

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/13/2024	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints IN00446341, IN00444901, IN00444774, IN00435166, IN00434264, IN00430789, IN00428631, IN00427639, IN00427436. Complaint IN00446341 - State deficiencies related to the allegations are cited at R0064. Complaint IN00444901 - No deficiencies related to the allegations are cited. Complaint IN00444774 - State deficiencies related to the allegations are cited at R0297. Complaint IN00435166 - No deficiencies related to the allegations are cited. Complaint IN00434264 - No deficiencies related to the allegations are cited.	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 accept this plan of correction for this survey. Please find the sufficient documentation 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. Should additional information be necessary to confirm said compliance, please feel free to contact Tony Stewart, Executive Director, Silver Birch of Kokomo.				

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Complaint IN00430789 - No deficiencies related to the allegations are cited.

Complaint IN00428631 - State deficiencies related to the allegations are cited at R0297.

Complaint IN00427639 - No deficiencies related to the allegations are cited.

Complaint IN00427436 - No deficiencies related to the allegations are cited.

Survey dates: November 12 and 13, 2024.

Facility number: 014137

Residential Census: 101

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality review was completed on November 15, 2024.

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R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure residents were free from misappropriation of property related to their narcotic and controlled substance medications were not kept safe from a staff member who diverted the narcotic and controlled medications for 4 of 4 residents reviewed for misappropriation of property. (Residents D, E, F and M) Findings include: A document, titled "Indiana State Department of Health Survey Report System," dated 10/29/24, indicated Resident D, E, and F accused QMA 2 of not giving them their narcotic medications as signed out in the Medication Administration Record (MAR). 1. During an interview, on 11/12/24 at 10:50 a.m., Resident D indicated she never requested narcotic pain	R 0064	R064: Resident Rights Residents D,E,F and M experienced no adverse effects related to the occurrence. All residents receiving narcotic and controlled substance medications had the potential to be affected. Audit of medication carts and narcotic records revealed no other issues. All staff administering medications were educated by the DON on 10/29/2024. New systems were initiated on 10/29/2024, in which staff were documenting all PRN medications given each shift. The following day the list is reviewed again by the nurse to ensure accuracy of medications given and proper documentation is being done. Shift to shift narcotic counts continue and are verified by licensed nurse. Review of PRN controlled substances not being utilized by residents completed and orders requested to discontinue medications. A QAPI plan has been initiated. To ensure ongoing compliance the DON/Designee will complete the audit tool "Controlled Substance Audit Tool" Monday-Friday until 100%	12/06/2024
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medication and only took Tylenol for pain.

The clinical record for Resident D was reviewed on 11/12/24 at 11:30 a.m. The diagnoses included, but were not limited to, major depressive disorder, hypertension, and type 2 diabetes.

A facility document, titled "Narcotic Inventory Sheet," dated 6/27/24, indicated the resident had Hydrocodone-APAP (Acetaminophen) 5-325 mg (milligrams) prescribed. The directions indicated to take 1 tablet by mouth every 6 hours as needed.

The narcotic inventory sheet indicated the medication was received from the pharmacy on 6/28/24. The medication had only been signed out by QMA 2 between the dates of 10/3/24 to 10/28/24.

The Medication Administration Record (MAR) for Resident D indicated the Hydrocodone-APAP 5-325 mg was not documented as given by QMA 2 on the dates between 10/3/24 to 10/28/24.

A written statement, dated 10/29/24, indicated Resident D did not ask for pain medication. She knew how many pills she received, and she took 7 pills in the morning and 3 pills in the

compliance is maintained for three consecutive months. Any issues noted during auditing will be immediately addressed. Audits will be reviewed in the monthly QAPI meeting. The QAPI plan will be reviewed and revised as needed at that time.

Date of compliance: December 6, 2026

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evening. Resident D indicated she counted her pills before taking them and indicated the number of pills she was taking had not changed.

2. The clinical record for Resident E was reviewed on 11/12/24 at 1:32 p.m. The diagnoses included, but were not limited to, pain, injury of peroneal nerve at lower leg level, and hypertension.

A facility document, titled "Narcotic Inventory Sheet," dated 9/25/24, indicated the resident had Oxycodone 5 mg prescribed. The directions indicated to take 1 tablet by mouth every 6 hours as needed for pain.

The narcotic inventory sheet indicated the medication was received from the pharmacy on 9/27/24. The medication had only been signed out by QMA 2 between the dates of 9/30/24 to 10/27/24.

The MAR for Resident E indicated the Oxycodone 5 mg was not documented as given by QMA 2 on the dates between 9/30/24 to 10/27/24.

A written statement, dated 10/29/24, indicated Resident E had not taken any pain medication since returning from the hospital on 10/24/24 and had not noticed any change in the medications she had been

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receiving.

3. During an interview, on 11/12/24 at 10:29 a.m., Resident F indicated she had not taken any of her narcotic pain medication because she did not like the side effects of the medication.

The clinical record for Resident F was reviewed on 11/12/24 at 10:50 a.m. The diagnoses included, but were not limited to, spinal stenosis (narrowing of space between the bone in the spine) of the lumbar region (lower back), spinal stenosis of the cervical region (neck), and pain.

A facility document, titled "Narcotic Inventory Sheet," dated 7/26/24 indicated the resident had Hydrocodone-APAP 5-325 mg prescribed. The directions indicated to take 1 tablet by mouth three times daily as needed for pain.

The narcotic inventory sheet indicated the medication had only been signed out by QMA 2 between the dates of 8/2/24 to 10/25/24.

The MAR for Resident F indicated the Hydrocodone-APAP 5-325 mg was not documented as given by QMA 2 on the dates between 8/2/24 to 10/25/24.

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A written statement, dated 10/29/24, indicated Resident F had never taken her prescribed Hydrocodone pain medication.

4. The clinical record for Resident M was reviewed on 11/13/24 at 2:05 p.m. The diagnoses included, but were not limited to, dementia, Alzheimer's, and anxiety disorder.

A facility document, titled "Narcotic Inventory Sheet," dated 8/28/24 indicated the resident had Lorazepam (a medication for anxiety) 0.5 mg prescribed. The directions indicated to take 1 tablet by mouth twice daily as needed.

The narcotic inventory sheet indicated the medication had been signed out by QMA 2 on 8/29/24 and between the dates of 9/2/24 to 10/16/24.

The MAR for Resident M indicated the Lorazepam 0.5 mg was not documented as given by QMA 2 on the dates between 9/2/24 to 10/16/24.

A written facility statement, dated 10/29/24, indicated QMA 4 was completing a narcotic audit when she noticed narcotics were signed out for three residents. The residents did not normally ask for pain medication. The medication was only signed out by QMA 2.

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A written facility statement, dated 10/29/24, indicated QMA 3 was informed by QMA 4, three residents narcotic count sheets had been signed repeatedly by QMA 2. The three residents did not call out for pain medication regularly.

A written facility statement by the Director of Nursing (DON), dated 10/29/24, indicated after reporting the concern to the Executive Director (ED), she reviewed the narcotic count sheets for the three residents. The DON discovered all 3 medications were signed out by QMA 2. QMA 2 was questioned about the narcotics.

A written facility statement by QMA 2, dated 10/29/24, indicated Resident D complained of pain in her eye from a recent eye surgery and of general pain throughout for the past week. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

A written facility statement by QMA 2, dated 10/29/24, indicated after Resident E returned from the hospital, there had been several occasions when the resident told her she was in pain. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

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A written facility statement by QMA 2, dated 10/29/24, indicated Resident F had been complaining of pain in her legs and of pain in general. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

During an interview, on 11/13/24 at 1:40 p.m., the DON indicated it was brought to her attention three narcotic count sheets for different residents had been signed out several times by QMA 2. The three residents did not normally request pain medication.

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During an interview, on 11/13/24 at 9:08 a.m., the DON indicated Resident M was not included in the Indiana State Department of Health Survey Report System because the discrepancy for Resident M was found after the report had been made and a statement was not obtained from Resident M due to her mental cognition deficits. If a QMA needed to administer an as needed medication, they should contact LPN 5 or the DON prior to giving the medication, and a note would be attached to the medication administration progress note in the MAR. QMA 2 did not contact LPN 5 or the DON prior to administering the as needed medications. QMA 2 did not document the administration of the medications in the MAR.

A current facility document, titled "Job Title: Qualified Medication Assistant (QMA)," dated as updated 5/23/22 indicated "...The QMA supports resident care that includes...administration of medications in alignment with documentation...The below statements are intended to describe the general nature and scope of work being performed by this position...Dispenses, administers, monitors and documents medications and treatments as prescribed by treating physicians and in accordance with scope of

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practice and company policy...documents in electronic health record the assistance provided to residents...After hours and when no manager or nurse is on duty in the community, the QMAs are designated person in charge and responsible for notifying the Executive Director and Director of Nursing and Wellness of any reportable occurrences during the shift...."

A current facility policy, titled "Core Process: Medication Administration," dated 01/24, indicated "...It is the duty and responsibility of all applicable team members to adhere to the Rights of Medication Administration without exception...PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician...The QMA must receive appropriate authorization for each administration of a PRN medication...All contacts with a nurse not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicated the time and date of the contact...QMA's may...Administer...(PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call...Obtain permission to

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administer the medication each time the symptoms occur in the resident...."

A current facility policy, titled "Medication Administration Program Policy," dated as last revised 3/24/21 and received by the DON on 11/12/24 at 11:32 a.m., indicated "...Our community will provide medication assistance to residents who request assistance. This service...will be in compliance with the state's administrative rule and regulation...Residents receiving medication assistance will have...Documentation of the medication name, dose, time taken by resident...The community Executive Director and Director of health and wellness will ensure adequate professional oversight of the medication administration program. The elements of an approved medication administration system are as follows...Written policies related to medication assistance and administration are followed by...Qualified Medication Aides (QMA's), within their scope of practice...Documentation in the medication record is complete and accurate...."

This citation relates to Complaint IN00446341.

Based on interview and record review, the facility failed to

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ensure residents were free from misappropriation of property related to their narcotic and controlled substance medications were not kept safe from a staff member who diverted the narcotic and controlled medications for 4 of 4 residents reviewed for misappropriation of property. (Residents D, E, F and M)

Findings include:

A document, titled "Indiana State Department of Health Survey Report System," dated 10/29/24, indicated Resident D, E, and F accused QMA 2 of not giving them their narcotic medications as signed out in the Medication Administration Record (MAR).

1. During an interview, on 11/12/24 at 10:50 a.m., Resident D indicated she never requested narcotic pain medication and only took Tylenol for pain.

The clinical record for Resident D was reviewed on 11/12/24 at 11:30 a.m. The diagnoses included, but were not limited to, major depressive disorder, hypertension, and type 2 diabetes.

A facility document, titled "Narcotic Inventory Sheet," dated 6/27/24, indicated the resident had Hydrocodone-APAP

(Acetaminophen) 5-325 mg (milligrams) prescribed. The directions indicated to take 1 tablet by mouth every 6 hours as needed.

The narcotic inventory sheet indicated the medication was received from the pharmacy on 6/28/24. The medication had only been signed out by QMA 2 between the dates of 10/3/24 to 10/28/24.

The Medication Administration Record (MAR) for Resident D indicated the Hydrocodone-APAP 5-325 mg was not documented as given by QMA 2 on the dates between 10/3/24 to 10/28/24.

A written statement, dated 10/29/24, indicated Resident D did not ask for pain medication. She knew how many pills she received, and she took 7 pills in the morning and 3 pills in the evening. Resident D indicated she counted her pills before taking them and indicated the number of pills she was taking had not changed.

2. The clinical record for Resident E was reviewed on 11/12/24 at 1:32 p.m. The diagnoses included, but were not limited to, pain, injury of peroneal nerve at lower leg level, and hypertension.

A facility document, titled "Narcotic Inventory Sheet,"

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dated 9/25/24, indicated the resident had Oxycodone 5 mg prescribed. The directions indicated to take 1 tablet by mouth every 6 hours as needed for pain.

The narcotic inventory sheet indicated the medication was received from the pharmacy on 9/27/24. The medication had only been signed out by QMA 2 between the dates of 9/30/24 to 10/27/24.

The MAR for Resident E indicated the Oxycodone 5 mg was not documented as given by QMA 2 on the dates between 9/30/24 to 10/27/24.

A written statement, dated 10/29/24, indicated Resident E had not taken any pain medication since returning from the hospital on 10/24/24 and had not noticed any change in the medications she had been receiving.

3. During an interview, on 11/12/24 at 10:29 a.m., Resident F indicated she had not taken any of her narcotic pain medication because she did not like the side effects of the medication.

The clinical record for Resident F was reviewed on 11/12/24 at 10:50 a.m. The diagnoses included, but were not limited to, spinal stenosis (narrowing of space between the bone in the

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spine) of the lumbar region (lower back), spinal stenosis of the cervical region (neck), and pain.

A facility document, titled "Narcotic Inventory Sheet," dated 7/26/24 indicated the resident had Hydrocodone-APAP 5-325 mg prescribed. The directions indicated to take 1 tablet by mouth three times daily as needed for pain.

The narcotic inventory sheet indicated the medication had only been signed out by QMA 2 between the dates of 8/2/24 to 10/25/24.

The MAR for Resident F indicated the Hydrocodone-APAP 5-325 mg was not documented as given by QMA 2 on the dates between 8/2/24 to 10/25/24.

A written statement, dated 10/29/24, indicated Resident F had never taken her prescribed Hydrocodone pain medication.

4. The clinical record for Resident M was reviewed on 11/13/24 at 2:05 p.m. The diagnoses included, but were not limited to, dementia, Alzheimer's, and anxiety disorder.

A facility document, titled "Narcotic Inventory Sheet," dated 8/28/24 indicated the

resident had Lorazepam (a medication for anxiety) 0.5 mg prescribed. The directions indicated to take 1 tablet by mouth twice daily as needed.

The narcotic inventory sheet indicated the medication had been signed out by QMA 2 on 8/29/24 and between the dates of 9/2/24 to 10/16/24.

The MAR for Resident M indicated the Lorazepam 0.5 mg was not documented as given by QMA 2 on the dates between 9/2/24 to 10/16/24.

A written facility statement, dated 10/29/24, indicated QMA 4 was completing a narcotic audit when she noticed narcotics were signed out for three residents. The residents did not normally ask for pain medication. The medication was only signed out by QMA 2.

A written facility statement, dated 10/29/24, indicated QMA 3 was informed by QMA 4, three residents narcotic count sheets had been signed repeatedly by QMA 2. The three residents did not call out for pain medication regularly.

A written facility statement by the Director of Nursing (DON), dated 10/29/24, indicated after reporting the concern to the Executive Director (ED), she reviewed the narcotic count sheets for the three residents.

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The DON discovered all 3 medications were signed out by QMA 2. QMA 2 was questioned about the narcotics.

A written facility statement by QMA 2, dated 10/29/24, indicated Resident D complained of pain in her eye from a recent eye surgery and of general pain throughout for the past week. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

A written facility statement by QMA 2, dated 10/29/24, indicated after Resident E returned from the hospital, there had been several occasions when the resident told her she was in pain. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

A written facility statement by QMA 2, dated 10/29/24, indicated Resident F had been complaining of pain in her legs and of pain in general. She had been putting the narcotic pain medication in the resident's pill cup with her other medications.

During an interview, on 11/13/24 at 1:40 p.m., the DON indicated it was brought to her attention three narcotic count sheets for different residents had been signed out several times by QMA 2. The three residents did

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not normally request pain medication.

During an interview, on 11/13/24 at 9:08 a.m., the DON indicated Resident M was not included in the Indiana State Department of Health Survey Report System because the discrepancy for Resident M was found after the report had been made and a statement was not obtained from Resident M due to her mental cognition deficits. If a QMA needed to administer an as needed medication, they should contact LPN 5 or the DON prior to giving the medication, and a note would be attached to the medication administration progress note in the MAR. QMA 2 did not contact LPN 5 or the DON prior to administering the as needed medications. QMA 2 did not document the administration of the medications in the MAR.

A current facility document, titled "Job Title: Qualified Medication Assistant (QMA)," dated as updated 5/23/22 indicated "...The QMA supports resident care that includes...administration of medications in alignment with documentation...The below statements are intended to describe the general nature and scope of work being performed by this position...Dispenses, administers, monitors and documents medications and

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treatments as prescribed by treating physicians and in accordance with scope of practice and company policy...documents in electronic health record the assistance provided to residents...After hours and when no manager or nurse is on duty in the community, the QMAs are designated person in charge and responsible for notifying the Executive Director and Director of Nursing and Wellness of any reportable occurrences during the shift...."

A current facility policy, titled "Core Process: Medication Administration," dated 01/24, indicated "...It is the duty and responsibility of all applicable team members to adhere to the Rights of Medication Administration without exception...PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician...The QMA must receive appropriate authorization for each administration of a PRN medication...All contacts with a nurse not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicated the time and date of the contact...QMA's may...Administer...(PRN) medication only if authorization

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	is obtained from the facility's licensed nurse on duty or on call...Obtain permission to administer the medication each time the symptoms occur in the resident...." A current facility policy, titled "Medication Administration Program Policy," dated as last revised 3/24/21 and received by the DON on 11/12/24 at 11:32 a.m., indicated "...Our community will provide medication assistance to residents who request assistance. This service...will be in compliance with the state's administrative rule and regulation...Residents receiving medication assistance will have...Documentation of the medication name, dose, time taken by resident...The community Executive Director and Director of health and wellness will ensure adequate professional oversight of the medication administration program. The elements of an approved medication administration system are as follows...Written policies related to medication assistance and administration are followed by...Qualified Medication Aides (QMA's), within their scope of practice...Documentation in the medication record is complete and accurate...."			
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	This citation relates to Complaint IN00446341.			
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 record review and interview, the facility failed to ensure staff met the	R 0117	R117: Personnel All residents had the potential to be affected by this finding. There were no adverse events which occurred. There was CPR certification class conducted 11-15-24. Currently all nursing staff with exception of one are CPR and first aid certified. Another class is scheduled for 11-27-24 and then 100% of clinical staff will be certified. Facility will also be reviewing all new clinical hires to ensure CPR and First Aid certification is present. In the event the new employee does not have current certification they will be provided with access to get this completed within 1 month of hire. A QAPI plan has been initiated. To ensure ongoing compliance the Business Office Manager will complete the audit tool "CPR Certification Audit Tool" monthly until 100% compliance is maintained for three consecutive months. Any issues noted during auditing will be immediately addressed. Audits will be reviewed in the monthly QAPI meeting. The QAPI plan	12/06/2024

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requirements of
Cardiopulmonary Resuscitation
(CPR) and first aid training for 7
of 21 shifts reviewed for CPR
and first aid.

Findings include:

A record review, on 11/13/24 at
11:00 a.m., indicated multiple
shifts from Sunday 11/3/24
through Saturday 11/9/24 were
not staffed with CPR and first
aid certified staff. The dates and
shifts included were:

a. Monday, 11/4/24, there was
no CPR coverage for the night
shift.

b. Tuesday, 11/5/24, there was
no first aid and CPR coverage
for the night shift.

c. Wednesday, 11/6/24, there
was no first aid coverage for the
night shift.

d. Thursday, 11/7/24, there was
no first aid and CPR coverage
for the night shift.

e. Friday, 11/8/24, there was no
first aid coverage for the night
shift.

f. Saturday, 11/9/24, there was
no CPR coverage for the
evening and night shift.

During an interview, on 11/13/24
at 2:30 p.m., the Business
Office Manager indicated
several shifts were missing CPR

will be reviewed and revised as
needed at that time.

Date of compliance: December
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and first aid coverage.

During an interview, on 11/13/24 at 3:12 p.m., the Director of Nursing (DON) indicated CPR, and first aid coverage was required every shift.

During an interview, on 11/13/24 at 3:45 p.m., the Executive Director indicated they did not have a CPR or first aid policy. The Wellness Nurse, Qualified Medication Assistant (QMA) and Certified Nursing Assistant (CNA) job descriptions indicated a valid CPR, and first aid certification was required.

The facility did not have a policy on CPR and first aid requirements.

Based on record review and interview, the facility failed to ensure staff met the requirements of Cardiopulmonary Resuscitation (CPR) and first aid training for 7 of 21 shifts reviewed for CPR and first aid.

Findings include:

A record review, on 11/13/24 at 11:00 a.m., indicated multiple shifts from Sunday 11/3/24 through Saturday 11/9/24 were not staffed with CPR and first aid certified staff. The dates and shifts included were:

a. Monday, 11/4/24, there was no CPR coverage for the night

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shift.

b. Tuesday, 11/5/24, there was no first aid and CPR coverage for the night shift.

c. Wednesday, 11/6/24, there was no first aid coverage for the night shift.

d. Thursday, 11/7/24, there was no first aid and CPR coverage for the night shift.

e. Friday, 11/8/24, there was no first aid coverage for the night shift.

f. Saturday, 11/9/24, there was no CPR coverage for the evening and night shift.

During an interview, on 11/13/24 at 2:30 p.m., the Business Office Manager indicated several shifts were missing CPR and first aid coverage.

During an interview, on 11/13/24 at 3:12 p.m., the Director of Nursing (DON) indicated CPR, and first aid coverage was required every shift.

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	During an interview, on 11/13/24 at 3:45 p.m., the Executive Director indicated they did not have a CPR or first aid policy. The Wellness Nurse, Qualified Medication Assistant (QMA) and Certified Nursing Assistant (CNA) job descriptions indicated a valid CPR, and first aid certification was required. The facility did not have a policy on CPR and first aid requirements.			
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 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 medications were available as prescribed for 1 of 1 resident reviewed for medication. (Resident J) Finding includes: During an interview, on 11/13/24 at 10:34 a.m., Resident J	R 0297	R297: Pharmaceutical Services Resident J had no adverse effects related to the finding. Resident has been receiving diabetic medication as ordered. All residents whom facility administers medication to have the potential to be affected. No residents have been identified with any adverse events related to this finding. Nursing staff inservice completed to discuss policy for missed medications. DONW/Designee will be reviewing Monday-Friday the Missed Medication Audit report in Point Click Care. New process has been implemented for staff passing medications. Any medication not available will be documented on	12/06/2024

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indicated several doses of her ordered diabetic medication were missed. The facility would run out of medication. The resident was told by Licensed Practical Nurse (LPN) 5 the diabetic medication was ordered.

The clinical record for Resident J was reviewed on 11/13/24 at 12:43 p.m. The diagnoses included, but were not limited to, diabetes mellitus, anxiety disorder, dementia, and major depressive disorder.

A physician's order, dated 10/4/24, indicated to inject 1 milligram of Ozempic (a medication to help manage diabetes mellitus) subcutaneously on Friday.

A Medication Administration Record (MAR), dated October 2024, indicated Ozempic was not given on 10/4/24 and 10/11/24. The reason documented on the MAR was the medication was not available.

During an interview, on 11/13/24 at 1:07 p.m., LPN 5 indicated the resident missed two doses of Ozempic.

During an interview, on 11/13/24 at 2:23 p.m., the Director of Nursing (DON) indicated the nursing staff needed to notify the pharmacy and the physician when a medication was

Missed Medication Sheet. The sheet is then reviewed by the nurse and necessary follow up is completed.

A QAPI plan has been initiated.

To ensure ongoing compliance the DON/Designee will complete the audit tool "Missed Medication Verification Audit Tool" Monday-Friday until 100% compliance is maintained for three consecutive months. Any issues noted during auditing will be immediately addressed. Audits will be reviewed in the monthly QAPI meeting. The QAPI plan will be reviewed and revised as needed at that time.

Date of compliance: December 6, 2024

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unavailable.

A current facility policy, titled "Core Process: Medication Administration," dated 1/2024 and received from the DON on 11/13/24 at 11:00 a.m., indicated "...Ensure medications are administered at the ordered time and frequency. Medications should be administered no more than an hour earlier than an ordered time and no later than one hour following...."

This citation relates to Complaint IN00428631 and IN00444774.

Based on interview and record review, the facility failed to ensure medications were available as prescribed for 1 of 1 resident reviewed for medication. (Resident J)

Finding includes:

During an interview, on 11/13/24 at 10:34 a.m., Resident J indicated several doses of her ordered diabetic medication were missed. The facility would run out of medication. The resident was told by Licensed Practical Nurse (LPN) 5 the diabetic medication was ordered.

The clinical record for Resident J was reviewed on 11/13/24 at 12:43 p.m. The diagnoses included, but were not limited to, diabetes mellitus, anxiety

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disorder, dementia, and major depressive disorder.

A physician's order, dated 10/4/24, indicated to inject 1 milligram of Ozempic (a medication to help manage diabetes mellitus) subcutaneously on Friday.

A Medication Administration Record (MAR), dated October 2024, indicated Ozempic was not given on 10/4/24 and 10/11/24. The reason documented on the MAR was the medication was not available.

During an interview, on 11/13/24 at 1:07 p.m., LPN 5 indicated the resident missed two doses of Ozempic.

During an interview, on 11/13/24 at 2:23 p.m., the Director of Nursing (DON) indicated the nursing staff needed to notify the pharmacy and the physician when a medication was unavailable.

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	A current facility policy, titled "Core Process: Medication Administration," dated 1/2024 and received from the DON on 11/13/24 at 11:00 a.m., indicated "...Ensure medications are administered at the ordered time and frequency. Medications should be administered no more than an hour earlier than an ordered time and no later than one hour following...." This citation relates to Complaint IN00428631 and IN00444774.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure residents had an annual health statement for 3 of 9 residents reviewed for annual health statements. (Residents B, D and H) Findings include: 1. The clinical record for Resident B was reviewed on	R 0409	R410: Infection Control Residents B,D,and H have now had annual health statements completed and signed by the practitioner. All residents have the potential to be affected. All residents have been audited to ensure that annual health statement has been documented. DONW has reached out to the provider to ensure annual health statement is completed. All orders for annual health statement have been updated to include statement that "Resident is free of communicable disease including tuberculosis in an infectious stage". A binder has been implemented to include health statements for	12/06/2024

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	11/12/24 at 1:00 p.m. The diagnoses included, but were not limited to, major depressive disorder, coronary artery disease, and chronic obstructive pulmonary disease (COPD). A physician signed annual health statement was not located in the resident's medical record prior to 11/13/24. 2. The clinical record for Resident D was reviewed on 11/12/24 at 2:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, major depressive disorder, and hypertension. A physician's order, dated 7/27/23, indicated the resident was free of communicable disease. Another physician signed annual health statement was not signed by the physician until 11/13/24 at 8:22 a.m. 3. The clinical record for Resident H was reviewed on 11/12/24 at 11:00 a.m. The diagnoses included, but were not limited to, COPD, hypertension, and chronic pain. A physician's order, dated 6/2/22, indicated the resident was free of communicable disease. A physician signed annual health statement was not		all residents in the community. Health statements will be obtained yearly in January. To ensure ongoing compliance the DON/Designee will complete the audit tool "Annual Health Statement and TB" Monthly ongoing until 100% compliance is maintained for three consecutive months. Any issues noted during auditing will be immediately addressed. Audits will be reviewed in the monthly QAPI meeting. The QAPI plan will be reviewed and revised as needed at that time. Date of compliance: December 6, 2024	
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located in the resident's medical record after 6/2/22.

During an interview, on 11/13/24 at 1:44 p.m., the Director of Nursing (DON) indicated the facility was to complete annual health statements yearly.

The facility did not provide an annual health statement or an annual health statement policy by the time of exit.

Based on interview and record review, the facility failed to ensure residents had an annual health statement for 3 of 9 residents reviewed for annual health statements. (Residents B, D and H)

Findings include:

1. The clinical record for Resident B was reviewed on 11/12/24 at 1:00 p.m. The diagnoses included, but were not limited to, major depressive disorder, coronary artery disease, and chronic obstructive pulmonary disease (COPD).

A physician signed annual health statement was not located in the resident's medical record prior to 11/13/24.

2. The clinical record for Resident D was reviewed on 11/12/24 at 2:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, major depressive disorder, and

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hypertension.

A physician's order, dated 7/27/23, indicated the resident was free of communicable disease.

Another physician signed annual health statement was not signed by the physician until 11/13/24 at 8:22 a.m.

3. The clinical record for Resident H was reviewed on 11/12/24 at 11:00 a.m. The diagnoses included, but were not limited to, COPD, hypertension, and chronic pain.

A physician's order, dated 6/2/22, indicated the resident was free of communicable disease.

A physician signed annual health statement was not located in the resident's medical record after 6/2/22.

During an interview, on 11/13/24 at 1:44 p.m., the Director of Nursing (DON) indicated the facility was to complete annual health statements yearly.

The facility did not provide an annual health statement or an annual health statement policy by the time of exit.

R 0410

Infection Control - Noncompliance
410 IAC 16.2-5-12(e)(f)(g)

R 0410

R410: Infection Control

Resident D no longer resides in

12/06/2024

(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.

(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on interview and record review, the facility failed to ensure a 2-step Mantoux tuberculosis test was completed prior to admission for 2 of 4 residents reviewed for infection control. (Residents D and G)

Findings include:

1. The clinical record for Resident D was reviewed on 11/12/24 at 1:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes

the facility. Resident G has had two step TB test completed.

All residents have the potential to be affected. An audit was completed of all residents TB testing. All residents admitting in the past 12 months were reviewed to ensure that 2 step Mantoux was completed.

A binder has been implemented to include health statements and TB tests/annual screens for all residents in the community. After initial 2 step Mantoux, the health screen for TB will be completed annually in January.

An admission checklist will be added to all new admission records to ensure all required information is completed for new admissions.

A binder has been implemented to include health statements for all residents in the community. Health statements will be obtained yearly in January.

mellitus with diabetic retinopathy and polyneuropathy, edema, and monoplegia (paralysis) of right dominant side arm following cerebral infarction (stroke).

The clinical record did not include a result for any Mantoux tuberculosis (TB) skin test, or an Interferon Gamma Release Assay (blood test to detect tuberculosis) given within 3 months of the resident's admission to the facility.

2. The clinical record for Resident G was reviewed on 11/12/24 at 1:45 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and viral hepatitis C.

The clinical record did not include the 2nd step Mantoux TB skin test within 3 months of the resident's admission to the facility.

During an interview, on 11/13/24 at 11:50 a.m., the Director of Nursing (DON) indicated she had not located any TB tests for Resident D or Resident G's 2nd step. She had emailed the physician to see if the office had any record of testing for TB.

The TB testing information was requested on 11/12/24 at 2:00 p.m., and again on 11/13/24 at

To ensure ongoing compliance the DON/Designee will complete the audit tool "Annual Health Statement and TB" Monthly ongoing until 100% compliance is maintained for three consecutive months. Any issues noted during auditing will be immediately addressed. Audits will be reviewed in the monthly QAPI meeting. The QAPI plan will be reviewed and revised as needed at that time.

Date of compliance: December 6, 2024

10:00 a.m.

On 11/13/24 at 2:30 p.m., the DON indicated the facility had not received any further information from the physician's office.

The facility did not provide any further TB testing results for either resident by survey exit on 11/13/24 at 4:05 p.m.

A current facility policy, titled "Tuberculosis Screening Policy," dated as revised on 1/23/19 and received from the DON on 11/13/24 at 3:45 p.m., indicated "...all residents are to be screened for active Tuberculosis (TB) at the time of move in...a tuberculin skin test must be completed upon admission...The result will be recorded...For residents who have not had a documented negative tuberculin skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method...."

Based on interview and record review, the facility failed to ensure a 2-step Mantoux tuberculosis test was completed prior to admission for 2 of 4 residents reviewed for infection control. (Residents D and G)

Findings include:

1. The clinical record for Resident D was reviewed on

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11/12/24 at 1:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic retinopathy and polyneuropathy, edema, and monoplegia (paralysis) of right dominant side arm following cerebral infarction (stroke).

The clinical record did not include a result for any Mantoux tuberculosis (TB) skin test, or an Interferon Gamma Release Assay (blood test to detect tuberculosis) given within 3 months of the resident's admission to the facility.

2. The clinical record for Resident G was reviewed on 11/12/24 at 1:45 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and viral hepatitis C.

The clinical record did not include the 2nd step Mantoux TB skin test within 3 months of the resident's admission to the facility.

During an interview, on 11/13/24 at 11:50 a.m., the Director of Nursing (DON) indicated she had not located any TB tests for Resident D or Resident G's 2nd step. She had emailed the physician to see if the office had any record of testing for TB.

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The TB testing information was requested on 11/12/24 at 2:00 p.m., and again on 11/13/24 at 10:00 a.m.

On 11/13/24 at 2:30 p.m., the DON indicated the facility had not received any further information from the physician's office.

The facility did not provide any further TB testing results for either resident by survey exit on 11/13/24 at 4:05 p.m.

A current facility policy, titled "Tuberculosis Screening Policy," dated as revised on 1/23/19 and received from the DON on 11/13/24 at 3:45 p.m., indicated "...all residents are to be screened for active Tuberculosis (TB) at the time of move in...a tuberculin skin test must be completed upon admission...The result will be recorded...For residents who have not had a documented negative tuberculin skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method...."

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