STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF EVANSVILLE	475 S GOVERNOR STREET, EVANSVILLE, , 47713

(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 IN00375979 and IN00378430. Complaint IN00375979 - Unsubstantiated. Due to lack of evidence. Complaint IN00378430 - Substantiated. State Residential Findings related to the allegations are cited at R 216, R 242, R 243. Survey date: May 4, 5, 2022 Facility number: 014238 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 11, 2022.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction provides the facility's credible evidence of compliance effective June 13, 2022. We respectfully ask for desk review and consideration for paper compliance of substantial compliance based on the POC	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d)	R 0216	What corrective action will be accomplished for those	06/13/2022

	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review the facility failed to ensure self-administration of medication assessments were completed for 1 of 3 residents reviewed for medications. (Resident B) Finding includes: During an interview on 5/4/22 at 8:50 A.M., the DON (Director of Nursing) indicated Resident B administered their own oral medications, and blood sugar testing and insulin injections were administered by staff.		residents found to have been affected by the deficient practice? Residents wishing to self-administer their own medications were reviewed by a licensed nurse and self-administration assessment was completed to determine resident ability to self-administer. 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 that self-administer medications could be affected by the same deficient practice 1. Licensed nurse will audit the residents that wish to self-administer medications and update their self-administration assessment. 2. Licensed nurse will assess residents on admission to determine if the resident is suitable for medication	

	During an interview on 5/4/22 at 9:09 A.M., Resident B indicated they gave themselves their own medications, and the medications were kept in their room. Resident B indicated blood sugar checks and injections were administered by staff. At that time, a box was observed on Resident B's table with a label for Spiriva Inhaler, as well as several medication blister packs on the counter. Resident B was alert and oriented. On 5/4/22 at 10:11 A.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, Type 2 Diabetes Mellitus. The most recent Self Administration of Medications Assessment, dated 9/4/20, indicated Resident B was unsafe to self deliver medications. Resident B's MAR (Medication Administration Record) for 4/2022 indicated oral medications given on 4/13/22 and everyday after were self administered. The current orders lacked a self administration of medications order. During an interview on 5/5/22 at 8:40 A.M., the DON indicated staff considered Resident B to self administer medications		self-administration 3. Residents that self-administer medications will be re-assessed quarterly; findings reported to Executive Director quarterly for review. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Licensed nurse will audit the residents that wish to self-administer medications and update their self-administration assessment. Licensed nurse will assess residents on admission to determine if the resident is suitable for medication self-administration Residents that self-administer medications will be re-assessed quarterly; findings reported to Executive Director quarterly for review	

	several months ago when nursing staff went to Resident B's room to administer medications and were asked by Resident B to leave them on the table, as they had a visitor at that time. The DON indicated to her knowledge, Resident B had been able to self administer medications since then. On 5/5/22 at 10:25 A.M., a current Medication Program for Self-Medication Policy was provided, revised 3/2/20, and indicated "Any resident wishing to administer their own medications will be assessed by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications" This Residential tag relates to Complaint IN00378430. Based on observation, interview, and record review the facility failed to ensure self-administration of medication assessments were completed for 1 of 3 residents reviewed for medications. (Resident B) Finding includes: During an interview on 5/4/22 at 8:50 A.M., the DON (Director of Nursing) indicated Resident B administered their own oral medications, and blood sugar testing and insulin injections		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? Quarterly review of residents that self-administer medications with findings forwarded toExecutive Director for review When systemic changes will be completed: Date: 6/13	

were administered by staff.

During an interview on 5/4/22 at 9:09 A.M., Resident B indicated they gave themselves their own medications, and the medications were kept in their room. Resident B indicated blood sugar checks and injections were administered by staff. At that time, a box was observed on Resident B's table with a label for Spiriva Inhaler, as well as several medication blister packs on the counter. Resident B was alert and oriented.

On 5/4/22 at 10:11 A.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, Type 2 Diabetes Mellitus.

The most recent Self Administration of Medications Assessment, dated 9/4/20, indicated Resident B was unsafe to self deliver medications.

Resident B's MAR (Medication Administration Record) for 4/2022 indicated oral medications given on 4/13/22 and everyday after were self administered.

The current orders lacked a self administration of medications order.

During an interview on 5/5/22 at 8:40 A.M., the DON indicated

	staff considered Resident B to self administer medications several months ago when nursing staff went to Resident B's room to administer medications and were asked by Resident B to leave them on the table, as they had a visitor at that time. The DON indicated to her knowledge, Resident B had been able to self administer medications since then. On 5/5/22 at 10:25 A.M., a current Medication Program for Self-Medication Policy was provided, revised 3/2/20, and indicated "Any resident wishing to administer their own medications will be assessed by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications" This Residential tag relates to Complaint IN00378430.			
R 0242	Health Services - Offense 410 IAC 16.2-5-4(e)(2) (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.	R 0242	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Education of staff administering tests or reporting parameters of effects of medications	06/13/2022

	Based on interview and record review, the facility failed to ensure the physician was notified as ordered for high glucose levels. A resident's physician was not notified for glucose levels over 350 for 1 of 3 residents reviewed for insulin. (Resident B) Finding includes: On 5/4/22 at 10:11 A.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, Type 2 Diabetes Mellitus. Current orders included, but were not limited to: NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 150-190 = 3 units 191-230 = 6 units 231-270 = 9 units 271-310 = 12 units 311-350 = 15 units subcutaneously three times a day, ordered at 0700, 1100, and 1600, started 3/30/22 Current orders included, but were not limited to:		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 that have accucheck orders will be reviewed and parameters entered in electronic chart to alert staff when to call for an adverse result What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? DON will run alert report daily and assess and report on residents that have had a blood sugar higher than parameter 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;	

	NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 200-250 = 3 units 251-300 = 5 units 301-999 - 7 units 350 or above call the md, subcutaneously at bedtime, ordered at 1900, started 4/20/22 Resident B's MAR (Medication Administration Record) from 3/1/2022 through 4/13/2022 indicated the following blood sugar levels over 350 that lacked notification to the physician: 3/1/22 366 3/9/22 364 3/12/22 355 3/22/22 374 3/28/22 475 and 350 3/29/22 377 and 390 3/30/22 462 4/6/22 350 4/10/22 353 x2 4/11/22 350 and 354 4/13/22 356		Daily Alert report will be reviewed daily When systemic changes will be completed: Date: 6/13	

	During an interview on 5/4/22 at 11:02 A.M., QMA 5 (Qualified Medication Aide) and RN 13 (Registered Nurse) indicated when blood sugar levels were out of the perimeters on the resident's orders, staff should notify the resident's physician by calling and fax, then document the notification in the resident's clinical record. During an interview on 5/5/22 at 8:58 A.M., the DON (Director of Nursing) indicated she was unsure if Resident B's physician was notified after each blood sugar over 350, and would need to speak with the staff that had worked to see of they remembered notifying the physician. On 5/5/22 at 10:25 A.M., a current Resident Change in Condition Policy and Procedure, dated 9/22/21, was provided and indicated "The physician and family, or legal representative, will be notified of a change in a resident's status ... The following are some, but not all of the reasons for notification ... Treatment previously prescribed that is not effective" This Residential tag relates to Complaint IN00378430. Based on interview and record review, the facility failed to ensure the physician was			

	notified as ordered for high glucose levels. A resident's physician was not notified for glucose levels over 350 for 1 of 3 residents reviewed for insulin. (Resident B) Finding includes: On 5/4/22 at 10:11 A.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, Type 2 Diabetes Mellitus. Current orders included, but were not limited to: NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 150-190 = 3 units 191-230 = 6 units 231-270 = 9 units 271-310 = 12 units 311-350 = 15 units subcutaneously three times a day, ordered at 0700, 1100, and 1600, started 3/30/22 Current orders included, but were not limited to:			

	NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 200-250 = 3 units 251-300 = 5 units 301-999 - 7 units 350 or above call the md, subcutaneously at bedtime, ordered at 1900, started 4/20/22 Resident B's MAR (Medication Administration Record) from 3/1/2022 through 4/13/2022 indicated the following blood sugar levels over 350 that lacked notification to the physician: 3/1/22 366 3/9/22 364 3/12/22 355 3/22/22 374 3/28/22 475 and 350 3/29/22 377 and 390 3/30/22 462 4/6/22 350 4/10/22 353 x2 4/11/22 350 and 354 4/13/22 356			

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R 0243	Health Services - Deficiency	R 0243	What corrective action will be accomplished for those	06/13/2022

410 IAC 16.2-5-4(e)(3)

(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:

(A) time;

(B) name of medication or treatment;

(C) dosage (if applicable); and

(D) name or initials of the person administering the drug or treatment.

Based on record interview and record review, the facility failed to ensure ordered medications were documented as given for 2 of 3 residents reviewed for medication administration. (Resident D, Resident C)

Findings include:

1. On 5/4/22 at 12:29 P.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, malignant neoplasm of bones of skull and face, secondary malignant neoplasm of lung, and seizure disorder.

Physician orders included, but were not limited to:

HYDROcodone-Acetaminophen (a pain medication) Tablet 10-325, 1 tablet every 6 hours scheduled at 0200, 0800, 1400,

residents found to have been affected by the deficient practice.

Nurse/QMA will receive in-service on policy of Medication Administration

Missed Medication report reviewed twice daily by licensed nurse

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:

Missed Medication reports will be reviewed daily to identify any missed medications. Missed medications will be reviewed and documented by licensed nurse

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

Licensed nurse to review report of missed medications twice

	and 2000, started 10/7/21 through 4/12/22 HYDROcodone-Acetaminophen (a pain medication) Tablet 10-325, 1 tablet four times a day scheduled at 0600, 1100, 1600, 1900, started 4/12/22 through 4/20/22 Resident D's MAR (Medication Administration Record) from 2/2022 through 4/2022 indicated the following times HYDROcodone-Acetaminophen was not given: 2/1/22 at 1400 2/20/22 at 0200 3/11/22 at 0200 3/14/22 at 0200 3/21/22 at 1400 3/25/22 at 1400 4/2/22 at 1400 4/3/22 at 1400 4/7/22 at 1400 4/9/22 at 0200 4/10/22 at 0200 4/18/22 at 1100 On 5/5/22 at 8:58 A.M., Resident D's Controlled Drug Use Record from 2/2022 through 4/2022 was reviewed		daily and document reason a medication was missed 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. Licensed nurse to review report of missed medications twice daily and document reason a medication was missed When systemic changes will be completed: Date: 6/13	

with the DON (Director of Nursing). The following dates a HYDROcodone-Acetaminophen 10-325 was taken from the medication cart:

2/1/22 at 1300

2/20/22 at 0200

3/11/22 at 0200

3/14/22 at 0200

3/21/22 at 1300

3/25/22 at 1200

4/2/22 at 1200

4/3/22 at 1200

4/7/22 at 1230

4/18/22 at 1100

At that time, the DON indicated she was unsure why the medications pulled from the medication cart were not documented in the MAR as given.

2. On 5/4/22 at 12:29 P.M., Resident C's clinical record was reviewed. Diagnosis included, but were not limited to, schizoaffective disorder, and major depressive disorder.

Resident C's MAR from 2/2022 through 5/2022 was reviewed and indicated the following orders and medications that were not given:

Atorvastitin Calcium Tablet 80mg (milligram), 1 tablet at bedtime: not given on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22

diphenhydramine hcl tablet 25mg, 1 tablet at bedtime: not given on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

Invega Sustenna Suspension prefilled syringe 234mg/1.5ml (milliliter) (Paliperidone Palmitate ER) inject 1.5ml intramuscularly one time a day every 28 days: not given on 2/23/22

Levothyroxine Sodium tablet 75mcg, 1 tablet in thee morning: not given on 2/5/22, 2/7/22, 2/11/22, 2/12/22 2/13/22, 2/20/22, 3/11/22, 3/23/22, 3/28/22, 4/6/22, 4/11/22, 4/12/22, 4/13/22, 4/14/22

Quetiapine Fumarate tablet 400mg, 1 tablet at bedtime: not given on 2/18/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

haloperidol tablet 5mg, 1 tablet two times a day: not given at 1900 on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/18/22,

4/23/22, 4/30/22, 5/1/22

Norco tablet 5-325mg, 1 tablet two times a day: not given at 1900 on 2/18/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

Metoprolol tartrate tablet 25mg, 1 tablet two times a day: not given at 1900 on 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

metformin hcl tablet 500mg, 1 tablet two times a day: not given at 1700 on 4/14/22, 4/23/22, 4/30/22, 5/1/22

During an interview on 5/5/22 at 8:41 A.M., the DON indicated staff administering medications should have put a code in the MAR to indicate why a medication was not given if not administered. She further indicated the same staff member was working on several days that Resident C was not administered medications, and believed he gave the medications, but did not document them as given.

On 5/5/22 at 10:25 A.M., a current Medication Administration Program Policy, dated 8/1/18, was provided and indicated "Residents receiving medication assistance will have: ... Documentation of the medication name, dose, time taken by resident ... Medication record is correctly noted, with

signatures and explanations for missed medications noted properly"

This Residential tag relates to Complaint IN00378430.

Based on record interview and record review, the facility failed to ensure ordered medications were documented as given for 2 of 3 residents reviewed for medication administration. (Resident D, Resident C)

Findings include:

1. On 5/4/22 at 12:29 P.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, malignant neoplasm of bones of skull and face, secondary malignant neoplasm of lung, and seizure disorder.

Physician orders included, but were not limited to:

HYDROcodone-Acetaminophen (a pain medication) Tablet 10-325, 1 tablet every 6 hours scheduled at 0200, 0800, 1400, and 2000, started 10/7/21 through 4/12/22

HYDROcodone-Acetaminophen (a pain medication) Tablet 10-325, 1 tablet four times a day scheduled at 0600, 1100, 1600, 1900, started 4/12/22 through 4/20/22

Resident D's MAR (Medication

Administration Record) from 2/2022 through 4/2022 indicated the following times HYDROcodone-Acetaminophen was not given:

2/1/22 at 1400

2/20/22 at 0200

3/11/22 at 0200

3/14/22 at 0200

3/21/22 at 1400

3/25/22 at 1400

4/2/22 at 1400

4/3/22 at 1400

4/7/22 at 1400

4/9/22 at 0200

4/10/22 at 0200

4/18/22 at 1100

On 5/5/22 at 8:58 A.M., Resident D's Controlled Drug Use Record from 2/2022 through 4/2022 was reviewed with the DON (Director of Nursing). The following dates a HYDROcodone-Acetaminophen 10-325 was taken from the medication cart:

2/1/22 at 1300

2/20/22 at 0200

3/11/22 at 0200

3/14/22 at 0200

3/21/22 at 1300

3/25/22 at 1200

4/2/22 at 1200

4/3/22 at 1200

4/7/22 at 1230

4/18/22 at 1100

At that time, the DON indicated she was unsure why the medications pulled from the medication cart were not documented in the MAR as given.

2. On 5/4/22 at 12:29 P.M., Resident C's clinical record was reviewed. Diagnosis included, but were not limited to, schizoaffective disorder, and major depressive disorder.

Resident C's MAR from 2/2022 through 5/2022 was reviewed and indicated the following orders and medications that were not given:

Atorvastitin Calcium Tablet 80mg (milligram), 1 tablet at bedtime: not given on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22

diphenhydramine hcl tablet 25mg, 1 tablet at bedtime: not

given on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

Invega Sustenna Suspension prefilled syringe 234mg/1.5ml (milliliter) (Paliperidone Palmitate ER) inject 1.5ml intramuscularly one time a day every 28 days: not given on 2/23/22

Levothyroxine Sodium tablet 75mcg, 1 tablet in thee morning: not given on 2/5/22, 2/7/22, 2/11/22, 2/12/22 2/13/22, 2/20/22, 3/11/22, 3/23/22, 3/28/22, 4/6/22, 4/11/22, 4/12/22, 4/13/22, 4/14/22

Quetiapine Fumarate tablet 400mg, 1 tablet at bedtime: not given on 2/18/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

haloperidol tablet 5mg, 1 tablet two times a day: not given at 1900 on 2/18/22, 3/30/22, 4/11/22, 4/14/22, 4/18/22, 4/23/22, 4/30/22, 5/1/22

Norco tablet 5-325mg, 1 tablet two times a day: not given at 1900 on 2/18/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

Metoprolol tartrate tablet 25mg, 1 tablet two times a day: not given at 1900 on 3/30/22, 4/11/22, 4/14/22, 4/23/22, 4/30/22, 5/1/22

	metformin hcl tablet 500mg, 1 tablet two times a day: not given at 1700 on 4/14/22, 4/23/22, 4/30/22, 5/1/22 During an interview on 5/5/22 at 8:41 A.M., the DON indicated staff administering medications should have put a code in the MAR to indicate why a medication was not given if not administered. She further indicated the same staff member was working on several days that Resident C was not administered medications, and believed he gave the medications, but did not document them as given. On 5/5/22 at 10:25 A.M., a current Medication Administration Program Policy, dated 8/1/18, was provided and indicated "Residents receiving medication assistance will have: ... Documentation of the medication name, dose, time taken by resident ... Medication record is correctly noted, with signatures and explanations for missed medications noted properly" This Residential tag relates to Complaint IN00378430.			

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