STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF FORT WAYNE	7125 S HANNA STREET, FORT WAYNE, , 46816

(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 Complaints IN00442078, IN00442083, IN00443731 and IN00443943. Complaint IN00442078 - No deficienies related to the allegations are cited. Complaint IN00442083 - No deficienies related to the allegations are cited. Complaint IN00443731 - State deficiencies related to the allegations are cited at R0064 Complaint IN00443943- State deficiencies related to the allegations are cited at R0064 and R0247. Survey date: September 27, 2024 Facility number: 014316 Residential Census: 81 These State Residential Findings are cited in accordance	R 0000	Please accept the following as the community's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	

	with 410 IAC 16.2-5. Quality review completed September 27, 2024			
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 of misappropriation of property for 1 of 6 residents reviewed (Resident B). Findings include: An investigation file was provided by the Administrator on 9/26/24 at 10:48 AM. The file included the following: A facility reported incident, dated 9/19/24, indicated on 9/17/24 QMA 2 transported Resident B to Walmart (shopping store) and her (QMA 2) home via Resident B's personal vehicle without management approval. The file indicated Resident B paid for some of QMA 2 groceries and	R 0064	R064 Residents' Rights It is the policy of Silver Birch of Fort Wayne that residents' property will be free from loss or theft. Resident B continues to reside in the community. There have been no further issues noted. Resident B shows no signs of distress. All residents have the potential to be affected. There have been no other identified concerns. All staff were re-educated on resident rights and misappropriation of residents property on 9/26/2024. See attachment. Resident rights will be reviewed in the upcoming resident council meeting October 15, 2024. A QAPI action plan has been initiated. To ensure ongoing compliance, The Executive Director/designee will interview at least 10% of resident population monthly	10/14/2024

	QMA 2 received disciplinary action. Resident B's statement, dated 9/19/24, indicated on 9/17/24 Resident B asked QMA 2 to take him to Walmart due to resident not feeling comfortable driving at night. Resident B indicated they bought groceries then went to QMA 2's house where QMA 2 unloaded her groceries. Resident B indicated he met QMA 2's family. Resident B indicated afterwards QMA 2 drove Resident B back to the facility. Resident B also indicated he paid for some of QMA 2's groceries. A statement by Employee 9, dated 9/19/24, indicated Employee 9 observed Resident B and QMA 2 at Walmart and observed QMA 2 get into Resident B's car around 7:46 PM on 9/17/24. Licensed Practical Nurse (LPN) 3's statement, dated 9/19/24, indicated a visitor observed QMA 2 get out of Resident B's car. The visitor asked if the resident had a personal driver. During an interview on 9/26/24 at 9:20 AM, Director of Nursing (DON) indicated Resident B asked QMA 2 to drive his car due to it being dark and the resident didn't feel safe driving. QMA 2 and Resident B went to Walmart, grabbed a couple		regarding resident rights. Concerns will be addressed immediately. The QAPI plan will be reviewed/revised as needed in the monthly facility quality meeting. The QAPI plan will continue until 100% compliance has been met for three consecutive months. Date of compliance: 10-14-24	

	items, then dropped some stuff off at QMA 2's house. Resident B indicated he met QMA 2's family, then QMA 2 and Resident B returned to facility. The DON indicated QMA 2 did not receive permission from facility management to drive Resident B's car. QMA 2 received disciplinary action. The DON indicated QMA 2 should not have transported Resident B in his personal vehicle without permission. The DON indicated she interviewed QMA 2 who indicated she was just trying to help Resident B. The DON also indicated QMA 2 was gone for 1-2 hours without leave based on the staff statements. During an interview on 9/26/24 at 10:34 AM, Housekeeper 7 indicated staff should never drive a resident's personal vehicle. Housekeeper 7 indicated staff should never ask or accept gifts, money or food from residents. QMA 2's signed employee handbook, dated 8/6/24, was provided by the Administrator on 9/26/24 at 12:16 PM. The employee handbook indicated staff should not leave work without prior approval, not accept gifts/gratuities from residents nor have unauthorized possession or use of property of residents. This citation relates to			

Complaints IN00443731 and IN00443943.

Based on interview and record review, the facility failed to ensure residents were free of misappropriation of property for 1 of 6 residents reviewed (Resident B).

Findings include:

An investigation file was provided by the Administrator on 9/26/24 at 10:48 AM. The file included the following:

A facility reported incident, dated 9/19/24, indicated on 9/17/24 QMA 2 transported Resident B to Walmart (shopping store) and her (QMA 2) home via Resident B's personal vehicle without management approval. The file indicated Resident B paid for some of QMA 2 groceries and QMA 2 received disciplinary action.

Resident B's statement, dated 9/19/24, indicated on 9/17/24 Resident B asked QMA 2 to take him to Walmart due to resident not feeling comfortable driving at night. Resident B indicated they bought groceries then went to QMA 2's house where QMA 2 unloaded her groceries. Resident B indicated he met QMA 2's family. Resident B indicated afterwards QMA 2 drove Resident B back to the facility. Resident B also

	indicated he paid for some of QMA 2's groceries. A statement by Employee 9, dated 9/19/24, indicated Employee 9 observed Resident B and QMA 2 at Walmart and observed QMA 2 get into Resident B's car around 7:46 PM on 9/17/24. Licensed Practical Nurse (LPN) 3's statement, dated 9/19/24, indicated a visitor observed QMA 2 get out of Resident B's car. The visitor asked if the resident had a personal driver. During an interview on 9/26/24 at 9:20 AM, Director of Nursing (DON) indicated Resident B asked QMA 2 to drive his car due to it being dark and the resident didn't feel safe driving. QMA 2 and Resident B went to Walmart, grabbed a couple items, then dropped some stuff off at QMA 2's house. Resident B indicated he met QMA 2's family, then QMA 2 and Resident B returned to facility. The DON indicated QMA 2 did not receive permission from facility management to drive Resident B's car. QMA 2 received disciplinary action. The DON indicated QMA 2 should not have transported Resident B in his personal vehicle without permission. The DON indicated she interviewed QMA 2 who indicated she was just trying to help Resident B. The DON also			

	indicated QMA 2 was gone for 1-2 hours without leave based on the staff statements. During an interview on 9/26/24 at 10:34 AM, Housekeeper 7 indicated staff should never drive a resident's personal vehicle. Housekeeper 7 indicated staff should never ask or accept gifts, money or food from residents. QMA 2's signed employee handbook, dated 8/6/24, was provided by the Administrator on 9/26/24 at 12:16 PM. The employee handbook indicated staff should not leave work without prior approval, not accept gifts/gratuities from residents nor have unauthorized possession or use of property of residents. This citation relates to Complaints IN00443731 and IN00443943.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review the facility failed to	R 0247	R247 Health Services It is the policy of Silver Birch of Fort Wayne that all medications are stored in a manner that prohibits access by other residents. medications are only accessible to the designated responsible staff. All residents have the potential to be affected by the noted deficiency. There were no negative	10/14/2024

	ensure medication carts were only accessible by licensed personal for 1 of 4 medication carts. Findings include: An investigation file was provided by the Administrator on 9/26/24 at 10:48 AM. The file included the following: A facility reported incident (FRI), dated 9/19/24, indicated on 9/17/24 Qualified Medication Aide (QMA) 2 left the facility with Resident B. A statement from QMA 5, dated, 9/19/24 indicated on 9/17/24 she observed QMA 2's medication cart unattended from 4:30 PM until around 8 PM. QMA 5 indicated the medication cart was open until a coworker observed and then locked the cart. QMA 5 also indicated she observed a kitchen staff bring QMA 2's medication cart keys to Licensed Practical Nurse (LPN) 3 about 6:00 PM. A statement from Licensed Practical Nurse (LPN) 3, indicated on 9/17/24 around 5:30 PM - 6:00 PM LPN 3 was outside on break when a kitchen staff member handed her the keys for QMA 2's medication cart. A statement from QMA 6, dated 9/19/24, indicated on 9/17/24 around 5:50 PM she observed a		outcomes noted. All staff responsible for medication administration were re-educated on the policy for medication administration, which included the safe storage of medications on 9/26/2024. A QAPI plan has been initiated. To ensure ongoing compliance, the DON/Designee will complete medication cart checks daily M-F for two weeks, then 3x weekly for 2 weeks and then weekly thereafter. Any issues identified will be addressed immediately. Audit tools will be reviewed and revised as needed in the monthly QAPI meeting. The plan will continue until 100% compliance is met for 3 consecutive months. Date of Compliance: 10/14/2024	

kitchen staff give LPN 3 keys to QMA 2's medication cart. QMA 6 indicated QMA 2 returned the facility around 8 PM.

During an interview on 9/26/24 at 11:43 AM, the Director of Nursing (DON) indicated the medication cart should be locked when not in use. The DON also indicated only licensed personal should have access to the medication carts or the keys to the medication carts.

A current policy, last revised 3/24/21, titled "Medication Administration Program Policy," was provided by the DON on 9/27/24 at 12:02 PM. The policy indicated medications are stored in a manner that prohibited access by other residents. The policy also indicated medications are only accessible to the designated responsible staff.

This citation relates to Complaint IN00443943.

Based on interview and record review the facility failed to ensure medication carts were only accessible by licensed personal for 1 of 4 medication carts.

Findings include:

An investigation file was provided by the Administrator on 9/26/24 at 10:48 AM. The file

included the following:

A facility reported incident (FRI), dated 9/19/24, indicated on 9/17/24 Qualified Medication Aide (QMA) 2 left the facility with Resident B.

A statement from QMA 5, dated, 9/19/24 indicated on 9/17/24 she observed QMA 2's medication cart unattended from 4:30 PM until around 8 PM. QMA 5 indicated the medication cart was open until a coworker observed and then locked the cart. QMA 5 also indicated she observed a kitchen staff bring QMA 2's medication cart keys to Licensed Practical Nurse (LPN) 3 about 6:00 PM.

A statement from Licensed Practical Nurse (LPN) 3, indicated on 9/17/24 around 5:30 PM - 6:00 PM LPN 3 was outside on break when a kitchen staff member handed her the keys for QMA 2's medication cart.

A statement from QMA 6, dated 9/19/24, indicated on 9/17/24 around 5:50 PM she observed a kitchen staff give LPN 3 keys to QMA 2's medication cart. QMA 6 indicated QMA 2 returned the facility around 8 PM.

During an interview on 9/26/24 at 11:43 AM, the Director of Nursing (DON) indicated the medication cart should be locked when not in use. The

	DON also indicated only licensed personal should have access to the medication carts or the keys to the medication carts. A current policy, last revised 3/24/21, titled "Medication Administration Program Policy," was provided by the DON on 9/27/24 at 12:02 PM. The policy indicated medications are stored in a manner that prohibited access by other residents. The policy also indicated medications are only accessible to the designated responsible staff. This citation relates to Complaint IN00443943.			

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