STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Intake IN00465066. Intake IN00465066-State deficiencies related to the allegations are cited at R247. Survey dates: October 6 and 7, 2025. Facility number: 014137 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 15, 2025.	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 submittedbecause of requirements under state and federal law. Please accept this plancorrection for this survey. Please finddocumentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Shouldadditional information be necessary to confirm said compliance, please feel free to contact Tony Stewart, Executive Director, Silver Birch of Kokomo.	
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the	R 0247	1. CORRECTIVE ACTION FOR RESIDENT IDENTIFIEDResident C's medication administration was reviewedat oncefollowing the citation.The physician was notified of all instances of insulin being	10/27/2025

resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.

Based on interview and record review, the facility failed to ensure insulin was administered according to the physician's order and the physician was notified when the order was not followed for 1 of 6 residents reviewed for medications. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 10/6/25 at 10:35 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus with diabetic nephropathy, hypoglycemia, and stage 3 chronic kidney disease.

A physician's order, dated 3/27/25, indicated to administer Humalog 2 units at bedtime if the blood glucose reading was greater than 250.

1. A Medication Administration Record (MAR), dated August 2025, indicated Resident C received Humalog 2 units at bedtime on the following dates with blood glucose readings less than 250.

a. On 8/11/25, with a blood glucose reading of 142.

administered when the blood glucose was under 250.No adverse effects were noted for Resident C. The physician reviewed and confirmed updated insulin parameters.TheQMAinvolved received immediate 1:1 re-education and counseling on insulin administration and following physician orders.The resident’s medication administration record (MAR) was audited and corrected to ensureaccuratedocumentation.2. IDENTIFICATION OF OTHER RESIDENTS POTENTIALLY AFFECTEDA 100% audit was completedall residents receiving insulin to ensure administration matched physician orders.Any discrepanciesidentifiedwere corrected, and the respective physicians were notified for clarification and updated orders as needed.No other residents were found to have insulin administered contrary to physician orders.3. SYSTEMIC CHANGES TO PREVENT RECURRENCEAll nursing staff received re-education on the facility’s Medication Administration Policy and Insulin Administration Guidelines, emphasizing:

Verification of blood glucose levels prior to insulin administration. Immediate notification of the physician when blood glucose readings do not align with current orders.Accurate documentation of blood glucose levels and administered doses on the MAR.A Competency Checklist on insulin administration and documentation was completed by all nurses by 10/24/25.The Director of Nursing (DON) reviewed and revised the

	b. On 8/14/25, with a blood glucose reading of 176. c. On 8/15/25, with a blood glucose reading of 125. d. On 8/17/25, with a blood glucose reading of 214. e. On 8/20/25, with a blood glucose reading of 230. f. On 8/21/25, with a blood glucose reading of 192. g. On 8/23/25, with a blood glucose reading of 173. h. On 8/24/25, with a blood glucose reading of 105. i. On 8/25/25, with a blood glucose reading of 250. j. On 8/27/25, with a blood glucose reading of 222. 2. A MAR, dated September 2025, indicated Resident C received Humalog 2 units at bedtime on the following dates with blood glucose readings less than 250. a. On 9/1/25, with a blood glucose reading of 149. b. On 9/4/25, with a blood glucose reading of 192. c. On 9/17/25, with a blood glucose reading of 224.		“Medication Administration Program Policy” to reinforce physician notification procedures and correct documentation practices.New signage was posted in the medication room reminding nurses: “Verify order ¿ Verify blood sugar ¿ Document ¿ Notify MD for variances.”4. MONITORING AND QUALITY ASSURANCEThe DON or designee will conduct random audits of five insulin-dependent residents’ MARs weekly for four weeks, then biweekly for two months, and monthly thereafter for three months to ensure compliance.Audit results will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee for review and continued oversight. Ongoing education or corrective action will be implemented immediatelyfor any non-complianceidentified.5. COMPLETION DATEAll corrective actions were completed by October 27, 2025.	

d. On 9/20/25, with a blood glucose reading of 187.

e. On 9/26/25, with a blood glucose reading of 162.

3. A MAR, dated October 2025, indicated Resident C received Humalog 2 units at bedtime on the following dates with blood glucose readings less than 250.

a. On 10/2/25, with a blood glucose reading of 200.

During an interview, on 10/7/25 at 11:00 a.m., the Director of Nursing indicated insulin should be administered according to the physician's order. The nurse should not have given insulin when the blood sugar was not over 250. The nurse should have contacted the doctor to adjust the order before administering.

A current facility policy, titled "Medication Administration Program Policy," dated 3/24/21 and received from the Administrator on 10/6/25 at 1:45 p.m., indicated "...Resident receives medications as prescribed...."

This citation relates to Intake IN00465066.

Based on interview and record review, the facility failed to ensure insulin was administered according to the physician's order and the physician was

notified when the order was not followed for 1 of 6 residents reviewed for medications. (Resident C)

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAntonio D Stewart	TITLEExecutive Director	(X6) DATE10/27/2025