STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF KOKOMO	408 S WASHINGTON STREET, KOKOMO, , 46901

(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 Complaint IN00360897. This visit included a Quality Assurance Walk Through Survey. Complaint IN00360897 - Substantiated. State deficiencies related to the allegations are cited at R36, R117 and R241. Survey dates: September 2, 3 and 7, 2021 Facility number: 014137 Residential Census: 115 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 13, 2021.	R 0000	R 0000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facilities allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance.	

			Should additional information be necessary to confirm said compliance, please feel free to contact me. Respectfully, Angela M Mann HRA, RCA, CNA Executive Director Silver Birch Assisted Living	
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.	R 0036	**Tag 036 Resident Rights** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Due to the nature of the survey residents were not able to be identified. **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;**	09/24/2021

	Based on interview and record review, the facility failed to notify a resident's family member in a timely manner, when she was sent out to the ER (Emergency Room) for 1 of 3 residents reviewed for notification of a change in condition (Resident B) and the facility failed to notify residents, the residents' family members and/or Representatives in a timely manner of the COVID-19 cases. This deficient practice affected 115 of 115 residents residing in the facility and their family members and/or Representatives. Findings include: 1. During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from CNA 5 regarding Resident B "Not acting right." The DON indicated she spoke to Resident B on CNA 5's cell phone, continuing to speak to her while CNA 5 left the apartment to let the EMS (Emergency Medical Service) in the building. Resident B was not making any sense and she could not form logical sentences. After CNA 5 let the EMS staff into the resident's apartment, the DON hung up. The DON indicated she fell back to sleep after she got off the phone with Resident B, so she did not get the		Family member or legal representative of residents who are sent out to ER will be notified in a timely manner. Residents & Representative will be notified timely of COVID-19 cases. Executive Director (ED) & Director of Nursing & Wellness (DONW) to be reeducated on or before 09/24/2021 by Senior Clinical Advisor on Resident Change of Condition to residents' family or legal representative and COVID protocol notification to staff, residents' family or legal representative. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DONW or designee will review 5 days/week – M-F residents who are sent to ER to assure notification was made timely to resident family or legal representative. ED or designee will validate that notification of COVID-19 is submitted timely **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what**	

	resident's Representative/family member notified of her change in condition or she was sent to the ER for evaluation and treatment until approximately an hour after she arrived at the ER. The DON indicated Resident B's daughter text her on 8/12/21 at 7:48 a.m., notifying her she was at the ER with the resident and when she got to the hospital Resident B was unresponsive and having seizure like activity. The resident had a toilet full of blood when EMS went to her apartment. The resident's daughter was wanting answers as to what happened and why she was not called right after the resident was sent to the hospital. The DON indicated she explained to Resident B's daughter she fell asleep after hanging up the phone from talking with CNA 5 and apologized for falling asleep and not calling her. Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease. A progress note, written on 8/12/21 at 7:29 a.m., by the DON indicated she was called by a CNA who indicated Resident B was not acting like herself and asked if the DON		**quality assurance program will be put into place;** An audit tool will be used to assure compliance is met, any errors or omissions will be corrected at time of discovery. The CQI Tool will be implemented beginning on 09/24/2021 the Director of Nursing / Designee will Audit residents sent to ER, daily for 2 weeks weekly for 4 weeks; then monthly thereafter for 6 months. Director of Nursing and Wellness / Designee will report findings at monthly QAPI ongoing until 100% compliance is maintained per QAPI. An audit tool will be used to assure compliance is met, any errors or omissions will be corrected at time of discovery. The CQI Tool will be implemented beginning on 09/24/2021; the ED / Designee will Audit COVID-19 notifications were sent per state guidelines at the initial onset of a new COVID community outbreak, daily as updates require, then weekly thereafter. Audits will be conducted daily for 2 weeks; weekly for 4 weeks; then monthly thereafter or until compliance is maintained for 6 months. ED / Designee will report findings at monthly QAPI	

	would speak to her. The DON spoke with the resident who was confused. The DON asked the resident if she would go to the ER to be checked out and she refused, then approximately two minutes later she agreed to go, so 911 was called. The ED, POA and Area 5 care manager was notified of the resident's condition. A document, titled "Kokomo Discharge Summary," dated 8/26/21 at 10:20 a.m., indicated Resident B came to the Emergency Room (ER) on 8/12/21 with unresponsiveness, bloody stools and had Hepatic Encephalopathy (the loss of brain function when a damaged liver did not remove toxins from the blood). There was a concern for a new onset of seizures. She received transfusions of blood during her hospitalization. During a phone interview, on 9/7/21 at 2:29 p.m., with LPN 1 in attendance, CNA 5 indicated she was asked to help CNA 8 with Resident B. Resident B was observed sitting on the toilet when she arrived at her apartment with CNA 8, with her eyes closed, shaking like she was having a "seizure." Both CNAs were calling her name, but she was not responding to them or answering them, so they made the decision to call 911. Both CNAs called the DON to let her know what was		ongoing until 100% compliance is maintained consecutively for 6 months. **What date the systemic changes will be completed:** 09/30/2021	

	happening with Resident B and she told them to call 911. CNA 5 stayed with the resident while CNA 8 went to the front door to let EMS into the facility. CNA 5 indicated she did not notify Resident B's family because she had never been told she could do that. During an interview, on 9/7/21 at 3:00 p.m., Resident B's daughter indicated she was not notified Resident B was sent to the hospital on 8/12/21 until 6:40 a.m., by the DON. She wanted to know why the facility waited so long to inform her the resident was sent to the hospital when they knew she was the POA (Power of Attorney). When the daughter arrived at the ER, the resident was unresponsive and was having "seizure like" activity. The resident's daughter indicated she had concerns with not being notified in a timely manner to meet her mother at the ER to give pertinent information to the healthcare providers caring for her mother, since she was unresponsive when she arrived at the hospital. She felt like she was not informed of the magnitude of seriousness of her mother's change of condition when she spoke with the DON. During a phone interview, on 9/7/21 at 6:35 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical			

	Support in attendance, CNA 8 indicated Resident B had turned on her bathroom call light on 8/12/21 at approximately 5:00 a.m., which was unusual for her. When she got into her apartment, she observed her to be sitting on the toilet with her pants pulled up, with a glazed look in her eyes. She went and got CNA 5 to assist her to help the resident back to bed. She asked the resident if she was ok and she indicated "No" She asked if she wanted to go to the hospital and she indicated she did not want to go to the hospital. The two CNAs called the DON on CNA 5's cell phone to inform her of the situation and she indicated to call 911. The CNAs were not able to have access into the computer to print any medical information off for the EMS personnel to take the hospital with the resident. CNA 8 indicated the CNAs were not allowed access to the computers when they sent someone out to the hospital, so when she was there she got into the resident's chart and wrote the name and birth date of the resident down on a piece of paper for them because she knew the hospital at least needed the birthdate and name of the resident to treat them. 2. During an interview, on 9/2/21 at 3:30 p.m., the ED (Executive Director) indicated the residents and their representatives and/or			

	family members were updated on the COVID-19 status in the facility by an automatic email, which was sent out by herself or her designee. The first email after the COVID-19 outbreak was sent out on 8/18/21, which indicated there was an outbreak in the facility. Each alert and oriented resident had a hand delivered note to their door. She updated the COVID-19 memo weekly. A copy of the email distribution for 8/18/21 was requested at that time. During the exit conference, on 9/7/21 at 6:00 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical Services (RDCS) in attendance, a request was made for a copy of the email distribution log, to verify the residents and their representatives and/or family members had been notified. The ED asked if she could email the information the following day. On 9/8/21 at 3:36 p.m., the (BOM) Business Office Manager indicated through an email, sent at that date and time, she had distributed a letter to the residents on (8/25/21), but she forgot to send the same notification out by email to the to the family members and/or representatives to notify them of the COVID-19 outbreak. On 9/9/21 at 10:24 a.m., the BOM indicated through an email			

	she sent the notification out to approximately 115 residents currently residing in the facility. A current policy, titled "COVID-19 Protocol," dated 8/3/21 and provided by the RDCS on 8/7/21 at 6:30 p.m., indicated "Residents: Guidelines...Licensed Nurse...Licensed Nurse to inform resident's family or responsible party of teat results and quarantine and document notification in PCC [Point Click Care]...Contact Tracing...Any resident with or without symptoms and positive test must have contact tracing completed by the nursing staff...Licensed Nurse to inform resident's family or responsible party of test results and quarantine and document notification in PCC...Testing: If a new case of COVID-19 among residents or staff is identified, the community should begin out break testing...Visitors who resume visitation on the unaffected floors of the Community should be notified of potential exposure, and signage should be placed in the Community regarding the outbreak on the particular floor...." A current policy, titled "Resident Rights Policy and Procedure," dated 8/7/21 and provided by the RDCS on 9/7/21 at 6:30 p.m., indicated "...Purpose: The			

	Executive Director will be an advocate for resident rights to ensure: resident rights are respected and protected...humane care for all residents, to inform residents of their rights...residents have the right to be treated with consideration respect, and recognition of their dignity and individuality...." This State finding relates to Complaint IN00360897. Based on interview and record review, the facility failed to notify a resident's family member in a timely manner, when she was sent out to the ER (Emergency Room) for 1 of 3 residents reviewed for notification of a change in condition (Resident B) and the facility failed to notify residents, the residents' family members and/or Representatives in a timely manner of the COVID-19 cases. This deficient practice affected 115 of 115 residents residing in the facility and their family members and/or Representatives. Findings include: 1. During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from CNA 5 regarding Resident B "Not acting right." The DON			

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	Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease. A progress note, written on 8/12/21 at 7:29 a.m., by the DON indicated she was called by a CNA who indicated Resident B was not acting like herself and asked if the DON would speak to her. The DON spoke with the resident who was confused. The DON asked the resident if she would go to the ER to be checked out and she refused, then approximately two minutes later she agreed to go, so 911 was called. The ED, POA and Area 5 care manager was notified of the resident's condition. A document, titled "Kokomo Discharge Summary," dated 8/26/21 at 10:20 a.m., indicated Resident B came to the Emergency Room (ER) on 8/12/21 with unresponsiveness, bloody stools and had Hepatic Encephalopathy (the loss of brain function when a damaged liver did not remove toxins from the blood). There was a concern for a new onset of seizures. She received transfusions of blood during her hospitalization. During a phone interview, on			

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	the ER to give pertinent information to the healthcare providers caring for her mother, since she was unresponsive when she arrived at the hospital. She felt like she was not informed of the magnitude of seriousness of her mother's change of condition when she spoke with the DON. During a phone interview, on 9/7/21 at 6:35 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical Support in attendance, CNA 8 indicated Resident B had turned on her bathroom call light on 8/12/21 at approximately 5:00 a.m., which was unusual for her. When she got into her apartment, she observed her to be sitting on the toilet with her pants pulled up, with a glazed look in her eyes. She went and got CNA 5 to assist her to help the resident back to bed. She asked the resident if she was ok and she indicated "No" She asked if she wanted to go to the hospital and she indicated she did not want to go to the hospital. The two CNAs called the DON on CNA 5's cell phone to inform her of the situation and she indicated to call 911. The CNAs were not able to have access into the computer to print any medical information off for the EMS personnel to take the hospital with the resident. CNA 8 indicated the CNAs were not allowed access to the			

	computers when they sent someone out to the hospital, so when she was there she got into the resident's chart and wrote the name and birth date of the resident down on a piece of paper for them because she knew the hospital at least needed the birthdate and name of the resident to treat them. 2. During an interview, on 9/2/21 at 3:30 p.m., the ED (Executive Director) indicated the residents and their representatives and/or family members were updated on the COVID-19 status in the facility by an automatic email, which was sent out by herself or her designee. The first email after the COVID-19 outbreak was sent out on 8/18/21, which indicated there was an outbreak in the facility. Each alert and oriented resident had a hand delivered note to their door. She updated the COVID-19 memo weekly. A copy of the email distribution for 8/18/21 was requested at that time.			

	During the exit conference, on 9/7/21 at 6:00 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical Services (RDCS) in attendance, a request was made for a copy of the email distribution log, to verify the residents and their representatives and/or family members had been notified. The ED asked if she could email the information the following day. On 9/8/21 at 3:36 p.m., the (BOM) Business Office Manager indicated through an email, sent at that date and time, she had distributed a letter to the residents on (8/25/21), but she forgot to send the same notification out by email to the to the family members and/or representatives to notify them of the COVID-19 outbreak. On 9/9/21 at 10:24 a.m., the BOM indicated through an email she sent the notification out to approximately 115 residents currently residing in the facility. A current policy, titled "COVID-19 Protocol," dated 8/3/21 and provided by the RDCS on 8/7/21 at 6:30 p.m., indicated "Residents: Guidelines...Licensed Nurse...Licensed Nurse to inform resident's family or responsible party of teat results and quarantine and document notification in PCC [Point Click Care]...Contact Tracing...Any			

	resident with or without symptoms and positive test must have contact tracing completed by the nursing staff...Licensed Nurse to inform resident's family or responsible party of test results and quarantine and document notification in PCC...Testing: If a new case of COVID-19 among residents or staff is identified, the community should begin out break testing...Visitors who resume visitation on the unaffected floors of the Community should be notified of potential exposure, and signage should be placed in the Community regarding the outbreak on the particular floor...." A current policy, titled "Resident Rights Policy and Procedure," dated 8/7/21 and provided by the RDCS on 9/7/21 at 6:30 p.m., indicated "...Purpose: The Executive Director will be an advocate for resident rights to ensure: resident rights are respected and protected...humane care for all residents, to inform residents of their rights...residents have the right to be treated with consideration respect, and recognition of their dignity and individuality...." This State finding relates to Complaint IN00360897.			

R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on interview and record review, the facility failed to report their positive cases of COVID-19 into the RED-cap system as required by the Indiana Department of Health for 2 of 2 positive residents and 5 of 5 positive staff which tested positive since 8/18/21. Finding includes: During an interview, on 9/2/21 at 3:30 p.m., the ED (Executive Director) indicated the residents and their representatives and/or family members were updated on the COVID-19 status in the facility by an automatic email,	R 0086	**Tag 086 Administration & Management**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;Due to the nature of the survey residents were not able to be identified.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;Residents who are positive with COVID-19 have the potential to be affected by this alleged practice.Executive Director (ED) & Director of Nursing & Wellness (DONW) to be educated on or before9/24/21 by Senior Clinical Advisor regarding the correct RED-cap website to use for reporting purposes and positive cases.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;ED or designee will validatethat positive cases of COVID-19 have been reported and entered into the LTC RED-cap Case Reporting Site.How the corrective action will be monitored to ensure the deficient practice will	09/30/2021

	which was sent out by herself or her designee. The first email after the COVID-19 outbreak was sent out on 8/18/21, which indicated there was an outbreak in the facility. During an interview, on 9/2/21 at 3:30 p.m., the ED indicated she had reported the positive cases into the REDcap system as required. When asked if she had reported the positive cases into both REDcap systems, she indicated she only knew of one REDcap system she needed to report the positive cases to. She had not been reporting the positive COVID-19 residents into the TLC (Long Term Care) REDcap Case Reporting site at https://redcap.isdh.in.gov/surveys/?s=TJPDYTRHT9 as required. A document, titled "COVID-19 Guidance for Point-of-Care COVID-19 Testing Reporting" dated as last updated 9/7/2020 indicated "...IDOH requires all facilities using point-of-care testing to report all results to IDOH as soon as possible to provide timely intervention and direction to the state ' s response to the public health emergency...." Based on interview and record review, the facility failed to report their positive cases of COVID-19 into the RED-cap system as required by the Indiana Department of Health		not recur, i.e., what quality assurance program will be put into place;An audit tool will be used to assure compliance is met. The CQI Tool will be implemented beginning on 09/24/2021; the ED / Designee will Audit to ensure positive cases of COVID-19 have been reported to the LTC RED-cap Case Reporting Site, daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained for 6 months. ED/ Designee will report findings at monthly QAPI ongoing until compliance is maintained per QAPI.What date the systemic changes will be completed: 09/30/2021	

	for 2 of 2 positive residents and 5 of 5 positive staff which tested positive since 8/18/21. Finding includes: During an interview, on 9/2/21 at 3:30 p.m., the ED (Executive Director) indicated the residents and their representatives and/or family members were updated on the COVID-19 status in the facility by an automatic email, which was sent out by herself or her designee. The first email after the COVID-19 outbreak was sent out on 8/18/21, which indicated there was an outbreak in the facility. During an interview, on 9/2/21 at 3:30 p.m., the ED indicated she had reported the positive cases into the REDcap system as required. When asked if she had reported the positive cases into both REDcap systems, she indicated she only knew of one REDcap system she needed to report the positive cases to. She had not been reporting the positive COVID-19 residents into the TLC (Long Term Care) REDcap Case Reporting site at https://redcap.isdh.in.gov/surveys/?s=TJPDYTRHT9 as required. A document, titled "COVID-19 Guidance for Point-of-Care COVID-19 Testing Reporting" dated as last updated 9/7/2020 indicated "...IDOH requires all facilities using point-of-care			

	testing to report all results to IDOH as soon as possible to provide timely intervention and direction to the state ' s response to the public health emergency...."			

R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was an adequate amount of qualified and trained staff available to meet the needs of a resident who required ER (Emergency Room) services for 1 of 3 residents	R 0117	**Tag 117 Resident Rights** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Due to the nature of the survey residents were not able to be identified. **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;** Residents who are sent to ER on night shift have the potential to be effected by this alleged practice. Face sheets for residents will be printed & placed in a resident face sheet binder for night shift to use when there is a resident sent to ER. Night shift to be educated on where the resident face binder is kept & protocol for	09/30/2021

	being reviewed for sufficient staff in numbers, qualifications and training to meet the needs of residents (Resident B). Finding includes: Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease. A progress note, written on 8/12/21 at 7:29 a.m., by the DON indicated she was called by a CNA who indicated Resident B was not acting like herself and asked if the DON would speak to her. The DON spoke with the resident who was confused. The DON asked if the resident would go to the ER to be checked out and she refused. Then approximately two minutes later, she agreed to go and 911 was called. The ED, POA and Area 5 care manager was notified of the resident's condition. A document, titled "Kokomo Consultation," dated 8/13/21 at 6:03 p.m., indicated the chief complaint was decreased responsiveness. The Neurologist obtained the resident's history from the ER records, the hospitalist records and her daughter. While		use the face sheets when a resident is sent to ER during night shift. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DONW /Designee to review resident binder with face sheets weekly to assure each resident's face sheet is available and current. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** An audit tool will be used to assure compliance is met, any errors or omissions will be corrected at time of discovery. The CQI Tool will be implemented on or before 09/30/2021; the Director of Nursing / Designee will Audit the resident face sheet binder weekly for 4 weeks; then monthly for 6 months. Director of Nursing and Wellness / Designee will report findings at monthly at	

	reviewing the systems in the resident's history, the Physician was unable to obtain information from the resident. She had trace lower edema. She only responded to the sternal rub with facial grimacing. She was unable to localize pain, could not follow commands and did not open her eyes. During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from CNA 5 regarding Resident B "Not acting right." She indicated there were two CNAs working this shift and she was the nurse on call because there was no nurse in the facility. During a phone interview, on 9/7/21 at 2:29 p.m., with LPN 1 in attendance, CNA 5 indicated she was asked to help CNA 8 with Resident B. Resident B was observed sitting on the toilet when she arrived at her apartment with CNA 8, with her eyes closed and she was shaking like she was having a "seizure." Both CNAs were calling her name, but she was not responding to them or answering them, so they made the decision to call 911. Both CNAs called the DON to let her know what was happening with Resident B and she told them to call 911. CNA 5 stayed with the resident while CNA 8 went to		QAPI ongoing. **<u>What date the systemic changes will be completed:</u>** 09.30.2021	

	the front door to let EMS into the facility. CNA 5 indicated while she was waiting on CNA 8 and EMS to get to the apartment, Resident B stood up off the toilet and she was very unsteady on her feet and shaking. She held her eyes closed and she was non-verbal. She would not listen to commands to sit back down. When Resident B stood up off the toilet, CNA 5 observed her toilet bowl to have blood (enough blood to turn the water red) with a bowel movement (BM) in the toilet. CNA 5 indicated Resident B did not talk on the phone with the DON. She was unresponsive the entire time she was in her apartment. During an interview, on 9/7/21 at 2:45 p.m., with LPN 1 in the Nurses' office, QMA 9 entered the Nurses' office indicating to LPN 1 she needed a resident's facesheet for (Name of Home Health Company), so they could draw his blood. QMA 9 indicated she was not allowed as a CNA to have access to residents' records in the computer to print off medical information if it was needed to get services for them. Now since she had been a QMA, she had not been given access yet. When asked if the staff member did not have computer access and a resident needed to go to the hospital for treatment, such as; on the			

	weekend or later in the evening, what did the staff member do to get EMS copies of the resident's record. She indicated they had no access to the computer, so the staff member would not be able to get any records for the EMS personnel. During an interview, on 9/7/21 at 3:00 p.m., Resident B's daughter indicated she was not notified Resident B was sent to the hospital on 8/12/21 until 6:40 a.m., by the DON. The resident's daughter indicated she had concerns with not being notified in a timely manner to meet her mother at the ER to give pertinent information to the healthcare providers caring for her mother. Since her mother was unresponsive when she arrived at the hospital, she felt like she was not informed of the magnitude of seriousness of her mother's change of condition. During a phone interview, on 9/7/21 at 6:35 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical Support in attendance, CNA 8 indicated the CNAs were not able to have access into the computer to print off any medical information for the EMS personnel to take the hospital with the resident. CNA 8 indicated the CNAs were not allowed access to the computers so she got into the resident's chart and wrote the			

name and birthdate of the resident down on a piece of paper for them because she knew the hospital at least needed the birthdate and name of the resident to treat them.

At that time, after the phone conversation with CNA 8 had ended, the ED indicated they needed to do some in-services and there needed to be a different system for when someone was sent out to the hospital when only CNAs were in the facility.

This State finding relates to Complaint IN00360897.

Based on interview and record review, the facility failed to ensure there was an adequate amount of qualified and trained staff available to meet the needs of a resident who required ER (Emergency Room) services for 1 of 3 residents being reviewed for sufficient staff in numbers, qualifications and training to meet the needs of residents (Resident B).

Finding includes:

Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease.

	A progress note, written on 8/12/21 at 7:29 a.m., by the DON indicated she was called by a CNA who indicated Resident B was not acting like herself and asked if the DON would speak to her. The DON spoke with the resident who was confused. The DON asked if the resident would go to the ER to be checked out and she refused. Then approximately two minutes later, she agreed to go and 911 was called. The ED, POA and Area 5 care manager was notified of the resident's condition. A document, titled "Kokomo Consultation," dated 8/13/21 at 6:03 p.m., indicated the chief complaint was decreased responsiveness. The Neurologist obtained the resident's history from the ER records, the hospitalist records and her daughter. While reviewing the systems in the resident's history, the Physician was unable to obtain information from the resident. She had trace lower edema. She only responded to the sternal rub with facial grimacing. She was unable to localize pain, could not follow commands and did not open her eyes. During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from			

	CNA 5 regarding Resident B "Not acting right." She indicated there were two CNAs working this shift and she was the nurse on call because there was no nurse in the facility. During a phone interview, on 9/7/21 at 2:29 p.m., with LPN 1 in attendance, CNA 5 indicated she was asked to help CNA 8 with Resident B. Resident B was observed sitting on the toilet when she arrived at her apartment with CNA 8, with her eyes closed and she was shaking like she was having a "seizure." Both CNAs were calling her name, but she was not responding to them or answering them, so they made the decision to call 911. Both CNAs called the DON to let her know what was happening with Resident B and she told them to call 911. CNA 5 stayed with the resident while CNA 8 went to the front door to let EMS into the facility. CNA 5 indicated while she was waiting on CNA 8 and EMS to get to the apartment, Resident B stood up off the toilet and she was very unsteady on her feet and shaking. She held her eyes closed and she was non-verbal. She would not listen to commands to sit back down. When Resident B stood up off the toilet, CNA 5 observed her toilet bowl to have blood (enough blood to turn the water red) with a bowel movement			

	(BM) in the toilet. CNA 5 indicated Resident B did not talk on the phone with the DON. She was unresponsive the entire time she was in her apartment. During an interview, on 9/7/21 at 2:45 p.m., with LPN 1 in the Nurses' office, QMA 9 entered the Nurses' office indicating to LPN 1 she needed a resident's facesheet for (Name of Home Health Company), so they could draw his blood. QMA 9 indicated she was not allowed as a CNA to have access to residents' records in the computer to print off medical information if it was needed to get services for them. Now since she had been a QMA, she had not been given access yet. When asked if the staff member did not have computer access and a resident needed to go to the hospital for treatment, such as; on the weekend or later in the evening, what did the staff member do to get EMS copies of the resident's record. She indicated they had no access to the computer, so the staff member would not be able to get any records for the EMS personnel. During an interview, on 9/7/21 at 3:00 p.m., Resident B's daughter indicated she was not notified Resident B was sent to the hospital on 8/12/21 until 6:40 a.m., by the DON. The resident's daughter indicated			

	she had concerns with not being notified in a timely manner to meet her mother at the ER to give pertinent information to the healthcare providers caring for her mother. Since her mother was unresponsive when she arrived at the hospital, she felt like she was not informed of the magnitude of seriousness of her mother's change of condition. During a phone interview, on 9/7/21 at 6:35 p.m., with the ED (present by phone), LPN 1 and the Regional Director of Clinical Support in attendance, CNA 8 indicated the CNAs were not able to have access into the computer to print off any medical information for the EMS personnel to take the hospital with the resident. CNA 8 indicated the CNAs were not allowed access to the computers so she got into the resident's chart and wrote the name and birthdate of the resident down on a piece of paper for them because she knew the hospital at least needed the birthdate and name of the resident to treat them.			

	At that time, after the phone conversation with CNA 8 had ended, the ED indicated they needed to do some in-services and there needed to be a different system for when someone was sent out to the hospital when only CNAs were in the facility. This State finding relates to Complaint IN00360897.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (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.	R 0241	**Tag 241 Health Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Due to the nature of the survey residents were not able to be identified. **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;** Residents with Congestive Heart Failure have the potential to be affected by this alleged deficient practice.	09/30/2021

	Based on interview and record review, the facility failed to weigh a resident as ordered, then administer a prescribed as needed diuretic medicine according to the Physician's orders for 1 of 3 residents reviewed for following Physician's prescribed orders (Resident B). This deficient practice had the potential to exacerbate Resident B's systolic Congestive Heart Failure. Finding includes: During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from CNA 5 regarding Resident B "Not acting right." She indicated there were two CNAs working this shift and she was the nurse on call because there was no nurse in the facility. Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease. A document, titled "Kokomo Consultation," dated 8/13/21 at 6:03 p.m., indicated the chief complaint was decreased responsiveness. The Neurologist obtained the		Nurses & QMAs to be reeducated by DONW or designee on or before 09/30/2021 regarding following physician orders. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DONW or designee will review 5 days/week EMAR to ensure weights are completed timely as ordered and physician to be notified if outside parameters. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** An audit tool will be used to assure compliance is met, any errors or omissions will be corrected at time of discovery. The CQI Tool will be implemented beginning on or before 09/30/2021, the Director of Nursing / Designee	

	resident's history from the Emergency Room (ER) records, the hospitalist records and her daughter. While reviewing the systems in the resident's history, the Physician was unable to obtain information from the resident. She had trace lower edema. She only responded to the sternal rub with facial grimacing. She was unable to localize pain, could not follow commands and did not open her eyes. The EMAR (Electronic Medication Administration Record), dated for August 2021, included, but was not limited to, the following orders: On 7/21/21, to take daily weights on the residents scale in her room at the same time daily for diagnosis of congestive heart failure and bilateral lower extremity edema. On 10/22/20, to take Furosemide tablet (a medication used to decrease the amount of fluid in a person's body) 80 mg (milligrams) by mouth as needed for weight gain related to systolic congestive heart failure for a weight gain of 3 pounds or more until the resident reaches baseline. The resident's daily weight order had initials in all the boxes from 8/1/21 to 8/11/21 (she was hospitalized, then at a		will Audit EMAR to ensure weights are completed timely , daily for 2 weeks weekly for 4 weeks; then monthly for 6 months. Director of Nursing and Wellness / Designee will report findings at monthly QAPI ongoing until compliance is met per QAPI. **<u>What date the systemic changes will be completed:</u>** **09/30/2021**	

rehabilitation facility from 8/12/21 to 9/3/21) to indicate it was documented as completed except 8/10/21. This box was blank indicating there was no initial in the box to indicate it was documented as completed.

There were no weights documented on the EMAR to indicate whether the resident required her as needed Furosemide or not.

The resident's as needed Furosemide tablet had not been administered during any of these days.

During an interview, on 9/7/21 at 1:45 p.m., QMA (Qualified Medication Aide) 10 indicated if a resident was on daily weights, their weights would be documented in the daily weight binder and if they were not in the binder, then they would have been documented in the computer under the vitals section.

At that time, she got the daily weight binder book and looked up Resident B's daily weights for the days between 8/1/21 to 8/11/21. The following weights were recorded on these dates:

On 8/1/21, 176 pounds.

On 8/2/21, No weight was obtained.

On 8/3/21, No weight was

obtained.

On 8/4/21, 176 pounds.

On 8/5/21, 177 pounds.

On 8/6/21, 177 pounds.

On 8/7/21, 167 pounds.

On 8/8/21, the resident refused.

On 8/9/21, 186 pounds.

On 8/10/21, No weight was obtained.

On 8/11/21, No weight was obtained.

There was no documentation in the resident's record to indicate the physician or the family was notified of the weight gain on 8/9/21.

There was no documentation in the resident's record to indicate the Furosemide 80 mg tablet was administered after the weight gain on 8/9/21.

During an interview, on 9/7/21 at 2:45 p.m., LPN 1 indicated Resident B did not get weighed consistently in her apartment, so this may be why there was a large weight discrepancy on some of those days. She indicated she thought her Furosemide order had been discontinued a while back ago.

During an interview, on 9/7/21 at

3:00 p.m., Resident B's daughter indicated she had concerns with Resident B not being weighed daily and being given her Fursoemide when she needed it for a weight gain. She indicated this was not the first time this had happened.

This State finding relates to Complaint IN00360897.

Based on interview and record review, the facility failed to weigh a resident as ordered, then administer a prescribed as needed diuretic medicine according to the Physician's orders for 1 of 3 residents reviewed for following Physician's prescribed orders (Resident B). This deficient practice had the potential to exacerbate Resident B's systolic Congestive Heart Failure.

Finding includes:

During a phone interview, on 9/3/21 at 1:17 p.m., the DON (Director of Nursing) indicated she received a phone call early in the morning on 8/12/21 from CNA 5 regarding Resident B "Not acting right." She indicated there were two CNAs working this shift and she was the nurse on call because there was no nurse in the facility.

Resident B's record was reviewed on 9/6/21 at 3:00 p.m. Diagnoses included, but were not limited to, systolic

congestive heart failure, hypertension, anemia, cirrhosis, diabetes mellitus and Chronic Obstructive Pulmonary Disease.

A document, titled "Kokomo Consultation," dated 8/13/21 at 6:03 p.m., indicated the chief complaint was decreased responsiveness. The Neurologist obtained the resident's history from the Emergency Room (ER) records, the hospitalist records and her daughter. While reviewing the systems in the resident's history, the Physician was unable to obtain information from the resident. She had trace lower edema. She only responded to the sternal rub with facial grimacing. She was unable to localize pain, could not follow commands and did not open her eyes.

The EMAR (Electronic Medication Administration Record), dated for August 2021, included, but was not limited to, the following orders:

On 7/21/21, to take daily weights on the residents scale in her room at the same time daily for diagnosis of congestive heart failure and bilateral lower extremity edema.

On 10/22/20, to take Furosemide tablet (a medication used to decrease the amount of fluid in a person's body) 80 mg

(milligrams) by mouth as needed for weight gain related to systolic congestive heart failure for a weight gain of 3 pounds or more until the resident reaches baseline.

The resident's daily weight order had initials in all the boxes from 8/1/21 to 8/11/21 (she was hospitalized, then at a rehabilitation facility from 8/12/21 to 9/3/21) to indicate it was documented as completed except 8/10/21. This box was blank indicating there was no initial in the box to indicate it was documented as completed.

There were no weights documented on the EMAR to indicate whether the resident required her as needed Furosemide or not.

The resident's as needed Furosemide tablet had not been administered during any of these days.

During an interview, on 9/7/21 at 1:45 p.m., QMA (Qualified Medication Aide) 10 indicated if a resident was on daily weights, their weights would be documented in the daily weight binder and if they were not in the binder, then they would have been documented in the computer under the vitals section.

At that time, she got the daily weight binder book and looked

up Resident B's daily weights for the days between 8/1/21 to 8/11/21. The following weights were recorded on these dates:

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On 8/7/21, 167 pounds.

On 8/8/21, the resident refused.

On 8/9/21, 186 pounds.

On 8/10/21, No weight was obtained.

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There was no documentation in the resident's record to indicate the physician or the family was notified of the weight gain on 8/9/21.

There was no documentation in the resident's record to indicate the Furosemide 80 mg tablet was administered after the weight gain on 8/9/21.

During an interview, on 9/7/21 at 2:45 p.m., LPN 1 indicated

	Resident B did not get weighed consistently in her apartment, so this may be why there was a large weight discrepancy on some of those days. She indicated she thought her Furosemide order had been discontinued a while back ago. During an interview, on 9/7/21 at 3:00 p.m., Resident B's daughter indicated she had concerns with Resident B not being weighed daily and being given her Fursoemide when she needed it for a weight gain. She indicated this was not the first time this had happened. This State finding relates to Complaint IN00360897.			

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