler 1 to 2 puffs by mouth as needed resident to self-administer, and nitroglycerin 0.4 sublingual tablet every 5 minutes for up to 3 doses for chest pain as needed may keep at bedside.

The Service Plan, signed on 9/5/25, indicated the resident's medications were to be administered by staff.

The October 2025 MAR indicated the resident was self-administering the Miralax, albuterol inhaler, and nitroglycerin tablet.

The Medication Self-Administration Safety Screen, dated 10/21/24, indicated the resident may not self-administer medications. There were no more recent screens available.

The Level of Service Assessment/Evaluation-Full List of Items-Assisted Living, dated 9/3/25 at 3:40 p.m., indicated the resident needed caregiver

administration and/or observation of medications requiring judgment for necessity, dosage and/or effect, assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers) at least two times per day, and insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day

During an interview on 10/1/25 at 3:32 p.m., the DON indicated the resident was not supposed to have any medications for self-administration per the assessment. The nurses were to administer all of the resident's medications.

3. On 10/1/25 at 2:45 p.m., Resident 7 was observed in his room and was reclined in his chair. He had a Fluticasone nasal spray in the cup holder of his chair. On the coffee table, there was a nasal saline spray and a bottle of men's multivitamins. There was also a nasal spray of ipratropium bromide sitting on top of the microwave.

During an interview at the time, Resident 7 indicated he would only take the multivitamin once a day. He no longer used the nasal sprays.

The record was reviewed for

Resident 7 on 10/1/25 at 11:50 a.m. Diagnoses included, but were not limited to, depression, schizoaffective disorder, anxiety, and adjustment disorder.

A Medication Self-Administration Safety Screen, dated 6/4/25, indicated the resident may not self-administer own medications.

The Service Plan, dated 9/3/25, indicated the resident had mild to moderate disorientation and required cueing related to schizophrenia. Medications were to be administered by staff and the resident would be supported to take medications safely and as ordered. The resident had behaviors and reported suicidal ideation and frequent thoughts of death. The resident received behavioral health services.

There were no physician orders for the three nasal sprays found in the resident's room.

Physician's Orders, dated 1/17/25, indicated to take 1 multivitamin by mouth once a day and to keep medication at the bedside.

Physician's Orders, dated 1/17/25, indicated to take 3 calcium/magnesium/zinc tablets by mouth once a day with meals and to keep medication at the

bedside.

The 6/2025 Medication Administration Record (MAR) indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 7/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 8/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

The 9/2025 MAR indicated the Multivitamin and Calcium/magnesium/zinc supplement were signed out as self-administered for the month of September.

During an interview on 10/1/25 at 4:03 p.m., DON indicated Resident 7 should not be self-administering any medication and should not have any medications at the bedside.

A facility policy titled, "Self-Medication Program Policy," noted as current, indicated "...Any resident wishing to administer their own medications will be assessed by

by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications. Any residents who administer their own medications must have written authorization from their physician/practitioner indicating they may self-administer. Procedure: 1. Residents must have a physician's written order for self-administration of prescription medications in PCC..."

Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and adhered to assessments to self-administer their own medications for 3 of 4 residents reviewed for self-administration of medications. (Residents 3, 4, and 7)

Findings include:

1. Record review for Resident 3 was completed on 10/1/25 at 11:47 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

A Service Plan, updated and signed by the resident on 3/5/25, indicated the resident would receive medications from

	the staff as ordered. The resident was unable to self-inject or self-administer medications. The resident required assistance with ordering medications. A Medication Self-Administration Safety Screen, dated 9/11/25, indicated the resident may not self administer medications. The October 2025 Physician's Order Summary (POS) indicated an order for: - nystatin powder (antifungal medication) applied to affected areas twice a day. The September 2025 Medication Administration Record (MAR) was signed out indicating the resident had self-administered the nystatin powder twice daily all month. During an interview on 10/2/25 at 9:48 a.m., the Director of Nursing (DON) indicated the resident should not have self-administered the nystatin powder.			

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 SIGNATURESandi Robinson	TITLEExecutive Director	(X6) DATE10/15/2025