STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/19/2021

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 a State Residential Licensure Survey. Survey dates: August 17, 18, & 19, 2021 Facility number: 014316 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reivew completed August 23, 2021	R 0000		
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview	R 0042	**R042** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** No residents were	10/01/2021

	and record review, the facility failed to ensure Indiana State Survey Reports and Plans of Correction (POC) were available for review by the residents or their families. There were 98 residents who resided in the facility. Findings include: During an observation of the facility's main floor common areas on 8/19/2021 between 10:30 a.m. and 11:00 a.m., the Indiana State Survey Reports were not found to be available for public access/viewing. On 8/19/2021 at 12:15 p.m., in an interview, Receptionist 6 indicated she did not know where the State Survey Binder was located in the facility but thought she had seen it somewhere. Receptionist 6 proceeded to look for the Survey Binder in the receptionist area. A framed sign sitting on top of two side by side 2-drawer file cabinets on the back wall of the receptionist area was observed. The framed sign was leaning against the wall. The sign read, " SILVER BIRCH LIVING...SURVEY BINDER LOCATED AT THE FRONT DESK." Receptionist 6 continued to look in the cabinet drawers but could not find the State Survey Binder. On 8/19/2021 at 12:20 p.m., the		identified . **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;** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. The binder is now located in the front living room, which is accessible for public/viewing. All residents have received written notice of where binder is located. They are encouraged to notify management if binder is missing. . **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

	Executive Director (ED) entered the reception area. She indicated the State Survey Binder should be available to see it without asking for it. On 8/19/21 at 12:25 p.m., observed Receptionist 6 and the BOM (Business Office Manager) at the Receptionist Desk, going through 2 Binders. Receptionist 6 indicated she had found the State Survey Binder in the bottom drawer of the file cabinet. She indicated they were checking to see if all of the survey reports matched the ED's Survey Binder. The BOM removed several pages from the ED's Survey Binder and indicated she was going to make copies for the State Survey Binder. The BOM indicated there were 8 survey reports not in the State Survey Binder in the reception area. On 8/19/21 at 12:50 p.m., Receptionist 7 provided copies of the State Survey Reports with the facility's Plan of Correction which were not in the State Survey Binder. The following survey reports were not in the State Survey Binder: 4 complaint surveys dated in 2019, 6/24/2019, 7/5/2019, 11/12/2019, 12/20/21. One complaint survey dated 1/7/2020, One complaint survey with a COVID-19 Focused Walk-Through Survey on 6/29/2020, and two COVID-19		All current employees will be reeducated on the survey binder location and need for binder to be available to residents and visitors at all times. Check survey binder is placed in designated location daily per Executive Director, or designee. **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;** Will check designated location of survey binder to verify binder is available Monday – Friday x 4 weeks at random times, then 3x/week x 4 weeks at random times, then randomly ongoing. If survey binder is missing, it will be replaced at time of discovery. **What date the systemic**	

	Residential Quality Assurance Walk Through Surveys on 11/24/2020 and 12/18/20. On 8/19/21 at 1:06 p.m., during an interview with the ED, she indicated the facility did not have a specific policy, but would follow the Indiana State Regulations for the availability of the State Survey Reports and also indicated all of the facility's survey reports should be in the binder for review. Based on observation, interview and record review, the facility failed to ensure Indiana State Survey Reports and Plans of Correction (POC) were available for review by the residents or their families. There were 98 residents who resided in the facility. Findings include: During an observation of the facility's main floor common areas on 8/19/2021 between 10:30 a.m. and 11:00 a.m., the Indiana State Survey Reports were not found to be available for public access/viewing. On 8/19/2021 at 12:15 p.m., in an interview, Receptionist 6 indicated she did not know where the State Survey Binder was located in the facility but thought she had seen it somewhere. Receptionist 6 proceeded to look for the Survey Binder in the receptionist		**changes will be completed:** To ensure that deficit practice will not occur, the ED, or designee will present the audit findings to the Quality Assurance Performance Committee monthly until 100% compliance is met for 3 consecutive months. Compliance date 10/1/21	

	area. A framed sign sitting on top of two side by side 2-drawer file cabinets on the back wall of the receptionist area was observed. The framed sign was leaning against the wall. The sign read, " SILVER BIRCH LIVING...SURVEY BINDER LOCATED AT THE FRONT DESK." Receptionist 6 continued to look in the cabinet drawers but could not find the State Survey Binder. On 8/19/2021 at 12:20 p.m., the Executive Director (ED) entered the reception area. She indicated the State Survey Binder should be available to see it without asking for it. On 8/19/21 at 12:25 p.m., observed Receptionist 6 and the BOM (Business Office Manager) at the Receptionist Desk, going through 2 Binders. Receptionist 6 indicated she had found the State Survey Binder in the bottom drawer of the file cabinet. She indicated they were checking to see if all of the survey reports matched the ED's Survey Binder. The BOM removed several pages from the ED's Survey Binder and indicated she was going to make copies for the State Survey Binder. The BOM indicated there were 8 survey reports not in the State Survey Binder in the reception area. On 8/19/21 at 12:50 p.m.,			

	Receptionist 7 provided copies of the State Survey Reports with the facility's Plan of Correction which were not in the State Survey Binder. The following survey reports were not in the State Survey Binder: 4 complaint surveys dated in 2019, 6/24/2019, 7/5/2019, 11/12/2019, 12/20/21. One complaint survey dated 1/7/2020, One complaint survey with a COVID-19 Focused Walk-Through Survey on 6/29/2020, and two COVID-19 Residential Quality Assurance Walk Through Surveys on 11/24/2020 and 12/18/20. On 8/19/21 at 1:06 p.m., during an interview with the ED, she indicated the facility did not have a specific policy, but would follow the Indiana State Regulations for the availability of the State Survey Reports and also indicated all of the facility's survey reports should be in the binder for review.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance	R 0116	**R116** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Dietary aid #2 and CNA #3	10/01/2021

	with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure screening of employees was completed for 2 of 5 employee records reviewed. (Dietary Aide 2 and Certified Nurse Aide CNA 3). Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of Dietary Aide 2's record indicated her start date was 1-4-2021. Dietary Aide 2 lacked completed references in her record. A review of CNA 3's (Certified Nurse Aide) record indicated her start date was 2-1-2021. CNA 3 lacked completed references in her record. An employee file checklist was attached to each record and under Training/Certifications, 2 or more references, was not checked or initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED on 8-18-2021 at 3:00 p.m., indicated she thought the BOM tracked the completion of all forms and trainings for the		reference checks to be completed All department managers will be reeducated on the requirement that reference checks for new hires are to be completed prior to day #1 of employment **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** All new hires have the potential to be affected by the alleged deficient practice. All department managers will be reeducated on their responsibility to check references on any new hires prior to day #1 of employment. Copies of the reference checks are to be filed in the employees' personnel file. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not**	

	employee records. A current policy, Employment Reference Checks, dated 4-12-2018, was provided by the ED (Executive Director) on 8-19-2021 at 9:10 a.m. The policy indicated, "...Silver Birch Living conducts employment reference checks in alignment with state and federal requirements...This policy applies to all applicants apply for employment...Applicants will be required to identify at least 3 references with contact information during the application and/or interview process...This process will authorize Silver Birch Living to investigate the applicant's employment background...Supervisor/Department Manager will conduct background checks for community level hiring...Reference checks may be conducted via phone or written correspondence documented using the Confidential Reference Check form...Complete a minimum of 2 reference checks...This will occur prior to day 1 of employment...."		**recur** The Business Office Manager, or designee, will utilize the new hire checklist until complete, including reference checks for all employees hired on or after 9/24/21. Personnel files for all new hires will be gone over in morning meeting to verify reference checks are in file, daily ongoing. Any missing reference checks will be corrected at the time of discovery. **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;**	

	Based on interview and record review, the facility failed to ensure screening of employees was completed for 2 of 5 employee records reviewed. (Dietary Aide 2 and Certified Nurse Aide CNA 3). Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of Dietary Aide 2's record indicated her start date was 1-4-2021. Dietary Aide 2 lacked completed references in her record. A review of CNA 3's (Certified Nurse Aide) record indicated her start date was 2-1-2021. CNA 3 lacked completed references in her record. An employee file checklist was attached to each record and under Training/Certifications, 2 or more references, was not checked or initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED on 8-18-2021 at 3:00 p.m., indicated she thought the BOM tracked the completion of all forms and trainings for the employee records. A current policy, Employment		The Business Office Manager will present a report of missing reference checks, and any trends, to the QAPI meeting monthly, along with the actions taken for correction. This will be ongoing until 100% compliance has been met for 6 months. **What date the systemic changes will be completed:** 10/1/21	

	Reference Checks, dated 4-12-2018, was provided by the ED (Executive Director) on 8-19-2021 at 9:10 a.m. The policy indicated, "...Silver Birch Living conducts employment reference checks in alignment with state and federal requirements...This policy applies to all applicants apply for employment...Applicants will be required to identify at least 3 references with contact information during the application and/or interview process...This process will authorize Silver Birch Living to investigate the applicant's employment background...Supervisor/Department Manager will conduct background checks for community level hiring...Reference checks may be conducted via phone or written correspondence documented using the Confidential Reference Check form...Complete a minimum of 2 reference checks...This will occur prior to day 1 of employment...."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the	R 0117	**R117**	10/01/2021

	residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure CPR (Cardiopulmonary Resuscitation) and first aid certified staff were on site at all times. 98 residents resided in the facility. Findings include: On 8-17-2021 at 12:32 p.m., the CPR and First Aid certifications for staff were reviewed with the as worked schedule for 8-10-2021 through 8-16-2021. CPR certified staff were not scheduled onsite for the		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. CPR/1st Aid training classes are set up for all nursing staff in October at our community. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**	

	following times: On Wednesday, 8-11-2021, third shift. On Friday, 8-13-2021, third shift. On Saturday, 8-14-2021, third shift. On Sunday, 8-15-2021, third shift. On Monday, 8-16-2021, third shift. First Aid certified staff were not scheduled onsite for the following times: On Tuesday, 8-10-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Wednesday, 8-11-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Thursday, 8-12-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Friday, 8-13-2021, day and night shift. On Saturday, 8-14-2021, there were no staff scheduled with First Aid certification. On Sunday, 8-15-2021, there were no staff scheduled with First Aid certification. On Monday, 8-16-2021, there		Staff with CPR/1st Aid certifications will be designated on nursing schedule to ensure that there is a certified employee in the building on every shift. **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** Director of Nursing and Wellness, or designee, will review and initial schedule daily to verify CPR/1st Aid staff ongoing. **What date the systemic changes will be completed:** DONW will report compliance with CPR/1st Aid certified staff, including difficulties met when scheduling to QAPI monthly. This will be ongoing until 100% compliance has been met for 6 months.	

	were no staff scheduled with First Aid certification. An interview with the DON (Director of Nursing) and the ED (Executive Director) on 8-18-2021 at 9:02 a.m., indicated they provided all the CPR/First Aid certificates they had for the scheduled staff. The DON indicated she had to get signed off to be an instructor and she was going to hold classes for the staff here for CPR/First Aid. The DON indicated she was not on the schedule provided from August 10, 2021 through August 16, 2021, as she was not required to clock in. The DON's work schedule was requested at this time. On 8-18-2021 at 10:20 a.m., the DON provided a CPR and First Aid certificate for the ED. The DON indicated the ED did not clock in/out and was not on the schedule from 8-10-2021 through 8-16-2021. The ED's work schedule was requested at this time. On 8-18-2021 at 11:30 a.m., the ED provided additional CPR records for the agency staff who worked in the facility from 8-10-2021 through 8-16-2021. On 8-18-2021 at 12:00 p.m., the ED indicated the facility did not have any more certifications for First Aid for staff. The ED			

	indicated she was aware they did not have First Aid coverage for most of the shifts during the 8-10-2021 through 8-16-2021 time period. The ED indicated she was aware some shifts were not covered with CPR certified staff. On 8-19-2021 at 3:27 p.m., the time of the exit conference, the ED and DON did not provide their work schedule for 8-10-2021 through 8-16-2021. A facility policy was not provided for the CPR and First Aid. Based on interview and record review, the facility failed to ensure CPR (Cardiopulmonary Resuscitation) and first aid certified staff were on site at all times. 98 residents resided in the facility. Findings include: On 8-17-2021 at 12:32 p.m., the CPR and First Aid certifications for staff were reviewed with the as worked schedule for 8-10-2021 through 8-16-2021. CPR certified staff were not scheduled onsite for the following times: On Wednesday, 8-11-2021, third shift. On Friday, 8-13-2021, third shift. On Saturday, 8-14-2021, third shift.			

	On Sunday, 8-15-2021, third shift. On Monday, 8-16-2021, third shift. First Aid certified staff were not scheduled onsite for the following times: On Tuesday, 8-10-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Wednesday, 8-11-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Thursday, 8-12-2021, day shift and from 2:00 p.m. to 6:00 p.m. On Friday, 8-13-2021, day and night shift. On Saturday, 8-14-2021, there were no staff scheduled with First Aid certification. On Sunday, 8-15-2021, there were no staff scheduled with First Aid certification. On Monday, 8-16-2021, there were no staff scheduled with First Aid certification. An interview with the DON (Director of Nursing) and the ED (Executive Director) on 8-18-2021 at 9:02 a.m., indicated they provided all the CPR/First Aid certificates they had for the scheduled staff. The			

	DON indicated she had to get signed off to be an instructor and she was going to hold classes for the staff here for CPR/First Aid. The DON indicated she was not on the schedule provided from August 10, 2021 through August 16, 2021, as she was not required to clock in. The DON's work schedule was requested at this time. On 8-18-2021 at 10:20 a.m., the DON provided a CPR and First Aid certificate for the ED. The DON indicated the ED did not clock in/out and was not on the schedule from 8-10-2021 through 8-16-2021. The ED's work schedule was requested at this time. On 8-18-2021 at 11:30 a.m., the ED provided additional CPR records for the agency staff who worked in the facility from 8-10-2021 through 8-16-2021. On 8-18-2021 at 12:00 p.m., the ED indicated the facility did not have any more certifications for First Aid for staff. The ED indicated she was aware they did not have First Aid coverage for most of the shifts during the 8-10-2021 through 8-16-2021 time period. The ED indicated she was aware some shifts were not covered with CPR certified staff. On 8-19-2021 at 3:27 p.m., the			

	time of the exit conference, the ED and DON did not provide their work schedule for 8-10-2021 through 8-16-2021. A facility policy was not provided for the CPR and First Aid.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and	R 0119	**R119** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. DONW will complete general orientation by 10/1/21	10/01/2021

	(D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure orientation was completed for 3 of 5 employee records reviewed. DON (Director of Nursing), Social Services, and CNA 3 (Certified Nurse Aide) Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of the DON's record indicated her start date was 5-3-2021. The record lacked documentation of general and job specific orientation. A review of Social Service's		Social Services Director will complete general orientation by 10/1/21 CNA # 3 will complete general orientation by 10/1/21 Current employees will have all received general orientation by compliance date of 10/1/21. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** BOM will utilize new hire checklist to ensure that general orientation is completed as required. **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** Personnel files for all new hires will be gone over in	

	record indicated her start date was 2-18-2021. The record lacked documentation of job specific orientation. A review of CNA 3's record indicated her start date was 2-1-2021. The record lacked documentation of job specific orientation. An employee file checklist was attached to the DON's record and the new hire orientation and job specific training was blank and not initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An employee file checklist was attached to the Social Services and CNA 3's record and the job specific training was blank and not initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m., indicated the DON did not have the general and job specific orientation and Social Services and CNA 3 did not have job specific orientation in their records. A current policy, Employee Orientation and Annual In-Service Training, revised on 4-9-2019, was provided by the ED on 8-19-2021 at 9:10 a.m.		morning meeting to verify that general orientation has been scheduled with Human Resources, and employee has been informed, daily ongoing. If the date of general orientation is not on the checklist, it will be added to the next orientation session at that time. BOM will discuss any employees' that have not completed orientation with their department head to have the employee removed from the schedule if orientation is not completed by the scheduled date. BOM will report the findings to the QAPI for discussion on measures that may be adjusted. **<u>What date the systemic changes will be completed:</u>** This will be ongoing as opened positions are filled.	

	The policy indicated "...It is the policy of Silver Birch Living that all employees receive general orientation at the time of hire and job specific orientation completed within the first 90 days of employment...." Based on interview and record review, the facility failed to ensure orientation was completed for 3 of 5 employee records reviewed. DON (Director of Nursing), Social Services, and CNA 3 (Certified Nurse Aide) Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of the DON's record indicated her start date was 5-3-2021. The record lacked documentation of general and job specific orientation. A review of Social Service's record indicated her start date was 2-18-2021. The record lacked documentation of job specific orientation. A review of CNA 3's record indicated her start date was 2-1-2021. The record lacked documentation of job specific orientation. An employee file checklist was attached to the DON's record and the new hire orientation and			

	job specific training was blank and not initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An employee file checklist was attached to the Social Services and CNA 3's record and the job specific training was blank and not initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m., indicated the DON did not have the general and job specific orientation and Social Services and CNA 3 did not have job specific orientation in their records. A current policy, Employee Orientation and Annual In-Service Training, revised on 4-9-2019, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated "...It is the policy of Silver Birch Living that all employees receive general orientation at the time of hire and job specific orientation completed within the first 90 days of employment...."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized	R 0120	**R120**	10/01/2021

	inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice DONW will complete Dementia training by 10/1/21 Social Services Director will complete Dementia training by 10/1/21 CNA # 3 will complete Dementia training by 10/1/21	

	(D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure 2 of 5 staff completed the dementia training within the required time frame. (Social Services and Certified Nurse Aide CNA 3) Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of Social Service's record indicated her start date was 2-18-2021. Social Services lacked a record of completion of 6 hours dementia training since her start date. Human Resources indicated there was not a training transcript for Social Services. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m. indicated Social Services was looking for her dementia training records. A review of CNA 3's (Certified Nurse Aide) record indicated her start date was 2-1-2021. CNA 3 lacked a record of completion of the 6 hours of dementia training		New hire orientation for Dementia training is set up in Relias Learning. **<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</u>** All employees will be reeducated on their responsibility for completing Relias training. Executive Director, or designee, will run weekly report in Relias to determine which new employees have completed their Dementia training. **<u>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</u>** Executive Director will discuss any employees' that have not completed Dementia training in morning meeting to have the employee removed from the schedule if orientation	

	and for resident abuse training since her start date. An employee file checklist was attached to each record and under Training/Certifications, Dementia Training, was not checked or initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED on 8-18-2021 at 3:00 p.m., indicated the facility did the abuse and dementia training through a named training resource. The ED indicated she thought the BOM tracked the staff training requirements to ensure completion. The ED indicated the BOM thought the Corporate office was supposed to track the completion of the training. A current policy, Employee Orientation and Annual In-Service Training, revised on 4-8-2019, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated, "...It is the responsibility of the Executive Director to see that all employees have the orientation and annual training module assigned...The employee is responsible for logging into the training system and begin the on-line training modules as assigned...It is the responsibility of the department manager to		is not completed by the scheduled date. What date the systemic changes will be completed: This will be ongoing as opened positions are filled.	

	maintain records of employee training and ensure that monthly in-services are completed in a timely manner...." Based on interview and record review, the facility failed to ensure 2 of 5 staff completed the dementia training within the required time frame. (Social Services and Certified Nurse Aide CNA 3) Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of Social Service's record indicated her start date was 2-18-2021. Social Services lacked a record of completion of 6 hours dementia training since her start date. Human Resources indicated there was not a training transcript for Social Services. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m. indicated Social Services was looking for her dementia training records. A review of CNA 3's (Certified Nurse Aide) record indicated her start date was 2-1-2021. CNA 3 lacked a record of completion of the 6 hours of dementia training and for resident abuse training since her start date.			

	An employee file checklist was attached to each record and under Training/Certifications, Dementia Training, was not checked or initialed as completed by the BOM/designee (Business Office Manager) for confirmation in the file. An interview with the ED on 8-18-2021 at 3:00 p.m., indicated the facility did the abuse and dementia training through a named training resource. The ED indicated she thought the BOM tracked the staff training requirements to ensure completion. The ED indicated the BOM thought the Corporate office was supposed to track the completion of the training. A current policy, Employee Orientation and Annual In-Service Training, revised on 4-8-2019, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated, "...It is the responsibility of the Executive Director to see that all employees have the orientation and annual training module assigned...The employee is responsible for logging into the training system and begin the on-line training modules as assigned...It is the responsibility of the department manager to maintain records of employee training and ensure that monthly in-services are completed in a			

	timely manner...."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to	R 0121	**R121** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified DONW will have Pre-Employment History and Physical form completed and signed by 10/1/21 Social Services Director will have Pre-Employment History and Physical form completed and signed by 10/1/21 CNA # 3 will have Pre-Employment History and Physical form completed and signed by 10/1/21 Dietary Aid #2 will have baseline TB test	10/01/2021

	complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure new hire health screens and TB (Tuberculosis) testing were completed for 4 of 5 new employees. DON (Director of Nursing), Social Services, CNA 3 and Dietary Aide 2 Findings include: The employee record review began on 8-18-2021 at 9:55 a.m. A review of the DON's employee record indicated her start date was 5-3-2021. The Pre-Employment History and Physical Form was completed and signed by the DON on 5-10-2021. The form lacked a signature from a nurse, nurse practitioner or physician who conducted the physical. A review of Social Service's employee record indicated her		**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 residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. The DONW, or designee, will utilize the new hire checklist to include ensuring that the Pre-Employment History and Physical form is complete and signed for all employees. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Personnel files for all new hires will be gone over in morning meeting to verify History and Physical forms are in file, daily ongoing. Any missing/unsigned forms will be corrected at the time of discovery.	

	start date was 2-18-2021. The Pre-Employment History and Physical Form was completed by Social Services on 2-18-2021. The form lacked a signature from a nurse, nurse practitioner or physician who conducted the physical. A review of CNA 3's employee record indicated her start date was 2-1-2021. The Pre-Employment History and Physical Form was completed and signed by CNA 3 on 2-1-2021. The form lacked a signature from a nurse, nurse practitioner or physician who conducted the physical. A review of Dietary Aide 2's employee record indicated her start date was 1-4-2021. The record lacked documentation of a first or second step TB test or a TB screen. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m., indicated there were no TB records for Dietary Aide 2 and she was unable to say why there was not a signature of the nurse, nurse practitioner or physician who conducted the physical on the Pre-Employment History and Physical Form. A current policy, Employment Files, dated 4-16-2018, was provided by the ED on 8-19-2021 at 9:10 a.m. The		**<u>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</u>** Director of Nursing and Wellness, or designee, will review Pre-Employment History and Physical form to verify complete and signed. **<u>What date the systemic changes will be completed:</u>** This will be ongoing as opened positions are filled	

policy indicated, "...Medical file may include but are not limited to...Pre-employment medical exams...TB test results...Pre-employment Medical Questionnaire/physical...."

A current policy, Tuberculosis Screening, dated 4-16-2018, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated, "...the Community Wellness Director is responsible for coordinating and conducting 2 step (Mantoux) tuberculin tests for all employees...testing should occur with contingent offer of employment and prior to hands on care...."

Based on interview and record review, the facility failed to ensure new hire health screens and TB (Tuberculosis) testing were completed for 4 of 5 new employees. DON (Director of Nursing), Social Services, CNA 3 and Dietary Aide 2

Findings include:

The employee record review began on 8-18-2021 at 9:55 a.m.

A review of the DON's employee record indicated her start date was 5-3-2021. The Pre-Employment History and Physical Form was completed and signed by the DON on 5-10-2021. The form lacked a

	signature from a nurse, nurse practitioner or physician who conducted the physical. A review of Social Service's employee record indicated her start date was 2-18-2021. The Pre-Employment History and Physical Form was completed by Social Services on 2-18-2021. The form lacked a signature from a nurse, nurse practitioner or physician who conducted the physical. A review of CNA 3's employee record indicated her start date was 2-1-2021. The Pre-Employment History and Physical Form was completed and signed by CNA 3 on 2-1-2021. The form lacked a signature from a nurse, nurse practitioner or physician who conducted the physical. A review of Dietary Aide 2's employee record indicated her start date was 1-4-2021. The record lacked documentation of a first or second step TB test or a TB screen. An interview with the ED (Executive Director) on 8-18-2021 at 2:54 p.m., indicated there were no TB records for Dietary Aide 2 and she was unable to say why there was not a signature of the nurse, nurse practitioner or physician who conducted the physical on the Pre-Employment			

	History and Physical Form. A current policy, Employment Files, dated 4-16-2018, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated, "...Medical file may include but are not limited to...Pre-employment medical exams...TB test results...Pre-employment Medical Questionnaire/physical...." A current policy, Tuberculosis Screening, dated 4-16-2018, was provided by the ED on 8-19-2021 at 9:10 a.m. The policy indicated, "...the Community Wellness Director is responsible for coordinating and conducting 2 step (Mantoux) tuberculin tests for all employees...testing should occur with contingent offer of employment and prior to hands on care...."			
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.	R 0216	**R216** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident #1 – Medication Self-administration assessment	10/01/2021

	(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 an assessment for self administration of medications was completed for 2 of 7 records reviewed. (Resident 1 and Resident 3) Findings include: 1. The record review for Resident 1 began on 8-19-2021 at 10:33 a.m. Diagnoses included but were not limited to, high blood pressure, insomnia, anxiety, depression, chronic pain syndrome, diabetes type 2, and chronic obstructive pulmonary disease. A review of the current physician orders indicated to leave medications in the microwave. A review of the most current Medication Self-Administration Safety Screen dated 5-19-2021 indicated Resident 1 was not		was updated 9/22/21, and deemed safe to administer own meds prepared by nursing staff, and set in microwave. Resident #3 -- Medication Self-administration assessment was completed on 9/22/21, and deemed safe to administer nasal spray, powder treatment, gel treatment, cream treatment, and inhaler. **<u>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</u>** Residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. No other residents self-administerating their medications are lacking an assessment. **<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient</u>**	

	safe to administer medications. An interview with the DON (Director of Nursing) on 8-19-2021 at 2:59 p.m., indicated there was not a service plan for Resident 1. The DON indicated on 8-19-2021 at 3:04 p.m., there was not a current Medication Self-Administration Safety Screen completed for Resident 1 as it was due now. The DON provided the most current medication self-administration safety screen dated 5-19-2021, which indicated the resident was not safe to administer medications and per the physician, the resident may not self administer medications. The DON also indicated she was aware the nursing staff was to leave the prepared medications in the microwave for the resident to take later. 2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia. A review of the most current physician orders indicated the following: Flonase Suspension 50 mcg (micrograms) 1 spray in both nostrils one time a day for		**practice does not recur** All licensed nurses and QMA's will be reeducated on following physician's orders, following self-administration, and monitoring residents for ability to take own medications. Any resident having difficulty/change in condition will be reevaluated for self-administration of medication. DONW, or designee, will run a report of late/missing assessments Monday-Friday x2 weeks, then 3x/week x4 weeks, then weekly ongoing. Late/missing assessments on report will be completed, or brought up to date at the time of discovery. **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**	

	inflammation of nose, allergy, unsupervised self-administration, with a start date of 11-19-2019 Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) mcg 2 puff via trach every 4 hours for SOB (shortness of breath) unsupervised self-administration with a start date of 5-21-2021. Lac-Hydrin Cream 12 % (Ammonium Lactate), apply to both hands topically two times a day for dry skin, unsupervised self-administration ok to keep at bedside, with a start date of 4-6-2021. Nystatin Powder Apply to folds topically every shift for redness unsupervised self-administration revised on 6-22-2021 Admission orders dated 10-10-2019 were provided for Resident 3 by the DON on 8-19-2021 at 2:57 p.m. The orders indicated patient required staff to administer medications. The most current assessment dated 4-22-2021 for Resident 3 indicated the following statements were marked as follows: Caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect.		DONW will report findings or trends in late/missing assessments to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic changes will be completed:** Completion date of 10/1/21	

	Round the clock need. Insulin injections administered per caregiver and/or fingerstick glucose monitoring. At least one time per day. BID, TID, QID, (every 12 hours, every 8 hours and every 6 hours) and round the clock need. The most current service plan for medications for Resident 3 was revised on 4-27-2021 and indicated the following interventions: At times confused by medication and/or requires periodic supervision of dosage revised on 4-27-2021. Did not know name, reason or time of medication revised on 4-27-2021. Required daily supervision of medication. During an interview with Resident 3 on 8-18-2021 at 2:11 p.m., the resident indicated she had her nasal spray, inhaler and Nystatin powder in her room. The medications were observed to lined up neatly on a table next to the resident's bed. An interview with the DON on 8-19-2021 at 2:59 p.m., indicated Resident 3 did not have a Medication			

	Self-Assessment Safety Screen completed for the nasal spray, inhaler, lotion and Nystatin powder. A current policy, Medication Program for Self-Medication Policy, revised on 1-20-2020, was provided by the DON on 8-19-2021 at 3:12 p.m. The policy 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...." Based on observation, interview, and record review, the facility failed to ensure an assessment for self administration of medications was completed for 2 of 7 records reviewed. (Resident 1 and Resident 3) Findings include: 1. The record review for Resident 1 began on 8-19-2021 at 10:33 a.m. Diagnoses included but were not limited to, high blood pressure, insomnia, anxiety, depression, chronic pain syndrome, diabetes type 2, and chronic obstructive pulmonary disease. A review of the current physician orders indicated to			

	leave medications in the microwave. A review of the most current Medication Self-Administration Safety Screen dated 5-19-2021 indicated Resident 1 was not safe to administer medications. An interview with the DON (Director of Nursing) on 8-19-2021 at 2:59 p.m., indicated there was not a service plan for Resident 1. The DON indicated on 8-19-2021 at 3:04 p.m., there was not a current Medication Self-Administration Safety Screen completed for Resident 1 as it was due now. The DON provided the most current medication self-administration safety screen dated 5-19-2021, which indicated the resident was not safe to administer medications and per the physician, the resident may not self administer medications. The DON also indicated she was aware the nursing staff was to leave the prepared medications in the microwave for the resident to take later. 2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia.			

	A review of the most current physician orders indicated the following: Flonase Suspension 50 mcg (micrograms) 1 spray in both nostrils one time a day for inflammation of nose, allergy, unsupervised self-administration, with a start date of 11-19-2019 Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) mcg 2 puff via trach every 4 hours for SOB (shortness of breath) unsupervised self-administration with a start date of 5-21-2021. Lac-Hydrin Cream 12 % (Ammonium Lactate), apply to both hands topically two times a day for dry skin, unsupervised self-administration ok to keep at bedside, with a start date of 4-6-2021. Nystatin Powder Apply to folds topically every shift for redness unsupervised self-administration revised on 6-22-2021 Admission orders dated 10-10-2019 were provided for Resident 3 by the DON on 8-19-2021 at 2:57 p.m. The orders indicated patient required staff to administer medications.			

	The most current assessment dated 4-22-2021 for Resident 3 indicated the following statements were marked as follows: Caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. Round the clock need. Insulin injections administered per caregiver and/or fingerstick glucose monitoring. At least one time per day. BID, TID, QID, (every 12 hours, every 8 hours and every 6 hours) and round the clock need. The most current service plan for medications for Resident 3 was revised on 4-27-2021 and indicated the following interventions: At times confused by medication and/or requires periodic supervision of dosage revised on 4-27-2021. Did not know name, reason or time of medication revised on 4-27-2021. Required daily supervision of medication. During an interview with Resident 3 on 8-18-2021 at 2:11			

	p.m., the resident indicated she had her nasal spray, inhaler and Nystatin powder in her room. The medications were observed to lined up neatly on a table next to the resident's bed. An interview with the DON on 8-19-2021 at 2:59 p.m., indicated Resident 3 did not have a Medication Self-Assessment Safety Screen completed for the nasal spray, inhaler, lotion and Nystatin powder. A current policy, Medication Program for Self-Medication Policy, revised on 1-20-2020, was provided by the DON on 8-19-2021 at 3:12 p.m. The policy 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...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7;	R 0298	**R298** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**	10/01/2021

	(B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview, the facility failed to monitor the medication storage refrigerator temperatures for 6 of 8 months reviewed. Findings include: During an observation of the medication storage room on 8-19-21 at 10:15 a.m., a staff member was observed to be in front of the refrigerator and going through the medications. In front of the freezer door, was a empty clear clip. The wellness nurse indicated the temperature logs were kept in a book. During an observation of the temperature log book on 8-19-21 at 10:20 a.m., the book had a divider for each month of the year. For the month of January 2021, there was a		No residents were identified **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 residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. Medication refrigerator temperature logs have been available in the medication room, and been utilized since 8/18/21. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Nurses/QMA's reeducated on where to locate the blank temperature forms, and their responsibility for taking and recording the temperatures. The DONW, or designee, will monitor medication refrigerator temperature log Monday-Friday x4 weeks,	

	current temperature log. For the month of February 2021, there was not a temperature log. For the months of March and April, there were only temperature logs for the year 2019. For the month of May 2021, there was no current temperature log. For the month of June 2021, there was no current temperature log. For the month of July 2021, there was only a temperature log for the year 2019. For the month of August 2021, there was not temperature log started. The Director of Nursing (DON) was interviewed on 8-19-21 at 10:25 a.m. The DON indicated, they might have kept the current temperature logs in a different book. She indicated she would ask for it. The DON was interviewed on 8-19-21 at 10:49 a.m., and indicated they did not have another book with the medication refrigerator temperature documentation. The temperature logs which were in the current book was what they have. The DON indicated the third shift nursing staff were supposed to monitor the medication refrigerator temperatures. A current policy, Medication storage in the facility dated for January 2007, was provided by the Executive Director on 8-19-21 at 2:20 p.m. The policy		then 3x/week x4 weeks, and omissions will be corrected at the time of discovery. **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** DONW will report findings or trends in missing medication refrigerator temperature logs to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic changes will be completed:** Completion date of 10/1/21	

	indicated..." Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified...." Based on observation and interview, the facility failed to monitor the medication storage refrigerator temperatures for 6 of 8 months reviewed. Findings include: During an observation of the medication storage room on 8-19-21 at 10:15 a.m., a staff member was observed to be in front of the refrigerator and going through the medications. In front of the freezer door, was a empty clear clip. The wellness nurse indicated the temperature logs were kept in a book. During an observation of the temperature log book on 8-19-21 at 10:20 a.m., the book had a divider for each month of the year. For the month of January 2021, there was a current temperature log. For the month of February 2021, there was not a temperature log. For the months of March and April, there were only temperature logs for the year 2019. For the month of May 2021, there was no current temperature log. For the month of June 2021, there was no current temperature log. For the month of July 2021, there was only a temperature			

	log for the year 2019. For the month of August 2021, there was not temperature log started. The Director of Nursing (DON) was interviewed on 8-19-21 at 10:25 a.m. The DON indicated, they might have kept the current temperature logs in a different book. She indicated she would ask for it. The DON was interviewed on 8-19-21 at 10:49 a.m., and indicated they did not have another book with the medication refrigerator temperature documentation. The temperature logs which were in the current book was what they have. The DON indicated the third shift nursing staff were supposed to monitor the medication refrigerator temperatures. A current policy, Medication storage in the facility dated for January 2007, was provided by the Executive Director on 8-19-21 at 2:20 p.m. The policy indicated..." Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified...."			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs	R 0301	**R301** **What corrective action will be accomplished for those**	10/01/2021

	shall include the following: (A) Resident ' s full name. (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 prescription medications were labeled with the required information and stored correctly for 12 residents of 86 residents reviewed. (Resident 3, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 22, Resident 23, and Resident 24) Findings include: During an observation of the medication pass on 8-17-2021 at 11:32 a.m., Nurse 4 was		**<u>residents found to have been affected by the deficient practice</u>** Resident #3 – received a new, unopened, Lantus Solostar insulin pen on 8/17/21, old pen discarded. Resident #8 – received a new, unopened, Novolog Flexpen on 8/17/21, old pen discarded. Resident #9 -- received a new, unopened, Novolog Flexpen with a prescription label on 8/17/21, old pen discarded. Resident #10 -- received a new, unopened, Novolog Flexpen with a prescription label and a Lantus Solostar pen with a prescription label on 8/17/21, old pens discarded. Resident #11 -- received a new, unopened, Tresiba Flexpen with a prescription label and a Victoza insulin pen with a prescription label on 8/17/21, old pens discarded. Resident #12 -- - received 2 new, unopened, Novolog	

	observed to remove a Novolog FlexPen for Resident 22 from the insulin medication cart. The Novolog FlexPen was observed without the resident's name, opened date or a prescription label affixed to the pen. When this concern was brought to the attention of Nurse 4, the nurse was observed to write Resident 4's name on the pen and put an opened date of 8-17-2021 on the pen. On 8-17-2021 at 2:17 p.m., the insulin medication cart was observed with the DON (Director of Nursing) and Nurse 4 in the Wellness office. Inside the insulin medication cart in the second drawer, insulin pens were stored in open, plastic bins. The bins were labeled with a resident's first initial and last name. The following was observed in the insulin medication cart: Resident 3 had a Lantus SoloStar insulin pen with an opened date of 8-18-2021. There was about 100 units left of the 300 unit pen. Resident 8 had an opened Novolog FlexPen with a prescription label, but no opened date on the pen. An unlabeled, unopened Lantus SoloStar pen was observed in the bin labeled with Resident 8's first initial and last name.		Flexpens with prescription labels on 8/17/21, old pens discarded. Resident #13 -- received 2 new, unopened, Humalog Quickpens with prescription labels on 8/17/21, old pens discarded. Resident #14 -- received a new, unopened, Novolog Flexpen with a prescription label and a Lantus Solostar pen with a prescription label on 8/17/21, old pens discarded. Resident #15 -- received a new, unopened, Novolog Flexpen with a prescription label and a Lantus Solostar pen with a prescription label and a Humalog Quickpen with a prescription label on 8/17/21, old pens discarded. Resident #23 -- - received a new, unopened, Novolog Flexpen with a prescription label and a Lantus Solostar pen with a prescription label on 8/17/21, old pens discarded. Resident #24 -- received a new, unopened, Novolog Flexpen with a prescription label, a Lispro	

	Resident 9 had an opened Novolog FlexPen without a prescription label, no opened date and only the initials of her first and last name on the pen. Resident 10 had an opened Novolog FlexPen without a prescription label, no opened date and only the initials of his first and last name on the pen. An opened Lantus SoloStar pen was observed for Resident 10 without an opened date on the pen. Resident 11 had an unopened Tresiba Flextouch Pen without a prescription label in the insulin medication cart. Resident 11 also had an opened Victoza insulin pen without a prescription label and without an opened date. Resident 12 had an opened Novolog FlexPen without a prescription label and without an opened date. There was about 12 units left in the pen. Resident 12 had another opened Novolog FlexPen without a prescription label, and only the initials of her first and last name on the pen. There was an opened date written on the pen. Resident 23 had an unopened Novolog FlexPen with a prescription date of 6-19-2021 in his plastic bin in the insulin medication cart. Resident 23 also had an opened Lantus		Quickpen with a prescription label, and a Basaglar Flexpen with a prescription label on 8/17/21, old pens discarded. **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** Diabetic residents with insulin orders are at risk of the alleged deficit practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** DONW, or designee, to audit insulin cart Monday-Friday x4 weeks for prescription labels and open dates on insulin pens, then 3x/week x4 weeks, then weekly ongoing. **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** DONW will report findings or trends of	

	SoloStar pen with a prescription dated of 5-19-2021 and without an opened date. There was approximately 180 units left in the Lantus SoloStar pen. Resident 24 had an opened Novolog FlexPen without a prescription label and with an opened date of 7-13-2021. There was about 100 units left in the Novolog FlexPen. Resident 24 had an opened Basaglar FlexPen with a prescription date of 8-6-2021 and without an opened date. Resident 24 had an opened Novolog FlexPen with a prescription date of 7-21-2021 and without an opened date written on the pen. Resident 24 had an opened Insulin Lispro KwikPen with a prescription date of 7-20-2021 and no opened date written on the pen. There was about 80 units left in the Insulin Lispro pen. Resident 13 had an opened Humalog KwikPen without a prescription label on the pen and with an opened date of 7-28-2021. The resident's initials of her first and last name were on the pen. Resident 13 had an unopened Humalog KwikPen in Resident 14's bin without a prescription label and only the initials of her first and last name on the pen. A date of 7-22 was observed to be written on the pen.		non-labeled, non-dated insulin pens to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic changes will be completed:** Completion date of 10/1/21	

	Resident 14 had an opened Novolog FlexPen with a prescription label dated 7-13-2021 and without an opened date. The was about 75 units left in the Novolog FlexPen. Resident 14 also had an opened Lantus SoloStar pen with a prescription label dated 7-13-2021 and without an opened date on the pen. There was about 160 units of the Lantus insulin left in the pen. Resident 15 had a opened Lantus SoloStar pen without a prescription label on the pen and with an opened dated of 8-14-2021. The resident's initials of his first and last name was observed on the pen. Resident 15 also had an opened Novolog FlexPen without a prescription labels and with an opened date of 8-5-2021. The resident's initials of his first and last name was observed on the pen. Resident 15 had an opened Humalog KwikPen in his plastic bin without a prescription label, name or opened date on the pen. During an interview with the DON and Nurse 4 on 8-17-2021 at 2:45 p.m., both the DON and nurse indicated the insulin pens came from the pharmacy with a label on each of the insulin pens. They indicated the pens for each resident were in the refrigerator in a larger plastic			

	bag with a prescription label affixed to the plastic bag. Nurse 4 indicated when an insulin pen was removed from the plastic bag, the prescription labels on the pens sometimes stick together and pull off. The DON provided the storage information for the insulin pens. The DON provided the current pharmacy guidance, Stability of Common Insulins in Vials and Pens, from DiabetesinControl which was updated November (year not provided) on 8-17-2021 at 2:50 p.m. The guidance indicated the following: Humalog KwikPen insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Novolog FlexPen insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Lantus SoloStar insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Tresiba Flextouch insulin will expire after 56 days once opened or unopened and removed from the refrigerator.			

	Victoza insulin will expire after 30 days once opened or unopened and removed from the refrigerator. Current Novolog FlexPen instructions last revised 01/2019 was provided by the DON on 8-17-2021 at 2:50 p.m. The instructions indicated "...Where to store Novolog FlexPen...unused pens should be kept in the refrigerator...open or in-use pens should be kept at room temperature for a maximum of 28 days...After 28 days, Novolog FlexPen pens should be thrown away in the trash-even if there is leftover insulin...." A current policy, Medication Labels, dated May 2016, was provided by the Executive Director on 8-19-2021 at 2:30 p.m. The policy indicated "...Labels are permanently affixed to the outside of the prescription container...If a label does not fit directly onto the product...the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container...Each prescription label includes...Resident's name, specific directions for use, including route of administration...Medication name...strength of medication...Prescriber's			

	name...Date dispensed...Quantity of medication...Beyond use or expiration date of medication...name, address, and telephone number of dispensing pharmacy...prescription number...." Based on observation, interview, and record review, the facility failed to ensure prescription medications were labeled with the required information and stored correctly for 12 residents of 86 residents reviewed. (Resident 3, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 22, Resident 23, and Resident 24) Findings include: During an observation of the medication pass on 8-17-2021 at 11:32 a.m., Nurse 4 was observed to remove a Novolog FlexPen for Resident 22 from the insulin medication cart. The Novolog FlexPen was observed without the resident's name, opened date or a prescription label affixed to the pen. When this concern was brought to the attention of Nurse 4, the nurse was observed to write Resident 4's name on the pen and put an opened date of 8-17-2021 on			

	the pen. On 8-17-2021 at 2:17 p.m., the insulin medication cart was observed with the DON (Director of Nursing) and Nurse 4 in the Wellness office. Inside the insulin medication cart in the second drawer, insulin pens were stored in open, plastic bins. The bins were labeled with a resident's first initial and last name. The following was observed in the insulin medication cart: Resident 3 had a Lantus SoloStar insulin pen with an opened date of 8-18-2021. There was about 100 units left of the 300 unit pen. Resident 8 had an opened Novolog FlexPen with a prescription label, but no opened date on the pen. An unlabeled, unopened Lantus SoloStar pen was observed in the bin labeled with Resident 8's first initial and last name. Resident 9 had an opened Novolog FlexPen without a prescription label, no opened date and only the initials of her first and last name on the pen. Resident 10 had an opened Novolog FlexPen without a prescription label, no opened date and only the initials of his first and last name on the pen. An opened Lantus SoloStar pen was observed for Resident 10			

	without an opened date on the pen. Resident 11 had an unopened Tresiba Flextouch Pen without a prescription label in the insulin medication cart. Resident 11 also had an opened Victoza insulin pen without a prescription label and without an opened date. Resident 12 had an opened Novolog FlexPen without a prescription label and without an opened date. There was about 12 units left in the pen. Resident 12 had another opened Novolog FlexPen without a prescription label, and only the initials of her first and last name on the pen. There was an opened date written on the pen. Resident 23 had an unopened Novolog FlexPen with a prescription date of 6-19-2021 in his plastic bin in the insulin medication cart. Resident 23 also had an opened Lantus SoloStar pen with a prescription dated of 5-19-2021 and without an opened date. There was approximately 180 units left in the Lantus SoloStar pen. Resident 24 had an opened Novolog FlexPen without a prescription label and with an opened date of 7-13-2021. There was about 100 units left in the Novolog FlexPen. Resident 24 had an opened			

	Basaglar FlexPen with a prescription date of 8-6-2021 and without an opened date. Resident 24 had an opened Novolog FlexPen with a prescription date of 7-21-2021 and without an opened date written on the pen. Resident 24 had an opened Insulin Lispro KwikPen with a prescription date of 7-20-2021 and no opened date written on the pen. There was about 80 units left in the Insulin Lispro pen. Resident 13 had an opened Humalog KwikPen without a prescription label on the pen and with an opened date of 7-28-2021. The resident's initials of her first and last name were on the pen. Resident 13 had an unopened Humalog KwikPen in Resident 14's bin without a prescription label and only the initials of her first and last name on the pen. A date of 7-22 was observed to be written on the pen.			

	Resident 14 had an opened Novolog FlexPen with a prescription label dated 7-13-2021 and without an opened date. The was about 75 units left in the Novolog FlexPen. Resident 14 also had an opened Lantus SoloStar pen with a prescription label dated 7-13-2021 and without an opened date on the pen. There was about 160 units of the Lantus insulin left in the pen. Resident 15 had a opened Lantus SoloStar pen without a prescription label on the pen and with an opened dated of 8-14-2021. The resident's initials of his first and last name was observed on the pen. Resident 15 also had an opened Novolog FlexPen without a prescription labels and with an opened date of 8-5-2021. The resident's initials of his first and last name was observed on the pen. Resident 15 had an opened Humalog KwikPen in his plastic bin without a prescription label, name or opened date on the pen. During an interview with the DON and Nurse 4 on 8-17-2021 at 2:45 p.m., both the DON and nurse indicated the insulin pens came from the pharmacy with a label on each of the insulin pens. They indicated the pens for each resident were in the refrigerator in a larger plastic			

	bag with a prescription label affixed to the plastic bag. Nurse 4 indicated when an insulin pen was removed from the plastic bag, the prescription labels on the pens sometimes stick together and pull off. The DON provided the storage information for the insulin pens. The DON provided the current pharmacy guidance, Stability of Common Insulins in Vials and Pens, from DiabetesinControl which was updated November (year not provided) on 8-17-2021 at 2:50 p.m. The guidance indicated the following: Humalog KwikPen insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Novolog FlexPen insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Lantus SoloStar insulin will expire after 28 days once opened or unopened and removed from the refrigerator. Tresiba Flextouch insulin will expire after 56 days once opened or unopened and removed from the refrigerator.			

	Victoza insulin will expire after 30 days once opened or unopened and removed from the refrigerator. Current Novolog FlexPen instructions last revised 01/2019 was provided by the DON on 8-17-2021 at 2:50 p.m. The instructions indicated "...Where to store Novolog FlexPen...unused pens should be kept in the refrigerator...open or in-use pens should be kept at room temperature for a maximum of 28 days...After 28 days, Novolog FlexPen pens should be thrown away in the trash-even if there is leftover insulin...." A current policy, Medication Labels, dated May 2016, was provided by the Executive Director on 8-19-2021 at 2:30 p.m. The policy indicated "...Labels are permanently affixed to the outside of the prescription container...If a label does not fit directly onto the product...the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container...Each prescription label includes...Resident's name, specific directions for use, including route of administration...Medication name...strength of medication...Prescriber's			

	name...Date dispensed...Quantity of medication...Beyond use or expiration date of medication...name, address, and telephone number of dispensing pharmacy...prescription number...."			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview and record review, the facility failed to ensure medications were secured in locked carts for 2 of 4 medication carts observed. Findings include: An observation of Medication cart 1 in the Wellness nurse office on 8-17-2021 at 11:23 a.m., indicated the medication cart was unlocked. The door to the Wellness office from the hallway was observed to to open. Inside the office, there	R 0304	**R304** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. Nurse #4 is no longer employed at Silver Birch.	10/01/2021

	were doors to rooms which were closed. A NP (Nurse Practitioner) was observed in one office with the door opened and she did not have sight of Medication Cart 1. The NP was here to see residents and not employed by the facility. An observation of the insulin medication cart on 8-17-2021 at 11:45 a.m., indicated Nurse 4 was observed to prepare insulin for a resident in room 421. At 11:49 a.m., Nurse 4 entered the resident's room, closed the door, and left the insulin medication cart unlocked and unattended in the hallway. An observation in the Wellness Nurse office on 8-17-2021 at 11:58 a.m., indicated Nurse 4 was in the Wellness Nurse office and was preparing insulin for a resident. When the nurse was prompted to check the prescription label on the Novolog FlexPen, Nurse 4 found the insulin pen was for another resident. After looking in the insulin medication cart, she was unable to find the insulin pen for the resident she needed. The nurse was observed to enter the medication room at 12:01 p.m., leaving the resident standing right next to the unlocked insulin medication cart. Medication Cart 1 was observed to be unlocked at this time and was right next to the insulin medication cart. The		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Nurses/QMA's will be reeducated of their responsibility to lock medication/insulin carts when unattended. Nurse #4 is no longer employed at Silver Birch. **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** Random rounds on all shifts by the DONW, or designee. DONW will report findings or trends of non-labeled, non-dated insulin pens to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic**	

	door to the Wellness office remained opened as another resident was waiting in the doorway. Nurse 4 returned at 12:02 p.m. to the insulin medication cart. An interview with the DON (Director of Nursing) on 8-17-2021 at 2:45 p.m., indicated medication carts should be locked at all times when nursing staff were not right there with the medication carts. A current policy, Medication Storage in the Facility, dated December 2013, was provided by the ED (Executive Director) on 8-19-2021 at 2:20 p.m. The policy indicated, "...Medications are to be stored in a secure location (single locked), in accordance with state and federal laws...the facility must store all drugs and biologicals in a locked compartment under temperature controls and permit only authorized personnel to have access to the keys..." Based on observation, interview and record review, the facility failed to ensure medications were secured in locked carts for 2 of 4 medication carts observed. Findings include: An observation of Medication cart 1 in the Wellness nurse office on 8-17-2021 at 11:23		**changes will be completed:** Completion date of 10/1/21	

	a.m., indicated the medication cart was unlocked. The door to the Wellness office from the hallway was observed to to open. Inside the office, there were doors to rooms which were closed. A NP (Nurse Practitioner) was observed in one office with the door opened and she did not have sight of Medication Cart 1. The NP was here to see residents and not employed by the facility. An observation of the insulin medication cart on 8-17-2021 at 11:45 a.m., indicated Nurse 4 was observed to prepare insulin for a resident in room 421. At 11:49 a.m., Nurse 4 entered the resident's room, closed the door, and left the insulin medication cart unlocked and unattended in the hallway. An observation in the Wellness Nurse office on 8-17-2021 at 11:58 a.m., indicated Nurse 4 was in the Wellness Nurse office and was preparing insulin for a resident. When the nurse was prompted to check the prescription label on the Novolog FlexPen, Nurse 4 found the insulin pen was for another resident. After looking in the insulin medication cart, she was unable to find the insulin pen for the resident she needed. The nurse was observed to enter the medication room at 12:01 p.m., leaving the resident standing			

	right next to the unlocked insulin medication cart. Medication Cart 1 was observed to be unlocked at this time and was right next to the insulin medication cart. The door to the Wellness office remained opened as another resident was waiting in the doorway. Nurse 4 returned at 12:02 p.m. to the insulin medication cart. An interview with the DON (Director of Nursing) on 8-17-2021 at 2:45 p.m., indicated medication carts should be locked at all times when nursing staff were not right there with the medication carts. A current policy, Medication Storage in the Facility, dated December 2013, was provided by the ED (Executive Director) on 8-19-2021 at 2:20 p.m. The policy indicated, "...Medications are to be stored in a secure location (single locked), in accordance with state and federal laws...the facility must store all drugs and biologicals in a locked compartment under temperature controls and permit only authorized personnel to have access to the keys..."			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible	R 0356	**R356** **What corrective action will be accomplished for those**	10/01/2021

	for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to maintain current, updated information for the emergency preparedness book for 7 of 7 residents reviewed. (Resident 4, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, and Resident 21) Findings include:		**<u>residents found to have been affected by the deficient practice</u>** Resident #4 – photo of resident added to emergency preparedness book on facesheet on 8/19/21 Resident #16 – photo of resident added to emergency preparedness book on facesheet on 8/19/21 Resident #17 – photo of resident added to emergency preparedness book on facesheet on 8/19/21 Resident #18 -- photo of resident added to emergency preparedness book on facesheet on 8/19/21 Resident #19 – current room number changed on facesheet in emergency preparedness book on 8/19/21	

	During a record review of the emergency preparedness book on 8-18-21 at 2:00 p.m., the move in record for Resident 4, dated 8-13-21, lacked a photo of Resident 4 located on record. During a record review of the emergency preparedness book on 8-18-21 at 2:05 p.m., the move in record for Resident 16, dated 7-26-21, lacked a photo of Resident 16 located on record. During a record review of the emergency preparedness book on 8-18-21 at 2:07 p.m., the move in record for Resident 17, dated 7-26-21, lacked a photo of Resident 17 located on record. Resident 17's admission date was 7-21-21. During a record review of the emergency preparedness book on 8-18-21 at 2:09 p.m., the move in record for Resident 18, dated 8-13-21, lacked a photo of Resident 18 located on record. Resident 18's admission date was 8-12-21. During a record review of the emergency preparedness book on 8-18-21 at 2:12 p.m., the move in record for Resident 19, dated 2-29-20, indicated Resident 19 did not have current room number on record. During a record review of the emergency preparedness book on 8-18-21 at 2:15 p.m., the		Resident #20 – current room number changed on facesheet in emergency preparedness book on 8/19/21 Resident #21 – photo of resident added to emergency preparedness book on facesheet on 8/19/21 **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. Emergency preparedness bookhas been kept up to date. **<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</u>** All staff will be reeducated on where to locate the	

	move in record for Resident 20, dated 2-29-20, indicated Resident 20 did not have current room number on record. During a record review of the emergency preparedness book on 8-18-21 at 2:19 p.m., the move in record for Resident 21, dated 7-15-21, lacked a photo of Resident 21 located on record. Resident 21's admission date was 7-9-21. An interview with the ED (Executive Director) on 8-18-21 at 2:50 p.m., indicated the BOM (Business Office Manager) or the receptionist were responsible to keep the emergency preparedness book current. The ED indicated the facility did not have a current facility policy regarding the emergency preparedness book, but they would follow the state residential regulations. Based on interview and record review, the facility failed to maintain current, updated information for the emergency preparedness book for 7 of 7 residents reviewed. (Resident 4, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, and Resident 21) Findings include: During a record review of the emergency preparedness book on 8-18-21 at 2:00 p.m., the move in record for Resident 4,		emergency preparedness book. Business Office Manager will be reeducatd on updating book with any changes. The Business Office Manager,or designee, will monitor the emergency preparedness book Monday-Friday x4 weeks, then 3x/week x4 weeks, and omissions will be corrected at the time of discovery. **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** Business Office Manager will report findings of missing photos, or unchanged room numbers to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic changes will be completed:** Completion date of 10/1/21	

	dated 8-13-21, lacked a photo of Resident 4 located on record. During a record review of the emergency preparedness book on 8-18-21 at 2:05 p.m., the move in record for Resident 16, dated 7-26-21, lacked a photo of Resident 16 located on record. During a record review of the emergency preparedness book on 8-18-21 at 2:07 p.m., the move in record for Resident 17, dated 7-26-21, lacked a photo of Resident 17 located on record. Resident 17's admission date was 7-21-21. During a record review of the emergency preparedness book on 8-18-21 at 2:09 p.m., the move in record for Resident 18, dated 8-13-21, lacked a photo of Resident 18 located on record. Resident 18's admission date was 8-12-21. During a record review of the emergency preparedness book on 8-18-21 at 2:12 p.m., the move in record for Resident 19, dated 2-29-20, indicated Resident 19 did not have current room number on record.			

	During a record review of the emergency preparedness book on 8-18-21 at 2:15 p.m., the move in record for Resident 20, dated 2-29-20, indicated Resident 20 did not have current room number on record. During a record review of the emergency preparedness book on 8-18-21 at 2:19 p.m., the move in record for Resident 21, dated 7-15-21, lacked a photo of Resident 21 located on record. Resident 21's admission date was 7-9-21. An interview with the ED (Executive Director) on 8-18-21 at 2:50 p.m., indicated the BOM (Business Office Manager) or the receptionist were responsible to keep the emergency preparedness book current. The ED indicated the facility did not have a current facility policy regarding the emergency preparedness book, but they would follow the state residential regulations.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by	R 0410	**R410** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**	10/01/2021

	whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure a two step Mantoux test for Tuberculosis (TB) was completed upon admission or within 90 days of admission of 1 of 7 residents reviewed for TB testing/screening. Resident 4 Findings include: The record review for Resident 4 began on 8-19-2021 at 11:27 a.m. Diagnoses included but were not limited to, fibromyalgia, type 2 diabetes, depression, anxiety, hypertensive heart disease with heart failure, atrial fibrillation, peripheral vascular disease, and asthma.		Resident #4 – admission mantoux to be given **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** All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. DONW, or designee, will utilize new admission checklist to include ensuring that a mantoux is given to all new residents upon arrival to community. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**	

	A review of Resident 3's record indicated the step 1 Mantoux skin test for TB was completed on 8-7-2020 and was negative. No further TB testing/screenings were located in the resident's record. The ED (Executive Director) provided Resident 4's Mantoux skin test for TB documentation on 8-19-2021 at 2:35 p.m., which indicated the first step TB test was done on 8-7-2020. An interview with the ED on 8-19-2021 at 2:20 p.m., indicated Resident 3 did not have a second step TB, or any further TB test or screening for TB. A current policy, Tuberculosis Screening Policy, revised on 1-23-2019, was provided by the ED on 8-19-2021 at 2:35 p.m. The policy indicated "...It is the policy of Silver Birch Living that all residents are to be screened for active Tuberculosis (TB) at the time of move in and re-evaluated on an annual basis for the presence of active TB...The Director of Wellness is responsible for coordinating and conducting the Mantoux method tuberculin test for all residents, employees and volunteers...a tuberculin skin test must be completed upon admission and read between forty-eight (48) to seventy-two (72) hours...for residents who have not had a		New admission charts /PCC will be gone over in morning meeting to verify that mantoux has been given and documented. Any missing Mantoux will be corrected at the time of discovery. **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** DONW, or designee, will report findings or trends in missing admission mantouxs on check lists to QAPI committee monthly x6 months, or until 100% compliance is reached. **What date the systemic changes will be completed:** Completion date of 10/1/21	

documented negative tuberculin skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test....in lieu of tuberculin skin test, persons with a documented history of positive skin testing should have an annual risk assessment for the development of symptoms, suggestive of tuberculosis, including but not limited to, cough, fever, night sweats, and weight loss...."

Based on interview and record review, the facility failed to ensure a two step Mantoux test for Tuberculosis (TB) was completed upon admission or within 90 days of admission of 1 of 7 residents reviewed for TB testing/screening.

Resident 4

Findings include:

The record review for Resident 4 began on 8-19-2021 at 11:27 a.m. Diagnoses included but were not limited to, fibromyalgia, type 2 diabetes, depression, anxiety, hypertensive heart disease with heart failure, atrial fibrillation, peripheral vascular disease, and asthma.

A review of Resident 3's record

	indicated the step 1 Mantoux skin test for TB was completed on 8-7-2020 and was negative. No further TB testing/screenings were located in the resident's record. The ED (Executive Director) provided Resident 4's Mantoux skin test for TB documentation on 8-19-2021 at 2:35 p.m., which indicated the first step TB test was done on 8-7-2020. An interview with the ED on 8-19-2021 at 2:20 p.m., indicated Resident 3 did not have a second step TB, or any further TB test or screening for TB. A current policy, Tuberculosis Screening Policy, revised on 1-23-2019, was provided by the ED on 8-19-2021 at 2:35 p.m. The policy indicated "...It is the policy of Silver Birch Living that all residents are to be screened for active Tuberculosis (TB) at the time of move in and re-evaluated on an annual basis for the presence of active TB...The Director of Wellness is responsible for coordinating and conducting the Mantoux method tuberculin test for all residents, employees and volunteers...a tuberculin skin test must be completed upon admission and read between forty-eight (48) to seventy-two (72) hours...for residents who have not had a documented negative tuberculin			

	skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test....in lieu of tuberculin skin test, persons with a documented history of positive skin testing should have an annual risk assessment for the development of symptoms, suggestive of tuberculosis, including but not limited to, cough, fever, night sweats, and weight loss...."			
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. 3. A record review for Resident 6 on 8-19-21 at 2:35 p.m., indicated the resident's	R 0412	**R412** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident #2 – resident at rehab facility Resident #3 – annual mantoux given 9/24/21 Resident #6 – annual mantoux given 9/24/21	10/01/2021

admission date was on 4-15-19 and his discharge date was 8-7-21. Resident 6's current TB Mantoux skin test was last dated on, 1st step on 4-15-19 and the second step was dated on 4-30-19. Further record review, indicated Resident 6 did not have an annual TB Mantoux test or TB screening completed.

A current policy, Tuberculosis Screening Policy, revised on 1-23-2019, was provided by the ED on 8-19-2021 at 2:35 p.m. The policy indicated "...It is the policy of Silver Birch Living that all residents are to be screened for active Tuberculosis (TB) at the time of move in and re-evaluated on an annual basis for the presence of active TB...The Director of Wellness is responsible for coordinating and conducting the Mantoux method tuberculin test for all residents, employees and volunteers...a tuberculin skin test must be completed upon admission and read between forty-eight (48) to seventy-two (72) hours...for residents who have not had a documented negative tuberculin skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test....in lieu of tuberculin skin test, persons with a documented

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

All residents residing at Silver Birch of Fort Wayne have the potential to be affected by the alleged deficient practice. All immunizations are being added to PCC for better tracking.

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

Nurses reeducated on residents' annual mantouxs, and their responsibility for giving and documenting these. The DONW, or designee, will run immunization report Monday – Friday x4 weeks, then 3x/week x4 weeks, omissions will be corrected at the time of discovery.

history of positive skin testing should have an annual risk assessment for the development of symptoms, suggestive of tuberculosis, including but not limited to, cough, fever, night sweats, and weight loss...."

Based on interview and record review, the facility failed to ensure residents were tested/screened for TB (tuberculosis) annually for 3 of 7 records reviewed. (Resident 2, Resident 3 and Resident 6)

Findings include:

1. The record review for Resident 2 began on 8-19-2021 at 10:58 a.m. Diagnoses included but were not limited to, heart failure, heart murmur, high blood pressure, sleep apnea, and venous insufficiency.

A review of the last TB test documentation for Resident 2, indicated the 1st step Mantoux skin test (a test to check for tuberculosis) was administered on 4-25-2019 and 2nd step Mantoux skin test was administered on 5-8-2019. There was no further documentation of TB testing or a TB screen in the resident's record.

An interview with the ED (Executive Director) on 8-19-2021 at 2:20 p.m., indicated Resident 2 did not

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

DONW will report findings or trends in missing annual mantouxs to QAPI committee monthly x6 months, or until 100% compliance is reached.

What date the systemic changes will be completed:

Completion date of 10/1/21

have a TB screen or Mantoux skin test documented since her second step Mantoux skin test on 4-25-2019.

2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia.

The most recent TB screen was located in Resident 3's record and dated 3-11-2020.

The ED provided documentation of Resident 3's TB testing on 8-19-2021 at 3:06 p.m. The first step Mantoux skin test was documented as completed on 11-15-2019 and the 2nd step Mantoux skin test was documented as completed on 11-30-2019. The ED indicated there was no further TB test/screen documentation in Resident 3's record.

3. A record review for Resident 6 on 8-19-21 at 2:35 p.m., indicated the resident's admission date was on 4-15-19 and his discharge date was 8-7-21. Resident 6's current TB Mantoux skin test was last dated on, 1st step on 4-15-19 and the second step was dated on 4-30-19. Further record review, indicated Resident 6 did not have an annual TB Mantoux

test or TB screening completed.

A current policy, Tuberculosis Screening Policy, revised on 1-23-2019, was provided by the ED on 8-19-2021 at 2:35 p.m. The policy indicated "...It is the policy of Silver Birch Living that all residents are to be screened for active Tuberculosis (TB) at the time of move in and re-evaluated on an annual basis for the presence of active TB...The Director of Wellness is responsible for coordinating and conducting the Mantoux method tuberculin test for all residents, employees and volunteers...a tuberculin skin test must be completed upon admission and read between forty-eight (48) to seventy-two (72) hours...for residents who have not had a documented negative tuberculin skin test result during the preceding three (3) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test....in lieu of tuberculin skin test, persons with a documented history of positive skin testing should have an annual risk assessment for the development of symptoms, suggestive of tuberculosis, including but not limited to, cough, fever, night sweats, and weight loss...."

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A review of the last TB test documentation for Resident 2, indicated the 1st step Mantoux skin test (a test to check for tuberculosis) was administered on 4-25-2019 and 2nd step Mantoux skin test was administered on 5-8-2019. There was no further documentation of TB testing or a TB screen in the resident's record.

An interview with the ED (Executive Director) on 8-19-2021 at 2:20 p.m., indicated Resident 2 did not have a TB screen or Mantoux skin test documented since her second step Mantoux skin test on 4-25-2019.

2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes

type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia.

The most recent TB screen was located in Resident 3's record and dated 3-11-2020.

The ED provided documentation of Resident 3's TB testing on 8-19-2021 at 3:06 p.m. The first step Mantoux skin test was documented as completed on 11-15-2019 and the 2nd step Mantoux skin test was documented as completed on 11-30-2019. The ED indicated there was no further TB test/screen documentation in Resident 3's record.

3. A record review for Resident 6 on 8-19-21 at 2:35 p.m., indicated the resident's admission date was on 4-15-19 and his discharge date was 8-7-21. Resident 6's current TB Mantoux skin test was last dated on, 1st step on 4-15-19 and the second step was dated on 4-30-19. Further record review, indicated Resident 6 did not have an annual TB Mantoux test or TB screening completed.

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An interview with the ED (Executive Director) on 8-19-2021 at 2:20 p.m., indicated Resident 2 did not have a TB screen or Mantoux skin test documented since her second step Mantoux skin test on 4-25-2019.

2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia.

The most recent TB screen was located in Resident 3's record and dated 3-11-2020.

The ED provided documentation of Resident 3's TB testing on 8-19-2021 at 3:06 p.m. The first step Mantoux skin test was documented as completed on 11-15-2019 and the 2nd step Mantoux skin test was documented as completed on 11-30-2019. The ED indicated there was no further TB test/screen documentation in Resident 3's record.

3. A record review for Resident 6 on 8-19-21 at 2:35 p.m., indicated the resident's admission date was on 4-15-19 and his discharge date was 8-7-21. Resident 6's current TB Mantoux skin test was last dated on, 1st step on 4-15-19 and the second step was dated on 4-30-19. Further record review, indicated Resident 6 did not have an annual TB Mantoux test or TB screening completed.

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An interview with the ED (Executive Director) on 8-19-2021 at 2:20 p.m., indicated Resident 2 did not have a TB screen or Mantoux skin test documented since her second step Mantoux skin test on 4-25-2019.

2. The record review for Resident 3 began on 8-19-2021 at 9:28 a.m. Diagnoses included but were not limited to, diabetes type 2, chronic thromboembolic pulmonary hypertension, high blood pressure, and schizophrenia.

The most recent TB screen was located in Resident 3's record and dated 3-11-2020.

The ED provided documentation of Resident 3's TB testing on 8-19-2021 at 3:06 p.m. The first step Mantoux skin test was documented as completed on

	11-15-2019 and the 2nd step Mantoux skin test was documented as completed on 11-30-2019. The ED indicated there was no further TB test/screen documentation in Resident 3's record.			

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