STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/18/2026

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 Intake 470215. Intake 470215-State deficiencies related to the allegations are cited at R297. Survey dates: June 17 and 18, 2026. Facility number: 014137 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 2, 2026.	R 0000		
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the	R 0297		07/08/2026

following for that resident:

(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.

Based on interview and record review, the facility failed to ensure pharmaceutical services and prescribed medications were available timely for 1 of 3 residents reviewed for medication availability. (Resident B)

Findings include:

During an interview, on 6/17/26 at 4:45 p.m., Resident B indicated she did not receive her medications as ordered. She had withdrawal symptoms and told the nursing staff. The nursing staff told her the medication was not available, and they could send her to the emergency room. She was new to the area, did not know the hospital, and refused to go. She waited for her medications to be available, but she became sick after she did not receive her medications.

The clinical record for Resident B was reviewed on 6/17/26 at 4:45 p.m. The diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, and chronic pain

syndrome.

Resident B was cognitively intact.

A nursing progress note, dated 6/4/26, indicated Resident B's medication was reordered.

A pharmacy note, dated 6/8/26, indicated the medications needed a new doctor's order before disposition.

A nursing progress note, dated 6/9/26, indicated the physician's order was obtained and sent to the pharmacy.

The medication administration record (MAR) was reviewed and indicated the following medications were not available or administered to Resident B.

1. Alprazolam (a medication used to treat anxiety) 1 milligram (mg) tablet which was to be administered three times a day was not administered on 6/8/26 at 8:00 p.m., on 6/9/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m., on 6/10/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m., and on 6/11/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The medications were not available.

2. Pregabalin (a medication used to treat nerve pain) 200 mg capsule which was to be administered three times a day was not administered on 6/9/26

at 6:00 a.m., 2:00 p.m., and 10:00 p.m., on 6/10/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m., and on 6/11/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The medications were not available.

The clinical record indicated the Nurse Practitioner was aware the resident was missing medications and had ordered the staff to observe the resident and to transport to the emergency room if the resident had signs and symptoms of withdrawal.

A nursing progress note, dated 6/10/26 and 6/11/26, indicated the resident expressed signs and symptoms of withdrawal. The resident was advised to go to the emergency room according to the physician's order and she refused.

A nursing progress note, dated 6/11/26, indicated additional information from the physician was needed for the ordered medications before the medications could be dispensed.

A nursing progress note, dated 6/11/26, indicated the information was obtained from the physician and sent to the pharmacy.

A nursing progress note, dated 6/11/26, indicated the medication could not be

delivered until 6/12/2026. The Director of Nursing (DON) requested the medications be sent to a local pharmacy for pickup by the resident. The DON was told by the pharmacy that the resident would have to show a valid ID for pickup. The resident did not have a valid ID.

During an interview, on 6/18/26 at 3:06 p.m., QMA 4 indicated when a resident's medications were running low, the nursing staff should order the resident's medications at least 7 days prior to running out.

During an interview, on 6/17/26 at 3:24 p.m., QMA 5 indicated when a resident's medications were running low, the nursing staff should order the resident's medications at least 7 days prior to running out.

During an interview, on 6/17/26 at 4:01 p.m., LPN 6 indicated she did notify the pharmacy, on 6/1/26, the resident's medications needed renewed. The pharmacy said they did not receive her notification. Communication with the pharmacy was difficult.

During an interview, on 6/18/26 at 12:05 p.m., the Director of Nursing indicated when a resident's medications were running low, the nursing staff should order the resident's medications at least 7 days prior

to the running out. This was completed but there were no records or documentation found. The pharmacy indicated they did not receive the request from the facility. There was a note, dated 6/4/26, pharmacy was notified. The pharmacy called the facility on 6/8/26 and indicated a physician order was needed. The facility sent the pharmacy everything they had requested, and the medication should have been provided to Resident B in a timely manner. The resident did miss her medications, and she exhibited signs and symptoms of withdrawal on 6/10/26 and 6/11/26. Resident B refused to go to the emergency room on multiple occasions when staff offered. The resident did get her mediation on 6/12/26.

During an interview, on 6/18/26 at 3:35 p.m., the director of the pharmacy indicated she was not aware of any medication requests for Resident B prior to 6/8/26. There were issues related to proper documentation for Resident B's medications.

A current facility policy, titled "Consultant Pharmacy Services," dated as revised 4/11/18 and provided by the DON on 6/18/26 at 3:45 p.m., indicated "...Provide drugs, biologicals, and supplies in a prompt and timely manner...."

	This citation relates to Intake 470215.			

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