STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/25/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00446328 and IN00447740. Complaint IN00446328 - State deficiencies related to the allegations are cited at R349. Complaint IN00447740 - No deficiencies related to the allegations are cited. Survey dates: November 21, 22, & 25, 2024 Facility number: 014238 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 1, 2024.	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provided of the truth of facts alleged or correction set forth on the statements 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 documentations 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 check review. Should additional information be	

			necessary to confirm said compliance, please feel free to contact Dee Jolly, Executive Director, Silver Birch Living. Submission of this plan of correction does not constitute admission or agreement by the provided of the Birch of Evansville.	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (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. 5. On 11/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included,	R 0216	DONW or designee will educate all nursing staff on documentation of vitals including weights each month per orders. Staff education will be completed by 12/17/24. DONW or designee will perform an audit monitoring weights weekly for two weeks, then every other week for two weeks then monthly for six months, to ensure compliance.	12/17/2024

but were not limited to, diabetes mellitus. The resident was admitted to the facility on 10/4/22.

A Weights and Vitals Summary, provided by the Director of Nursing (DON) on 11/22/24 at 12:30 P.M., indicated Resident C was weighed by the facility on 1/9/24 and self-reported a weight on 8/2/24.

On 11/25/24 at 10:55 A.M., the DON indicated that she preferred to weigh residents every month, but the facility policy was to weigh residents every three months.

On 11/25/24 at 12:28 P.M., the DON provided a current Weight Monitoring policy, effective 2/14/20, that indicated "It is the policy of Silver Birch Living that all residents will be weighed upon admission and at least semiannually thereafter".

Based on interview and record review, the facility failed to ensure residents' weights were taken or recorded semiannually for 5 of 8 residents reviewed for weights after admission. (Resident 1, Resident T, Resident 6, Resident 7, Resident C)

Findings include:

1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included,

	but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23. Resident 1's clinical record did not include a weight taken between 3/2/24 through 9/30/24. 2. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21. Resident T's clinical record did not include a weight taken between 2/2/24 through 10/1/24. 3. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22. Resident 6's clinical record did not include a weight taken between 1/10/24 through 9/30/24. 4. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. Resident 7's clinical record did not include a weight taken			

	between 6/27/23 through 3/24/24. 5. On 11/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted to the facility on 10/4/22. A Weights and Vitals Summary, provided by the Director of Nursing (DON) on 11/22/24 at 12:30 P.M., indicated Resident C was weighed by the facility on 1/9/24 and self-reported a weight on 8/2/24. On 11/25/24 at 10:55 A.M., the DON indicated that she preferred to weigh residents every month, but the facility policy was to weigh residents every three months. On 11/25/24 at 12:28 P.M., the DON provided a current Weight Monitoring policy, effective 2/14/20, that indicated "It is the policy of Silver Birch Living that all residents will be weighed upon admission and at least semiannually thereafter".			

	Based on interview and record review, the facility failed to ensure residents' weights were taken or recorded semiannually for 5 of 8 residents reviewed for weights after admission. (Resident 1, Resident T, Resident 6, Resident 7, Resident C) Findings include: 1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23. Resident 1's clinical record did not include a weight taken between 3/2/24 through 9/30/24. 2. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21. Resident T's clinical record did not include a weight taken between 2/2/24 through 10/1/24. 3. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22.			

Resident 6's clinical record did not include a weight taken between 1/10/24 through 9/30/24.

4. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23.

Resident 7's clinical record did not include a weight taken between 6/27/23 through 3/24/24.

5. On 11/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted to the facility on 10/4/22.

A Weights and Vitals Summary, provided by the Director of Nursing (DON) on 11/22/24 at 12:30 P.M., indicated Resident C was weighed by the facility on 1/9/24 and self-reported a weight on 8/2/24.

On 11/25/24 at 10:55 A.M., the DON indicated that she preferred to weigh residents every month, but the facility policy was to weigh residents every three months.

On 11/25/24 at 12:28 P.M., the DON provided a current Weight Monitoring policy, effective

	2/14/20, that indicated "It is the policy of Silver Birch Living that all residents will be weighed upon admission and at least semiannually thereafter". Based on interview and record review, the facility failed to ensure residents' weights were taken or recorded semiannually for 5 of 8 residents reviewed for weights after admission. (Resident 1, Resident T, Resident 6, Resident 7, Resident C) Findings include: 1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23. Resident 1's clinical record did not include a weight taken between 3/2/24 through 9/30/24. 2. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21. Resident T's clinical record did not include a weight taken between 2/2/24 through 10/1/24. 3. On 11/22/24 at 1:04 P.M.,			

	Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22. Resident 6's clinical record did not include a weight taken between 1/10/24 through 9/30/24. 4. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. Resident 7's clinical record did not include a weight taken between 6/27/23 through 3/24/24. 5. On 11/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted to the facility on 10/4/22. A Weights and Vitals Summary, provided by the Director of Nursing (DON) on 11/22/24 at 12:30 P.M., indicated Resident C was weighed by the facility on 1/9/24 and self-reported a weight on 8/2/24. On 11/25/24 at 10:55 A.M., the DON indicated that she preferred to weigh residents every month, but the facility			

policy was to weigh residents every three months.

On 11/25/24 at 12:28 P.M., the DON provided a current Weight Monitoring policy, effective 2/14/20, that indicated "It is the policy of Silver Birch Living that all residents will be weighed upon admission and at least semiannually thereafter".

Based on interview and record review, the facility failed to ensure residents' weights were taken or recorded semiannually for 5 of 8 residents reviewed for weights after admission. (Resident 1, Resident T, Resident 6, Resident 7, Resident C)

Findings include:

1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23.

Resident 1's clinical record did not include a weight taken between 3/2/24 through 9/30/24.

2. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21.

	Resident T's clinical record did not include a weight taken between 2/2/24 through 10/1/24. 3. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22. Resident 6's clinical record did not include a weight taken between 1/10/24 through 9/30/24. 4. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. Resident 7's clinical record did not include a weight taken between 6/27/23 through 3/24/24.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the:	R 0217	DONW or designee will educate all nursing staff on residents signing and dating all service plans. Staff education will be completed by 12/17/24. DONW or designee will perform an audit that will be done	12/17/2024

	(A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed and dated for 7 of 8 residents who received services in the facility. (Resident 1, Resident M, Resident T,		weekly for two weeks, then every two weeks for two weeks, then monthly for six months. To ensure compliance.	

Resident 6, Resident 7, Resident 8, Resident D)

Findings include:

1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23.

The most recent service plan, completed on 7/4/24, was not signed or dated by Resident 1.

2. On 11/21/24 at 2:18 P.M. Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident M was admitted on 3/1/24.

The most recent service plan, completed on 6/27/24, was not signed or dated by Resident M.

3. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21.

The most recent service plan, completed on 7/12/24, was not signed or dated by Resident T.

4. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major

	depressive disorder. Resident 6 was admitted on 3/27/22. The clinical record lacked a service plan review completed since 7/25/23. 5. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident 7. 6. On 11/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Resident D was admitted to the facility on 2/8/23. The most current Resident Service Plan, completed on 6/27/24, was not signed or dated by the resident. 7. On 11/21/24 at 2:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 8 was admitted to the facility on 11/2/21.			

The most current Resident Service Plan, completed on 9/27/24, was not signed or dated by the resident.

On 11/22/24 at 8:19 A.M., the Director of Nursing (DON) indicated she could not find signed service plans and that she had the residents that were included in the survey sample sign their service plans on 11/21/24. At that time, the DON provided the service plans that were signed on 11/21/24. They were not dated.

On 11/25/24 at 12:35 P.M., the DON indicated the facility did not have a service plan policy, but she expected service plans to be signed and dated as per the State regulation.

Based on interview and record review, the facility failed to ensure service plans were signed and dated for 7 of 8 residents who received services in the facility. (Resident 1, Resident M, Resident T, Resident 6, Resident 7, Resident 8, Resident D)

Findings include:

1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23.

	The most recent service plan, completed on 7/4/24, was not signed or dated by Resident 1. 2. On 11/21/24 at 2:18 P.M. Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident M was admitted on 3/1/24. The most recent service plan, completed on 6/27/24, was not signed or dated by Resident M. 3. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident T. 4. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22. The clinical record lacked a service plan review completed since 7/25/23. 5. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on			

	6/9/23. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident 7. 6. On 11/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Resident D was admitted to the facility on 2/8/23. The most current Resident Service Plan, completed on 6/27/24, was not signed or dated by the resident. 7. On 11/21/24 at 2:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 8 was admitted to the facility on 11/2/21. The most current Resident Service Plan, completed on 9/27/24, was not signed or dated by the resident. On 11/22/24 at 8:19 A.M., the Director of Nursing (DON) indicated she could not find signed service plans and that she had the residents that were included in the survey sample sign their service plans on 11/21/24. At that time, the DON provided the service plans that were signed on 11/21/24. They were not dated.			

	On 11/25/24 at 12:35 P.M., the DON indicated the facility did not have a service plan policy, but she expected service plans to be signed and dated as per the State regulation. Based on interview and record review, the facility failed to ensure service plans were signed and dated for 7 of 8 residents who received services in the facility. (Resident 1, Resident M, Resident T, Resident 6, Resident 7, Resident 8, Resident D) Findings include: 1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23. The most recent service plan, completed on 7/4/24, was not signed or dated by Resident 1. 2. On 11/21/24 at 2:18 P.M. Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident M was admitted on 3/1/24. The most recent service plan, completed on 6/27/24, was not signed or dated by Resident M. 3. On 11/21/24 at 2:39 P.M.,			

	Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident T. 4. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22. The clinical record lacked a service plan review completed since 7/25/23. 5. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident 7. 6. On 11/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Resident D was admitted to the facility on 2/8/23. The most current Resident Service Plan, completed on 6/27/24, was not signed or			

dated by the resident.

7. On 11/21/24 at 2:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 8 was admitted to the facility on 11/2/21.

The most current Resident Service Plan, completed on 9/27/24, was not signed or dated by the resident.

On 11/22/24 at 8:19 A.M., the Director of Nursing (DON) indicated she could not find signed service plans and that she had the residents that were included in the survey sample sign their service plans on 11/21/24. At that time, the DON provided the service plans that were signed on 11/21/24. They were not dated.

On 11/25/24 at 12:35 P.M., the DON indicated the facility did not have a service plan policy, but she expected service plans to be signed and dated as per the State regulation.

Based on interview and record review, the facility failed to ensure service plans were signed and dated for 7 of 8 residents who received services in the facility. (Resident 1, Resident M, Resident T, Resident 6, Resident 7, Resident 8, Resident D)

Findings include:

1. On 11/21/24 at 2:00 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident 1 was admitted on 4/3/23.

The most recent service plan, completed on 7/4/24, was not signed or dated by Resident 1.

2. On 11/21/24 at 2:18 P.M. Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident M was admitted on 3/1/24.

The most recent service plan, completed on 6/27/24, was not signed or dated by Resident M.

3. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction. Resident T was admitted on 12/3/21.

The most recent service plan, completed on 7/12/24, was not signed or dated by Resident T.

4. On 11/22/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident 6 was admitted on 3/27/22.

	The clinical record lacked a service plan review completed since 7/25/23. 5. On 11/22/24 at 1:18 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Resident was admitted on 6/9/23. The most recent service plan, completed on 7/12/24, was not signed or dated by Resident 7. 6. On 11/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Resident D was admitted to the facility on 2/8/23. The most current Resident Service Plan, completed on 6/27/24, was not signed or dated by the resident. 7. On 11/21/24 at 2:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 8 was admitted to the facility on 11/2/21. The most current Resident Service Plan, completed on 9/27/24, was not signed or dated by the resident. On 11/22/24 at 8:19 A.M., the Director of Nursing (DON)			

	indicated she could not find signed service plans and that she had the residents that were included in the survey sample sign their service plans on 11/21/24. At that time, the DON provided the service plans that were signed on 11/21/24. They were not dated. On 11/25/24 at 12:35 P.M., the DON indicated the facility did not have a service plan policy, but she expected service plans to be signed and dated as per the State regulation.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for 3 of 3 medication carts observed. (100 Hall Medication Cart, 200 Hall Medication Cart, 300 Hall Medication Cart)	R 0300	DONW or designee will educate all QMA's and nurse's on proper medication labeling and storage. Education to be completed by 12/17/24. DONW or designee will complete an audit weekly for three weeks, then every two weeks for two weeks, then monthly for six months, to ensure compliance.	12/17/2024

Findings include:

1. On 11/21/24 at 9:20 A.M., the following was observed in the 200 Hall Medication Cart:

6 ondansetron (nausea medication) 4 mg (Milligram) pills without name and label

1 large bottle of Tums (antacid) for (Resident Name) without label or open date

2. On 11/21/24 at 9:46 A.M., the following was observed in the 300 Hall Medication Cart:

Airsupra (bronchodilator) inhaler without a name, label, or date opened

1 large oblong blue pill

1 small round pink pill

3. On 11/21/24 at 9:50 A.M., the following was observed in the 100 Hall Medication Cart:

1 small round peach pill

2 small round pink pills

1 bottle of Tussin DM (cough medicine) without a name, label, or open date

1 bottle of B12 (vitamin) without a name, label, or open date

During an interview on 11/21/24 at 9:22 A.M., QMA (Qualified Medication Aide) 7 indicated the

	Tums should have been discontinued because that resident had been discharged, there should be no loose pills in the medication cart, and everything should be labeled and dated. During an interview on 11/21/24 at 9:52 A.M., QMA 3 indicated bottles should be dated and labeled. On 11/25/24 at 12:29 P.M., the DON (Director of Nursing) provided a current Medication Administration Program policy, revised 3/24/21, that indicated "...the community will obtain prescribed medical authorization including a prescription label completed by a licensed pharmacy...and an area for storing medications in accordance with the Board of Pharmacy requirements...storage of medication is proper, separate from food and toxic chemicals, and accessible only to designated staff or appropriate resident...". Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for 3 of 3 medication carts observed. (100 Hall Medication Cart, 200 Hall Medication Cart, 300 Hall Medication Cart)			

Findings include:

1. On 11/21/24 at 9:20 A.M., the following was observed in the 200 Hall Medication Cart:

6 ondansetron (nausea medication) 4 mg (Milligram) pills without name and label

1 large bottle of Tums (antacid) for (Resident Name) without label or open date

2. On 11/21/24 at 9:46 A.M., the following was observed in the 300 Hall Medication Cart:

Airsupra (bronchodilator) inhaler without a name, label, or date opened

1 large oblong blue pill

1 small round pink pill

3. On 11/21/24 at 9:50 A.M., the following was observed in the 100 Hall Medication Cart:

1 small round peach pill

2 small round pink pills

1 bottle of Tussin DM (cough medicine) without a name, label, or open date

1 bottle of B12 (vitamin) without a name, label, or open date

During an interview on 11/21/24 at 9:22 A.M., QMA (Qualified Medication Aide) 7 indicated the

	Tums should have been discontinued because that resident had been discharged, there should be no loose pills in the medication cart, and everything should be labeled and dated. During an interview on 11/21/24 at 9:52 A.M., QMA 3 indicated bottles should be dated and labeled. On 11/25/24 at 12:29 P.M., the DON (Director of Nursing) provided a current Medication Administration Program policy, revised 3/24/21, that indicated "...the community will obtain prescribed medical authorization including a prescription label completed by a licensed pharmacy...and an area for storing medications in accordance with the Board of Pharmacy requirements...storage of medication is proper, separate from food and toxic chemicals, and accessible only to designated staff or appropriate resident...".			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name.	R 0301	DONW or designee will educate all QMA's and nurses on proper medication labeling and storage. Staff education to be completed by 12/17/24.	12/17/2024

	(B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to ensure medication was labeled in 2 of 3 medication carts reviewed. Insulin pens were not labeled. (200 Hall Medication Cart, 300 Hall Medication Cart) Findings include: 1. On 11/21/24 at 9:20 A.M., a Humalog insulin pen was observed laying in a drawer in the 200 Hall Medication Cart without a label or an open date. 2. On 11/21/24 at 9:40 A.M., the following was observed lying in a drawer in the 300 Hall Medication Cart:		DONW or designee will complete an audit weekly for three weeks, then every two weeks for two weeks, then monthly for six months, to ensure compliance.	

	2 Lantus insulin pens without a name, label, and open date 1 Humalog insulin pen without a name, label, and open date 1 Humalog insulin pen with (Resident Name) written in black marker, no label and open date During an interview on 11/21/24 at 9:44 A.M., QMA (Qualified Medication Aide) 11 indicated the pens should be labeled, dated, and locked in the medication drawer in the resident's room. On 11/25/24 at 12:29 P.M., the DON (Director of Nursing) provided a current Medication Administration Program policy, revised 3/24/21, that indicated "...the community will obtain prescribed medical authorization including a prescription label completed by a licensed pharmacy...and an area for storing medications in accordance with the Board of Pharmacy requirements...". Based on observation, interview, and record review, the facility failed to ensure medication was labeled in 2 of 3 medication carts reviewed. Insulin pens were not labeled. (200 Hall Medication Cart, 300 Hall Medication Cart) Findings include:			

	1. On 11/21/24 at 9:20 A.M., a Humalog insulin pen was observed laying in a drawer in the 200 Hall Medication Cart without a label or an open date. 2. On 11/21/24 at 9:40 A.M., the following was observed lying in a drawer in the 300 Hall Medication Cart: 2 Lantus insulin pens without a name, label, and open date 1 Humalog insulin pen without a name, label, and open date 1 Humalog insulin pen with (Resident Name) written in black marker, no label and open date During an interview on 11/21/24 at 9:44 A.M., QMA (Qualified Medication Aide) 11 indicated the pens should be labeled, dated, and locked in the medication drawer in the resident's room. On 11/25/24 at 12:29 P.M., the DON (Director of Nursing) provided a current Medication Administration Program policy, revised 3/24/21, that indicated "...the community will obtain prescribed medical authorization including a prescription label completed by a licensed pharmacy...and an area for storing medications in accordance with the Board of Pharmacy requirements...".			

R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. 3. On 11/21/24 at 2:18 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Current physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units/ML Kwik Pen - Inject five units subcutaneously three times a day for diabetes mellitus, start date 10/8/24. Lantus Solostar (a long-acting insulin) 100 units/ML - Inject 12 units subcutaneously at bedtime related to diabetes mellitus, start date 10/7/24. Resident M's October 2024 Medication Administration Record (MAR) lacked	R 0349	DONW or designee will educate all clinical staff about addressing all orders on the MAR each shift. Staff education to be completed by 12/17/24. DONW or designee will perform an audit on medication Administration Report daily for two weeks, then weekly for two weeks, then monthly for six months to confirm compliance.	12/17/2024

documentation of administration of Humalog and Lantus Solostar on 10/25/24 at 8:00 P.M.

4. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident T was admitted on 12/3/21.

Current physician orders included, but were not limited to:

Fluoxetine HCl (an antidepressant medication) Capsule 10 milligrams (mg), give one capsule by mouth one time a day for depression, start date 6/21/24.

Resident T's clinical record indicated Medicaid as the main payor source from 12/3/21 through 7/1/24. Resident T's clinical record lacked referral to a mental health service provider for a consultation on needed treatment services. Resident T's service plan did not address mental health, major depressive disorder, or refusal of mental health services.

During an interview, on 11/22/24 at 2:50 P.M., the Director of Nursing (DON) stated Resident T declined mental health services but indicated there was no documentation within the clinical record of the refusal of services.

On 11/25/24 at 8:20 A.M., the

Director of Nursing (DON) indicated that she came in to give insulin second shift on 10/25/24 because there were not any staff who could give insulin available. She indicated that she must have forgotten to mark in the MAR that she gave the insulins that day to the residents who required insulin.

On 11/25/24 at 12:28 P.M., the DON provided a current Medication Administration Program policy, revised 3/24/21, that indicated "Residents receiving medication administration will have...documentation of the medication name, dose, time taken by resident ... Documentation in the medication record is complete and accurate...".

On 11/25/24 at 12:28 P.M., the DON provided a current Progress Notes - Licensed Nursing policy, effective 8/1/18, that indicated "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical chart...".

On 11/25/24 at 12:35 P.M., the Director of Nursing provided a policy, dated 3/24, titled "Core Process: Service Plans" that indicated "For residents living with a major mental illness: The residential care facility, in cooperation with the mental

health service providers, shall develop the comprehensive care plan for the resident that includes the following: Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following: recreational and socialization activities; social skills; training, occupational, and work programs; opportunities for progression into less restrictive and more independent living arrangements".

This citation relates to complaint IN00446328.

Based on interview and record review, the facility failed to ensure documentation was complete for 3 of 3 residents reviewed for insulin and 1 of 4 residents reviewed for mental health screening. Insulin administration was not documented in the Medication Administration Record (MAR) and the refusal of mental health services was not documented in the clinical record. (Resident T, Resident M, Resident D, Resident C)

Findings include:

1. On 11/21/24 at 1/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were

not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident C was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 10 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously four times a day as per sliding scale; if 60-150 = 0; 151-200 = 3u; 201-250 = 5u; 251-300 = 7u; 301-350 = 9u; 351-400 = 11u; related to diabetes mellitus.

Lantus Solostar (a long-acting insulin) 100 u/mL - Inject 30 units subcutaneously one time a day related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident C received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident C received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M. and 8:00 P.M.

The October 2024 MAR did not indicate that Resident C received 30 units of Lantus Solostar insulin on 10/25/24 at 6:00 P.M.

2. On 11/21/24 at 1/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident D was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 5 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously three times a day as per sliding scale; if 151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u; related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident D received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident D received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M.

3. On 11/21/24 at 2:18 P.M.,

Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Current physician orders included, but were not limited to:

Humalog (a fast-acting insulin) 100 units/ML Kwik Pen - Inject five units subcutaneously three times a day for diabetes mellitus, start date 10/8/24.

Lantus Solostar (a long-acting insulin) 100 units/ML - Inject 12 units subcutaneously at bedtime related to diabetes mellitus, start date 10/7/24.

Resident M's October 2024 Medication Administration Record (MAR) lacked documentation of administration of Humalog and Lantus Solostar on 10/25/24 at 8:00 P.M.

4. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident T was admitted on 12/3/21.

Current physician orders included, but were not limited to:

Fluoxetine HCl (an antidepressant medication) Capsule 10 milligrams (mg), give one capsule by mouth one time a day for depression, start date 6/21/24.

Resident T's clinical record indicated Medicaid as the main payor source from 12/3/21 through 7/1/24. Resident T's clinical record lacked referral to a mental health service provider for a consultation on needed treatment services. Resident T's service plan did not address mental health, major depressive disorder, or refusal of mental health services.

During an interview, on 11/22/24 at 2:50 P.M., the Director of Nursing (DON) stated Resident T declined mental health services but indicated there was no documentation within the clinical record of the refusal of services.

On 11/25/24 at 8:20 A.M., the Director of Nursing (DON) indicated that she came in to give insulin second shift on 10/25/24 because there were not any staff who could give insulin available. She indicated that she must have forgotten to mark in the MAR that she gave the insulins that day to the residents who required insulin.

On 11/25/24 at 12:28 P.M., the DON provided a current Medication Administration Program policy, revised 3/24/21, that indicated "Residents receiving medication administration will have...documentation of the medication name, dose, time

taken by resident ... Documentation in the medication record is complete and accurate...".

On 11/25/24 at 12:28 P.M., the DON provided a current Progress Notes - Licensed Nursing policy, effective 8/1/18, that indicated "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical chart...".

On 11/25/24 at 12:35 P.M., the Director of Nursing provided a policy, dated 3/24, titled "Core Process: Service Plans" that indicated "For residents living with a major mental illness: The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident that includes the following: Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following: recreational and socialization activities; social skills; training, occupational, and work programs; opportunities for progression into less restrictive and more independent living arrangements".

This citation relates to complaint IN00446328.

Based on interview and record review, the facility failed to ensure documentation was complete for 3 of 3 residents reviewed for insulin and 1 of 4 residents reviewed for mental health screening. Insulin administration was not documented in the Medication Administration Record (MAR) and the refusal of mental health services was not documented in the clinical record. (Resident T, Resident M, Resident D, Resident C)

Findings include:

1. On 11/21/24 at 1/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident C was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 10 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously four times a day as per sliding scale; if 60-150 = 0; 151-200 = 3u; 201-250 = 5u; 251-300 = 7u; 301-350 = 9u;

351-400 = 11u; related to diabetes mellitus.

Lantus Solostar (a long-acting insulin) 100 u/mL - Inject 30 units subcutaneously one time a day related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident C received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident C received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M. and 8:00 P.M.

The October 2024 MAR did not indicate that Resident C received 30 units of Lantus Solostar insulin on 10/25/24 at 6:00 P.M.

2. On 11/21/24 at 1/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident D was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 5 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously three times a day as per sliding scale; if 151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u; related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident D received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident D received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M.

3. On 11/21/24 at 2:18 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Current physician orders included, but were not limited to:

Humalog (a fast-acting insulin) 100 units/ML Kwik Pen - Inject five units subcutaneously three times a day for diabetes mellitus, start date 10/8/24.

Lantus Solostar (a long-acting insulin) 100 units/ML - Inject 12 units subcutaneously at bedtime related to diabetes mellitus, start date 10/7/24.

Resident M's October 2024 Medication Administration Record (MAR) lacked documentation of administration

of Humalog and Lantus Solostar on 10/25/24 at 8:00 P.M.

4. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident T was admitted on 12/3/21.

Current physician orders included, but were not limited to:

Fluoxetine HCl (an antidepressant medication) Capsule 10 milligrams (mg), give one capsule by mouth one time a day for depression, start date 6/21/24.

Resident T's clinical record indicated Medicaid as the main payor source from 12/3/21 through 7/1/24. Resident T's clinical record lacked referral to a mental health service provider for a consultation on needed treatment services. Resident T's service plan did not address mental health, major depressive disorder, or refusal of mental health services.

During an interview, on 11/22/24 at 2:50 P.M., the Director of Nursing (DON) stated Resident T declined mental health services but indicated there was no documentation within the clinical record of the refusal of services.

On 11/25/24 at 8:20 A.M., the Director of Nursing (DON)

indicated that she came in to give insulin second shift on 10/25/24 because there were not any staff who could give insulin available. She indicated that she must have forgotten to mark in the MAR that she gave the insulins that day to the residents who required insulin.

On 11/25/24 at 12:28 P.M., the DON provided a current Medication Administration Program policy, revised 3/24/21, that indicated "Residents receiving medication administration will have...documentation of the medication name, dose, time taken by resident ... Documentation in the medication record is complete and accurate...".

On 11/25/24 at 12:28 P.M., the DON provided a current Progress Notes - Licensed Nursing policy, effective 8/1/18, that indicated "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical chart...".

On 11/25/24 at 12:35 P.M., the Director of Nursing provided a policy, dated 3/24, titled "Core Process: Service Plans" that indicated "For residents living with a major mental illness: The residential care facility, in cooperation with the mental health service providers, shall

develop the comprehensive care plan for the resident that includes the following: Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following: recreational and socialization activities; social skills; training, occupational, and work programs; opportunities for progression into less restrictive and more independent living arrangements".

This citation relates to complaint IN00446328.

Based on interview and record review, the facility failed to ensure documentation was complete for 3 of 3 residents reviewed for insulin and 1 of 4 residents reviewed for mental health screening. Insulin administration was not documented in the Medication Administration Record (MAR) and the refusal of mental health services was not documented in the clinical record. (Resident T, Resident M, Resident D, Resident C)

Findings include:

1. On 11/21/24 at 1/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident C was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 10 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously four times a day as per sliding scale; if 60-150 = 0; 151-200 = 3u; 201-250 = 5u; 251-300 = 7u; 301-350 = 9u; 351-400 = 11u; related to diabetes mellitus.

Lantus Solostar (a long-acting insulin) 100 u/mL - Inject 30 units subcutaneously one time a day related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident C received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident C received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M. and 8:00 P.M.

The October 2024 MAR did not indicate that Resident C received 30 units of Lantus Solostar insulin on 10/25/24 at 6:00 P.M.

2. On 11/21/24 at 1/21/24 at

1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident D was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 5 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously three times a day as per sliding scale; if 151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u; related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident D received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident D received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M.

3. On 11/21/24 at 2:18 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Current physician orders included, but were not limited to:

Humalog (a fast-acting insulin) 100 units/ML Kwik Pen - Inject five units subcutaneously three times a day for diabetes mellitus, start date 10/8/24.

Lantus Solostar (a long-acting insulin) 100 units/ML - Inject 12 units subcutaneously at bedtime related to diabetes mellitus, start date 10/7/24.

Resident M's October 2024 Medication Administration Record (MAR) lacked documentation of administration of Humalog and Lantus Solostar on 10/25/24 at 8:00 P.M.

4. On 11/21/24 at 2:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. Resident T was admitted on 12/3/21.

Current physician orders included, but were not limited to:

Fluoxetine HCl (an antidepressant medication) Capsule 10 milligrams (mg), give one capsule by mouth one time a day for depression, start date 6/21/24.

Resident T's clinical record indicated Medicaid as the main payor source from 12/3/21 through 7/1/24. Resident T's clinical record lacked referral to

a mental health service provider for a consultation on needed treatment services. Resident T's service plan did not address mental health, major depressive disorder, or refusal of mental health services.

During an interview, on 11/22/24 at 2:50 P.M., the Director of Nursing (DON) stated Resident T declined mental health services but indicated there was no documentation within the clinical record of the refusal of services.

On 11/25/24 at 8:20 A.M., the Director of Nursing (DON) indicated that she came in to give insulin second shift on 10/25/24 because there were not any staff who could give insulin available. She indicated that she must have forgotten to mark in the MAR that she gave the insulins that day to the residents who required insulin.

On 11/25/24 at 12:28 P.M., the DON provided a current Medication Administration Program policy, revised 3/24/21, that indicated "Residents receiving medication administration will have...documentation of the medication name, dose, time taken by resident ... Documentation in the medication record is complete and accurate...".

On 11/25/24 at 12:28 P.M., the DON provided a current Progress Notes - Licensed Nursing policy, effective 8/1/18, that indicated "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical chart...".

On 11/25/24 at 12:35 P.M., the Director of Nursing provided a policy, dated 3/24, titled "Core Process: Service Plans" that indicated "For residents living with a major mental illness: The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident that includes the following: Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following: recreational and socialization activities; social skills; training, occupational, and work programs; opportunities for progression into less restrictive and more independent living arrangements".

This citation relates to complaint IN00446328.

Based on interview and record review, the facility failed to ensure documentation was complete for 3 of 3 residents

reviewed for insulin and 1 of 4 residents reviewed for mental health screening. Insulin administration was not documented in the Medication Administration Record (MAR) and the refusal of mental health services was not documented in the clinical record. (Resident T, Resident M, Resident D, Resident C)

Findings include:

1. On 11/21/24 at 1/21/24 at 3:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident C was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 10 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously four times a day as per sliding scale; if 60-150 = 0; 151-200 = 3u; 201-250 = 5u; 251-300 = 7u; 301-350 = 9u; 351-400 = 11u; related to diabetes mellitus.

Lantus Solostar (a long-acting insulin) 100 u/mL - Inject 30 units subcutaneously one time a day related to diabetes mellitus.

The October 2024 MAR did not indicate that Resident C received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M.

The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident C received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M. and 8:00 P.M.

The October 2024 MAR did not indicate that Resident C received 30 units of Lantus Solostar insulin on 10/25/24 at 6:00 P.M.

2. On 11/21/24 at 1/21/24 at 1:59 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

The October 2024 Medication Administration Record (MAR) indicated Resident D was to receive the following medications:

Humalog (a fast-acting insulin) 100 units/milliliter (u/mL) - Inject 5 units subcutaneously three times a day for diabetes mellitus.

Humalog 100 u/mL - Inject subcutaneously three times a day as per sliding scale; if

	151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u; related to diabetes mellitus. The October 2024 MAR did not indicate that Resident D received 10 units of Humalog insulin on 10/25/24 at 4:00 P.M. The October 2024 MAR did not indicate a blood glucose level was obtained or that Resident D received sliding scale Humalog insulin on 10/25/24 at 4:00 P.M.			

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