STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH AT COOK ROAD	3731 WEST COOK ROAD, FORT WAYNE, , 46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00363848, IN00364285, IN00364274, IN00364441, IN00364663 and IN00364798. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00363848-Substantiated. State deficiencies related to the allegations are cited at R0246. Complaint IN00364285-Substantiated. State deficiencies related to the allegations are cited at R0036, R0090, R0246 and R0297 Complaint IN00364274-Substantiated. State deficiencies related to the allegations are cited at R0246.	R 0000		

	Complaint IN00364441 - Substantiated. State deficiencies related to the allegation is cited at R0036, R0246, and R0297. Complaint IN00364663 - Substantiated. State deficiencies related to the allegations are cited at R0246, and R0407. Complaint IN00364798 - Substantiated. State deficiencies related to the allegations are cited at R0090 and R0246. Unrelated deficiency cited. Survey dates: October 13, 14 and 15, 2021 Facility number: 014553 Residential Census: 99 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 20, 2021			
R 0030	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(e)(1-6) (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement.	R 0030	Residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice	11/15/2021

	(2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on interview and record review, the facility failed to ensure a resident remained in compliance with the admission agreement determined by the facility for 1 of 3 residents reviewed for admission, transfer and discharge. (Resident J) Finding includes: On 10/14/21 at 10:12 a.m., Resident K indicated the facility has done an illegal drug search of her room for no reason. She indicated there were residents		Residents will be re-educated on the Lease Agreements and lease rules by November 15th Resident lease agreement and rules will be adhered pertaining to discharge notifications; violations will be enforced following the resdients education on or before November 15th. Audits will be conducted by the Executive Director 2x/week for three months. IDR is requested for this deficiency due to discrepancies.	

selling drugs in the facility.

During an interview on 10/13/21 at 10:21 a.m., Resident F indicated there had been 3 overdoses in the past month with residents.

During an interview on 10/14/21 at 12:40 p.m., Resident B voiced concerns about residents being on drugs and possible drug dealers coming into the facility.

The clinical record for Resident J was reviewed on 10/13/21 at 12:20 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, diabetes mellitus, psychotic disorder and cocaine dependence.

A Resident Lease Agreement, dated 2/4/21, and signed by Resident J, indicated she received and understood the lease agreement. The agreement included, but was not limited to, the facility was a drug free environment and possession, use, sale or distribution of any controlled substances would not be tolerated and the lease would be terminated.

A progress note, dated 9/6/21 at 3:11 p.m., indicated the resident had been sleeping all day and not eating. She was asked if she smoked any crack while she was out. The resident admitted

she smoked one hundred dollars worth of crack while she was out.

On 9/7/21, a Nurse Practitioner (NP) note indicated the resident was seen for cocaine abuse. The NP progress note dated 9/9/21 at 11:01 a.m., indicated Resident J was sent to the hospital with abnormal vital signs. The resident admitted to using illegal drugs and the drugs were seized by the Executive Director.

A progress note, dated 9/13/21 at 9:19 p.m., indicated the resident returned to the facility and tested positive for cocaine use.

A progress note dated 9/20/21 at 8:59 a.m., the resident was clammy, sweating and confused. She was unable to hold her head up. The resident was questioned about drug use and was unable to answer. She was sent to the local hospital.

During an interview on 10/14/21 at 10:55 a.m., the Nurse Consultant and Administrator were unsure of the concern with Resident J. The resident did not appear to be doing drugs in the facility and they could not search her room for drugs.

Based on interview and record review, the facility failed to ensure a resident remained in compliance with the admission

agreement determined by the facility for 1 of 3 residents reviewed for admission, transfer and discharge. (Resident J)

Finding includes:

On 10/14/21 at 10:12 a.m., Resident K indicated the facility has done an illegal drug search of her room for no reason. She indicated there were residents selling drugs in the facility.

During an interview on 10/13/21 at 10:21 a.m., Resident F indicated there had been 3 overdoses in the past month with residents.

During an interview on 10/14/21 at 12:40 p.m., Resident B voiced concerns about residents being on drugs and possible drug dealers coming into the facility.

The clinical record for Resident J was reviewed on 10/13/21 at 12:20 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, diabetes mellitus, psychotic disorder and cocaine dependence.

A Resident Lease Agreement, dated 2/4/21, and signed by Resident J, indicated she received and understood the lease agreement. The agreement included, but was not limited to, the facility was a drug free environment and

possession, use, sale or distribution of any controlled substances would not be tolerated and the lease would be terminated.

A progress note, dated 9/6/21 at 3:11 p.m., indicated the resident had been sleeping all day and not eating. She was asked if she smoked any crack while she was out. The resident admitted she smoked one hundred dollars worth of crack while she was out.

On 9/7/21, a Nurse Practitioner (NP) note indicated the resident was seen for cocaine abuse. The NP progress note dated 9/9/21 at 11:01 a.m., indicated Resident J was sent to the hospital with abnormal vital signs. The resident admitted to using illegal drugs and the drugs were seized by the Executive Director.

A progress note, dated 9/13/21 at 9:19 p.m., indicated the resident returned to the facility and tested positive for cocaine use.

A progress note dated 9/20/21 at 8:59 a.m., the resident was clammy, sweating and confused. She was unable to hold her head up. The resident was questioned about drug use and was unable to answer. She was sent to the local hospital.

During an interview on 10/14/21

	at 10:55 a.m., the Nurse Consultant and Administrator were unsure of the concern with Resident J. The resident did not appear to be doing drugs in the facility and they could not search her room for drugs.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the physician and/or Power of Attorney (POA) when a resident had a change in condition for 1 of 3 residents reviewed with change in condition (Resident D). Findings include: The clinical record for Resident D was reviewed on 10/13/21 at 2:33 p.m. Diagnoses included,	R 0036	Residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice Nurse will document date and time of significant change in condition. Nurse to notify physician and legal representative. Nurse will receive a physician/NP order and, a notice of transfer or discharge will be completed (form V2). The DONW or designee will audit change in conditions and findings 3x/week for one month, 2x/week for one month wand 1x/week for 1month. The audits will remain in a secured location and monitored by the Administrator, DONW or Designee.	11/15/2021

	but were not limited to, cerebral infarction, diabetes mellitus, chronic kidney disease and aneurysm of artery. A family member was designated as Power of Attorney (POA) for care and primary emergency contact. Review of the October Medication Administration Record (MAR), the resident was hospitalized on 10/3/21. The resident has not been readmitted to the facility. The clinical record lacked a physician's order for transfer, POA notification, assessment or reason for the transfer. During an interview on 10/13/21 at 3:50 p.m., the Nurse Consultant indicated they did not have any progress notes, transfer order or notification to the physician or family the resident was sent to the hospital. The resident was sent to the hospital on 10/3/21 because he was "bent over" but she had not spoken to the hospital. Review of a current facility policy, titled 'RESIDENT CHANGE IN CONDITION POLICY & PROCEDURE," provided by the Administrator on 10/15/21 at 1:04 p.m., indicated the following:		All nursing staff will be educated on or before November 15th Date the systemic changes will be completed:November 15th	

	"PURPOSE The Director of Nursing and Wellness (DON-W) or designated licensed nurse will assess a resident reported to have a change in condition and will report the change to the physician and family or legal representative promptly. ...PROCEDURE: ...3. Documentation of the change in condition shall include: Date, time, and details of onset of condition Date, time, and orders received from physician notification Date, time, and name of the family member notified and response from family member." This State tag relates to Complaint IN00364285 and IN00364441. Based on interview and record review, the facility failed to notify the physician and/or Power of Attorney (POA) when a resident had a change in condition for 1 of 3 residents reviewed with change in condition (Resident D). Findings include: The clinical record for Resident D was reviewed on 10/13/21 at			

2:33 p.m. Diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus, chronic kidney disease and aneurysm of artery.

A family member was designated as Power of Attorney (POA) for care and primary emergency contact.

Review of the October Medication Administration Record (MAR), the resident was hospitalized on 10/3/21. The resident has not been readmitted to the facility.

The clinical record lacked a physician's order for transfer, POA notification, assessment or reason for the transfer.

During an interview on 10/13/21 at 3:50 p.m., the Nurse Consultant indicated they did not have any progress notes, transfer order or notification to the physician or family the resident was sent to the hospital. The resident was sent to the hospital on 10/3/21 because he was "bent over" but she had not spoken to the hospital.

Review of a current facility policy, titled 'RESIDENT CHANGE IN CONDITION POLICY & PROCEDURE," provided by the Administrator on 10/15/21 at 1:04 p.m., indicated the following:

	"PURPOSE The Director of Nursing and Wellness (DON-W) or designated licensed nurse will assess a resident reported to have a change in condition and will report the change to the physician and family or legal representative promptly. ...PROCEDURE: ...3. Documentation of the change in condition shall include: Date, time, and details of onset of condition Date, time, and orders received from physician notification Date, time, and name of the family member notified and response from family member." This State tag relates to Complaint IN00364285 and IN00364441.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, failed to ensure a resident was free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse	R 0053	Residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice. It is the policy of Silver Birch Living to ensure that Residents have the right to be	11/15/2021

	(Resident F, QMA 1). Findings include: During an interview on 10/13/21 at 10:21 a.m., Resident F indicated she filed a complaint related to verbal abuse by a Qualified Medication Aide (QMA). The incident happened on Sunday morning about 6:50 a.m. The QMA would not give her any of her morning medications. She had also requested an unscheduled medication for pain. The QMA started yelling at her and she told the QMA to not yell at her. When the QMA turned around the resident called her a d--b b-t-ch. She had several witnesses to the abuse. She reported the incident to the Administrator and was told by the Administrator she could not fire people just because she did not like them. The clinical record was reviewed on 10/13/21 at 1:29 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia and bipolar disorder. A service plan, dated 5/5/21, indicated the resident was able to groom herself and required daily supervision with medications. On 10/13/21 2:49 p.m., the Administrator provided a copy of the grievance form by Resident		free from physical, verbal, sexual and mental abuse as well as verbal abuse including the use of oral, written or gestured language. Residents are encouraged to file a grievance and follow the grievance procedures if they have concerns. To ensure resident rights are being exercised, audits will be conducted with residents by the Executive Director or designee as follows 3/week for one month, 2/x week for one month and 1/week for one month. Results will be addresses as needed with IDT team/QA meetings. Staff will be educated on Resident Rights Abuse policy by November 15, 2021. Date the systemic changes will be completed:Nov 15, 2021 R0090	

	F. The form, dated 10/10/21, indicated the QMA refused to give the resident her morning medication and was screaming in her face. Two hours later she received some of her medication, but not the pain pill. The form indicated the QMA was like that with several other people. On 10/12/21 at 6:00 p.m., the Administrator called QMA 1 who indicated she had asked the resident to wait for her medications because there was one nurse and a QMA that did not show up to work and she was staying over. She told the resident she had been at the facility since 5:00 a.m. and was trying to help everyone. She admitted she was frustrated, but did not feel she was screaming. The QMA was removed from the schedule pending an investigation. Review of an Indiana Department of Health (IDOH) reportable, dated 10/13/21 at 3:01 p.m., indicated the investigation was pending and the resident was to provide a list of other residents who may corroborate her story, but no additional statements or interviews were provided. On 10/14/21 at 10:12 a.m., Resident K indicated she witnessed QMA 1 yelling at Resident F. She had not yet			

been interviewed by the Administrator.

During an interview on 10/15/21 at 1:02 p.m., the Administrator indicated she was still collecting statements from other residents. Another resident did verify the QMA 1 was yelling at the resident. None of the statements were documented as she was still interviewing residents.

During a telephone interview on 10/15/21 at 2:17 p.m., QMA1 denied yelling or screaming at anyone.

Review of a current facility policy, titled 'Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," provided by the Administrator on 10/13/21 at 10:54 a.m., indicated the following:

"Purpose:

Each resident has the right to be free from abuse....Residents must not be subjected to abuse by anyone including, but not limited to, facility staff....

Policy:

Residents have the right to be free from physical, verbal, sexual and mental abuse....

Definitions:

	...Verbal abuse included the use of oral, written or gestured language...." Based on interview and record review, failed to ensure a resident was free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse (Resident F, QMA 1). Findings include: During an interview on 10/13/21 at 10:21 a.m., Resident F indicated she filed a complaint related to verbal abuse by a Qualified Medication Aide (QMA). The incident happened on Sunday morning about 6:50 a.m. The QMA would not give her any of her morning medications. She had also requested an unscheduled medication for pain. The QMA started yelling at her and she told the QMA to not yell at her. When the QMA turned around the resident called her a d--b b-t-ch. She had several witnesses to the abuse. She reported the incident to the Administrator and was told by the Administrator she could not fire people just because she did not like them. The clinical record was reviewed on 10/13/21 at 1:29 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia and bipolar			

	disorder. A service plan, dated 5/5/21, indicated the resident was able to groom herself and required daily supervision with medications. On 10/13/21 2:49 p.m., the Administrator provided a copy of the grievance form by Resident F. The form, dated 10/10/21, indicated the QMA refused to give the resident her morning medication and was screaming in her face. Two hours later she received some of her medication, but not the pain pill. The form indicated the QMA was like that with several other people. On 10/12/21 at 6:00 p.m., the Administrator called QMA 1 who indicated she had asked the resident to wait for her medications because there was one nurse and a QMA that did not show up to work and she was staying over. She told the resident she had been at the facility since 5:00 a.m. and was trying to help everyone. She admitted she was frustrated, but did not feel she was screaming. The QMA was removed from the schedule pending an investigation. Review of an Indiana Department of Health (IDOH) reportable, dated 10/13/21 at 3:01 p.m., indicated the investigation was pending and the resident was to provide a list			

	of other residents who may corroborate her story, but no additional statements or interviews were provided. On 10/14/21 at 10:12 a.m., Resident K indicated she witnessed QMA 1 yelling at Resident F. She had not yet been interviewed by the Administrator. During an interview on 10/15/21 at 1:02 p.m., the Administrator indicated she was still collecting statements from other residents. Another resident did verify the QMA 1 was yelling at the resident. None of the statements were documented as she was still interviewing residents. During a telephone interview on 10/15/21 at 2:17 p.m., QMA1 denied yelling or screaming at anyone. Review of a current facility policy, titled 'Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," provided by the Administrator on 10/13/21 at 10:54 a.m., indicated the following: "Purpose:			

	Each resident has the right to be free from abuse....Residents must not be subjected to abuse by anyone including, but not limited to, facility staff.... Policy: Residents have the right to be free from physical, verbal, sexual and mental abuse.... Definitions: ...Verbal abuse included the use of oral, written or gestured language...."			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;	R 0090	residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice. It is the policy of Silver Birch Living that the Executive Director is responsible for the timely reporting of unusual occurrences include but are not limited to: epidemic outbreaks poisonings fires major accidents falls with injury, allegations of theft, misappropriation of funds or extortion. Audits of potential	11/15/2021

	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years		reportable occurrences will be conducted 3/week for 1 month, 2x/week for 1 month and PRN thereafter by Executive Director. All findings of unusual occurrences will be reported timely per regulation. Results will be addressed as needed with IDT team/QA meetings Date the systemic changes will be completed:November 15, 2021.	

	and making the reports available for inspection to any member of the public upon request Based on interview, the Administrator failed to immediately report 1 of 1 criminal breaking and entering act by an unknown person who was then arrested while at the facility. Findings include: During an interview on 10/14/21 at 3:20 p.m., Employee 6 indicated a man and woman recently left blood all over the back door of the facility. The man jumped the back fence and got into the facility through the activity room door. the incident occurred around 3:00 a.m. The police were called and stated the man was high on cocaine. He was arrested while at the facility. During an interview on 10/14/21 at 3:33 p.m., the Administrator indicated the male did get into the building and was arrested inside the facility. She was unaware if he was on drugs or not, but the incident was not reported to the Indiana Department of Health. She received direction from the corporate office and they felt it was not a reportable incident. Review of a current facility policy, titled, "REPORTABLE			

	EVENTS POLICY AND PROCEDURE," provided by the Administrator on 10/14/21 at 1:43 p.m., indicated the following: "Purpose: The Executive Director of the community shall be responsible for the timely reporting of significant reportable events to the appropriate state reporting agency.... ...3. Unusual occurrences include, but are not limited to: epidemic outbreaks poisonings fires major accidents falls with injury allegations of theft, misappropriation of funds or extortion...." This State tag relates to Complaint IN00364285 and IN00364798. Based on interview, the Administrator failed to immediately report 1 of 1 criminal breaking and entering act by an unknown person who was then arrested while at the facility.			

Findings include:

During an interview on 10/14/21 at 3:20 p.m., Employee 6 indicated a man and woman recently left blood all over the back door of the facility. The man jumped the back fence and got into the facility through the activity room door. the incident occurred around 3:00 a.m. The police were called and stated the man was high on cocaine. He was arrested while at the facility.

During an interview on 10/14/21 at 3:33 p.m., the Administrator indicated the male did get into the building and was arrested inside the facility. She was unaware if he was on drugs or not, but the incident was not reported to the Indiana Department of Health. She received direction from the corporate office and they felt it was not a reportable incident.

Review of a current facility policy, titled, "REPORTABLE EVENTS POLICY AND PROCEDURE," provided by the Administrator on 10/14/21 at 1:43 p.m., indicated the following:

"Purpose:

The Executive Director of the community shall be responsible for the timely reporting of significant reportable events to the appropriate state reporting

	agency.... ...3. Unusual occurrences include, but are not limited to: epidemic outbreaks poisonings fires major accidents falls with injury allegations of theft, misappropriation of funds or extortion...." This State tag relates to Complaint IN00364285 and IN00364798.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to	R 0246	residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice When administering a PRN medication, the QMA will document prior notification of the nurse in the progress section of the EMAR in Point Click Care. Education will be provided to nursing staff on PRN Medication administration	11/15/2021

	obtain and document authorization to administer as needed (PRN) medications in the nursing notes for 3 of 3 residents reviewed with PRN medications. (Resident B, Resident D and Resident E.) 1. The clinical record for Resident B was reviewed on 10/13/21 at 11:39 a.m. Diagnoses included, but were not limited to, hypertension, depressive disorder, anxiety and chronic pain. An order, dated 4/6/21, indicated to give Zofran (to treat nausea) 4 mg every 8 hours as needed for nausea. Review of the October progress notes, the following medication were administer by a QMA without prior authorization from a licensed nurse: a. Zofran on 10/8/21 at 7:46 p.m., 10/11/21 at 9:20 p.m., 10/13/21 at 5:19 p.m. and 10/14/21 at 9:03 a.m. 2. The clinical record for Resident D was reviewed on 10/13/21 at 2:33 p.m. Diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus, chronic kidney disease and aneurysm of artery. An order, dated 12/3/20, indicated to give Norco (opioid pain medication) 10/325 mg, 1		and documentation of notification on November 15th. To monitor compliance, the DONW or designee will audit PRN medication administration and documentation of notification: 3x/week for one month, 2x/week for one month and 1x/month for one month. Date the systemic changes will be completed:November 15, 2021.	

	tablet every 6 hours as needed for pain. Another order, dated 5/12/21, indicated to give Fiorinal (to treat tension headaches) 50-325-40 mg, 2 tablets every 8 hours as needed for migraine. Review of the October progress notes, the following medications were administered by a QMA without prior authorization from a licensed nurse: a. Norco on 10/4/21 at 5:00 p.m., 10/7/21 at 12:00 p.m., 10/8/21 at 11:41 a.m., 10/9/21 at 9:16 p.m., 10/11/21 at 7:00 p.m. and 10/15/21 at 7:11 a.m. b. Fiorinal on 10/4/21 at 3:43 p.m., 10/7/21 at 7:00 a.m., 10/8/21 at 7:00 a.m., 10/8/21 at 10:03 p.m., 10/11/21 at 7:00 p.m., 10/12/21 at 7:20 a.m. and 10/15/21 at 7:00 a.m. 3. The clinical record for Resident E was reviewed on 10/13/21 at 2:46 p.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic pain, diabetes mellitus and anxiety. An order, dated 5/13/21, indicated to give Percocet (opioid pain reliever) 325 mg, 1 tablet every 4 hours. Review of the October progress notes, the following medication was administered by a QMA			

	without prior authorization from a licensed nurse: a. Percocet on 10/8/21 at 7:55 p.m. During an interview on 10/14/21 at 12:45 p.m., QMA 7 indicated when a resident asked for a PRN medication, they would call the nurse on call and document in the progress notes. During an interview on 10/15/21 at 10:15 a.m., QMA 3 indicated if they give a PRN medication, they used to call the former Director of Nursing (DON), but now they call the nurse on duty or the nurse consultant. Review of a current facility policy, titled 'QUALIFIED MEDICATION AIDE Scope of Practice," provided by the Administrator on 10/15/21 at 1:04 p.m., indicated the following: "The following tasks are within the scope of practice for the QMA unless prohibited by facility policy: ...11). Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on all. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the			

need for the medication....

(B) Document...facility's licensed nurse was contacted...."

This State tag relates to Complaint IN00363848, IN00364274, IN00364285, IN00364441, IN00364663 and IN00364798.

Based on record review and interview, the facility failed to obtain and document authorization to administer as needed (PRN) medications in the nursing notes for 3 of 3 residents reviewed with PRN medications. (Resident B, Resident D and Resident E.)

1. The clinical record for Resident B was reviewed on 10/13/21 at 11:39 a.m. Diagnoses included, but were not limited to, hypertension, depressive disorder, anxiety and chronic pain.

An order, dated 4/6/21, indicated to give Zofran (to treat nausea) 4 mg every 8 hours as needed for nausea.

Review of the October progress notes, the following medication were administer by a QMA without prior authorization from a licensed nurse:

a. Zofran on 10/8/21 at 7:46 p.m., 10/11/21 at 9:20 p.m., 10/13/21 at 5:19 p.m. and

10/14/21 at 9:03 a.m.

2. The clinical record for Resident D was reviewed on 10/13/21 at 2:33 p.m. Diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus, chronic kidney disease and aneurysm of artery.

An order, dated 12/3/20, indicated to give Norco (opioid pain medication) 10/325 mg, 1 tablet every 6 hours as needed for pain.

Another order, dated 5/12/21, indicated to give Fiorinal (to treat tension headaches) 50-325-40 mg, 2 tablets every 8 hours as needed for migraine.

Review of the October progress notes, the following medications were administered by a QMA without prior authorization from a licensed nurse:

a. Norco on 10/4/21 at 5:00 p.m., 10/7/21 at 12:00 p.m., 10/8/21 at 11:41 a.m., 10/9/21 at 9:16 p.m., 10/11/21 at 7:00 p.m. and 10/15/21 at 7:11 a.m.

b. Fiorinal on 10/4/21 at 3:43 p.m., 10/7/21 at 7:00 a.m., 10/8/21 at 7:00 a.m., 10/8/21 at 10:03 p.m., 10/11/21 at 7:00 p.m., 10/12/21 at 7:20 a.m. and 10/15/21 at 7:00 a.m.

3. The clinical record for Resident E was reviewed on

10/13/21 at 2:46 p.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic pain, diabetes mellitus and anxiety.

An order, dated 5/13/21, indicated to give Percocet (opioid pain reliever) 325 mg, 1 tablet every 4 hours.

Review of the October progress notes, the following medication was administered by a QMA without prior authorization from a licensed nurse:

a. Percocet on 10/8/21 at 7:55 p.m.

During an interview on 10/14/21 at 12:45 p.m., QMA 7 indicated when a resident asked for a PRN medication, they would call the nurse on call and document in the progress notes.

During an interview on 10/15/21 at 10:15 a.m., QMA 3 indicated if they give a PRN medication, they used to call the former Director of Nursing (DON), but now they call the nurse on duty or the nurse consultant.

Review of a current facility policy, titled 'QUALIFIED MEDICATION AIDE Scope of Practice," provided by the Administrator on 10/15/21 at 1:04 p.m., indicated the following:

"The following tasks are within

	the scope of practice for the QMA unless prohibited by facility policy: ...11). Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on all. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication.... (B) Document...facility's licensed nurse was contacted...." This State tag relates to Complaint IN00363848, IN00364274, IN00364285, IN00364441, IN00364663 and IN00364798.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.	R 0297	residents that reside at Silver Birch have the potential to be affected by this alleged deficient practice Medications will be administered following the resident scheduled times. To monitor	11/15/2021

	Based on observation, interview and record the review, the facility failed to ensure medications were administered to residents during scheduled times for 4 of 4 residents reviewed for late medication administration. (Resident O, Resident P, Resident Q and Resident R). Findings include: 1. During medication administration on 10/15/21 with QMA 5, Resident O recieved the following medications at 8:55 a.m: a. Amlodipine (to treat high blood pressure) 10 mg. b. Flonase (to relieve seasonal allergies) 1 spray each nostril. c. Lasix (diuretic) 40 mg. d. Cozaar (to treat high blood pressure) 100 mg. e. Metoprolol (to treat high blood pressure) 100 mg. f. Vitamin D3 1.25 mg. g. Flovent 44 mcg, 2 inhalations. h. Calcium 500 mg. i. Hydralazine (to treat high blood pressure) 10 mg.		compliance, the DONW or designee will implement an audit of resident EMAR's for missed administration and review administration times. This audit will begin the week on Nov 1 and will include ten residents per week until all residents have been reviewed over the next three months. Additionally, staff will be educated on medication administration processes on or before November 15th.	

j. Carbamazepine (to prevent and control seizures) 200 mg.

Review of Resident O's medication orders, the following medications were to be given at 6:00 a.m: amlodipine, Flonase, Cozaar and carbamazepine. The following medications were to be given at 7:00 a.m: Lasix, metoprolol, vitamin D3, Flovent, calcium and hydralazine.

2. Resident P received the following medication at 9:15 a.m. on 10/15/21 during medication pass observation.

a. Nicotine patch 7 mg/24 hr.

b. Metformin 1000 mg.

c. Aspirin 81 mg.

d. Coenzyme Q-10.

e. Zetia (lipid-lowering) 10 mg.

f. Neurontin (nerve pain) 300 mg.

g. Namenda (to treat moderate to severe confusion) 10 mg.

h. Lisinopril (to treat high blood pressure) hct 10-12.5 mg.

i. Lamotidine (treat heartburn) 100 mg.

j. Vitamin D3- 25 mcg.

k. WelChol (lipid-lowering and glucose-lowering agent).

	The following medications were scheduled to be given at 7:00 a.m: nicotine patch, aspirin, coenzyme Q-10, Zetia, Neurontin, Namenda, lisinopril, lamotidine, vitamin D3 and WelChol. 3. Resident Q received the following medcations at 9:25 a.m on 10/15/21 during medication pass observation: a. Neurontin 400 mg. b. Metoprolol 25 c. Omeprazole 20 mg, d. Tramadol (opioid) 50 mg e. Metoprolol 12.5 mg The following medications were scheduled to be given at 7:00 a.m: metoprolol, omeprazole, tramadol and metoprolol. Neurontin was scheduled to be given at 6:00 a.m. 4. Resident R received the following medications at 9:45 a.m on 10/15/21 during medication pass observation: a. Cymbalta (to treat depression) 60 mg. b. Metformin 1000 mg. c. Senna (to treat constipation) 8.6mg. The following medications were			

scheduled to be given at 7:00 a.m: Cymbalta, metformin and senna.

During an interview on 10/14/21 at 8:38 a.m., QMA 5 indicated the third floor medication administration was the heaviest med-pass. She pulled all the medications prior to starting and puts them in a cup with the residents name and room number. Scheduled medication is given 1 hour before or 1 hour after, unless it states something different.

During an interview oon 10/14/21 at 3:33 p.m., the Nurse Consultant indicated she was unsure how to print a report of the time a medication was actually given. The initials only state the medication was given and not the time or late entry was noted.

Review of a current facility policy, titled 'MEDICATION ADMINISTRATION PROGRAM POLICY," provided by the Administrator on 10/14/21 at 1:43 p.m., indicated the following:

"POLICY:

...4. If resident is not capable of self-administration of medications the Community will provide assistance that will include:

Medication stored in a

	manner.... Medications will be administered by a licensed nurse.... Documentation of the medication name, dose, time taken by resident...." ...The Executive Director and Director of Nursing and Wellness will ensure adequate professional oversight of the medication administration.... ...5. Documentation in the medical record is complete and accurate ...c. Medication record is correctly noted, with signatures and explanations for missed medications noted properly. d. Medication is available to the resident in a correct and timely manner...." This State tag relates to Complaint IN00364285 and IN00364441. Based on observation, interview and record the review, the facility failed to ensure medications were administered to residents during scheduled times for 4 of 4 residents reviewed for late medication administration. (Resident O, Resident P, Resident Q and Resident R).			

Findings include:

1. During medication administration on 10/15/21 with QMA 5, Resident O recieved the following medications at 8:55 a.m:

a. Amlodipine (to treat high blood pressure) 10 mg.

b. Flonase (to relieve seasonal allergies) 1 spray each nostril.

c. Lasix (diuretic) 40 mg.

d. Cozaar (to treat high blood pressure) 100 mg.

e. Metoprolol (to treat high blood pressure) 100 mg.

f. Vitamin D3 1.25 mg.

g. Flovent 44 mcg, 2 inhalations.

h. Calcium 500 mg.

i. Hydralazine (to treat high blood pressure) 10 mg.

j. Carbamazepine (to prevent and control seizures) 200 mg.

Review of Resident O's medication orders, the following medications were to be given at 6:00 a.m: amlodipine, Flonase, Cozaar and carbamazepine. The following medications were to be given at 7:00 a.m: Lasix, metoprolol, vitamin D3, Flovent, calcium and hydralazine.

	2. Resident P received the following medication at 9:15 a.m. on 10/15/21 during medication pass observation. a. Nicotine patch 7 mg/24 hr. b. Metformin 1000 mg. c. Aspirin 81 mg. d. Coenzyme Q-10. e. Zetia (lipid-lowering) 10 mg. f. Neurontin (nerve pain) 300 mg. g. Namenda (to treat moderate to severe confusion) 10 mg. h. Lisinopril (to treat high blood pressure) hct 10-12.5 mg. i. Lamotidine (treat heartburn) 100 mg. j. Vitamin D3- 25 mcg. k. WelChol (lipid-lowering and glucose-lowering agent). The following medications were scheduled to be given at 7:00 a.m: nicotine patch, aspirin, coenzyme Q-10, Zetia, Neurontin, Namenda, lisinopril, lamotidine, vitamin D3 and WelChol. 3. Resident Q received the following medcations at 9:25 a.m on 10/15/21 during medication pass observation:			

	a. Neurontin 400 mg. b. Metoprolol 25 c. Omeprazole 20 mg, d. Tramadol (opioid) 50 mg e. Metoprolol 12.5 mg The following medications were scheduled to be given at 7:00 a.m: metoprolol, omeprazole, tramadol and metoprolol. Neurontin was scheduled to be given at 6:00 a.m. 4. Resident R received the following medications at 9:45 a.m on 10/15/21 during medication pass observation: a. Cymbalta (to treat depression) 60 mg. b. Metformin 1000 mg. c. Senna (to treat constipation) 8.6mg. The following medications were scheduled to be given at 7:00 a.m: Cymbalta, metformin and senna. During an interview on 10/14/21 at 8:38 a.m., QMA 5 indicated the third floor medication administration was the heaviest med-pass. She pulled all the medications prior to starting and puts them in a cup with the residents name and room number. Scheduled medication			

	is given 1 hour before or 1 hour after, unless it states something different. During an interview oon 10/14/21 at 3:33 p.m., the Nurse Consultant indicated she was unsure how to print a report of the time a medication was actually given. The initials only state the medication was given and not the time or late entry was noted. Review of a current facility policy, titled 'MEDICATION ADMINISTRATION PROGRAM POLICY," provided by the Administrator on 10/14/21 at 1:43 p.m., indicated the following: "POLICY: ...4. If resident is not capable of self-administration of medications the Community will provide assistance that will include: Medication stored in a manner.... Medications will be administered by a licensed nurse.... Documentation of the medication name, dose, time taken by resident...." ...The Executive Director and Director of Nursing and Wellness will ensure adequate professional oversight of the			

	medication administration.... ...5. Documentation in the medical record is complete and accurate ...c. Medication record is correctly noted, with signatures and explanations for missed medications noted properly. d. Medication is available to the resident in a correct and timely manner...." This State tag relates to Complaint IN00364285 and IN00364441.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.	R 0407	Current residents and staff have the potential to be affected by the alleged deficient practice of not following infection prevention measures put in place. Silver Birch staff, ancillary staff, vendors, essential healthcare workers, and visitors (including State surveyors) are to enter through the front entrance. Upon entering the front entrance, a COVID-19 questionnaire will be filled out and a temperature will be taken and recorded on the questionnaire.	11/15/2021

	Based on observation, interview and record reviewed, the facility failed to ensure infection control system was inplace and practices were followed related CDC guidelines for Transition Based Precautions (TBP) isolation for 2 of 3 residents reviewed for infection control (Resident M and N). Findings include: 1. During on observation on 10/15/21 at 10:30 a.m., a cart containing Personal Protective Equipment (PPE) was noted outside the door. There was no signage in place to indicated the type of isolation precautions. There were no N95 mask in the cart, only gloves and gowns. During a second observation and interview on 10/15/21 at 11:56 a.m., the resident indicated she has had 1 Covid vaccine but needed to wait 2 weeks until another one. The isolation cart did not contain any N95 masks and no signage was on the door. The clinical record for Resident M was reviewed on 10/15/21 at 10:31 a.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, cardiomyopathy, diabetes mellitus and atrial fibrillation. Resident M was admitted to the facility on 10/14/21.		Redcap reporting, covid testing logs and vaccine statuses will be logged and managed in an Infection Control Survey Binder. Isolation signage and stocked isolation carts will be located outside of resident rooms as necessary. To ensure compliance, the ED or designee will monitor practices using audits that will occur 3x/week for 1 month, 2x/week for one month and 1x/month for one week. Results will be addressed as needed with IDT team/QA meetings Employees will be educated on Infection Control practices, including Covid protocol and PPE by Nov 15th Date the systemic changes will be completed: Nov 15th	

A progress note, dated 10/15/21 at 6:19 a.m., indicated the resident admitted from home on 10/14/21. The resident was a new admit and place on Covid quarantine.

B. During an observation on 10/15/21 at 10:51 a.m., a cart containing PPE was noted outside the door. There was no signage in place to indicated the type of isolation precautions. There were no N95 mask in the cart, only gloves and gowns.

During a second observation and interview on 10/15/21 at 12:06 p.m., the isolation cart did not contain any N95 masks and no signage was on the door.

The clinical record for Resident N was reviewed on 10/15/21 at 11:00 a.m. Diagnoses included, but were not limited to, chronic pain and aftercare.

A progress note, dated 10/11/21 at 4:55 p.m., indicated the resident arrived at the facility.

The clinical record lacked any mention of isolation or order for isolation.

On 10/15/21 at 10:22 a.m., QMA 3 indicated she worked for the facility and has not received any education on Covid.

During an interview on 10/15/21 at 10:33 a.m., CNA 4 indicated he was unsure of Resident M's

isolation status. He was not sure if she was vaccinated or unvaccinated and he had only recently seen surgical masks and not N95 masks. He indicated the resident would be in isolation for maybe 5 to 7 days. He has not received any education on Covid.

During an interview on 10/15/21 at 12:06 p.m., Housekeeper 2 was asked about type of isolation for room 320. She indicated the resident was new but had not tested positive for Covid, but could put on the PPE if I wanted to. She was asked about an N95 and stated "is that the white one " and pulled an N95 from her cleaning cart. She indicated she has worked at the facility for 3 months and has not received any Covid education.

On 10/15/21 at 1:43 p.m., no signage or N95 was in place for either room.

During an interview on 10/18/21 at 11:43 a.m., the Nurse Consultant indicated they were unable to find any Covid education provided to staff since May 2020.

On 10/15/21 at 11:44 a.m., the Administrator provided a red Covid binder. The binder only contained vaccination status of residents and information provided by the Indiana Department of Health (IDOH).

During an interview on 10/15/21 at 1:56 p.m., the Nurse Consultant indicated they were unable to find any infection control policies, testing logs books for both residents and staff or tracking of potential infections. She indicated no one had been yet designated to put a sign on the outside of the residents door or place N95 mask in the isolation carts.

2. On 10/13/21 at 11:15 a.m., the Corporate Nurse indicated the facility was in "turmoil" since they lost the Director of Nursing (DON) and other key staff. They were currently short-staff and using agency staff. They were not sure where the DON kept the information related to Covid-19 and infection control.

During an interview on 10/15/21 at 8:10 a.m., the Corporate Nurse indicated the facility did not have any infection control tracking logs at the facility. The information was sent "off-site" to someone who then entered the information. The infection control policies were not up to date and she indicated they were aware they had problems with their screening process. The information requested on 10/14/21 had yet been printed because their printer ran out of ink and they were waiting on a service person to fix it.

On 10/15/21 at 10:05 a.m., the

Nurse Consultant indicated the person who was entering the information related to infections took over approximately 2 months ago.

During an interview on 10/15/21 at 11:43 a.m., the Nurse Consultant indicated they were unable to find any Covid education provided to staff since May 2020.

On 10/15/21 at 11:44 a.m., the Administrator provided a red "Covid" binder. The binder only contained vaccination status of residents and information provided by the Indiana Department of Health (IDOH). The facility was unable to provide any information of what staff had tested positive for Covid-19 and were only able to state 1 resident who had Covid-19.

An employee list was provided by the Administrator on 10/15/21 at 1:55 p.m. for staff who worked 10/12/21 through 10/14/21. The facility lacked a temperature or screening form for 6 staff on 10/12/21, 3 staff on 10/13/21 and 3 staff on 10/14/21.

During an interview on 10/15/21 at 1:56 p.m., the Nurse Consultant indicated they were unable to find any infection control policies, testing logs books for both residents and

staff or tracking of potential infections. She indicated no one had been yet designated to put a sign on the outside of the residents doors or place N95 mask in the isolation carts. The facility was unable to provide a copy of transmission-based precaution restriction.

During the exit conference, the Administrator indicated they were unable to provide any information related to Research Electronic Data Capture (REDCap) reporting.

This State tag relates to Complaint IN00364663.

Based on observation, interview and record reviewed, the facility failed to ensure infection control system was inplace and practices were followed related CDC guidelines for Transition Based Precautions (TBP) isolation for 2 of 3 residents reviewed for infection control (Resident M and N).

Findings include:

1. During on observation on 10/15/21 at 10:30 a.m., a cart containing Personal Protective Equipment (PPE) was noted outside the door. There was no signage in place to indicated the type of isolation precautions. There were no N95 mask in the cart, only gloves and gowns.

During a second observation

and interview on 10/15/21 at 11:56 a.m., the resident indicated she has had 1 Covid vaccine but needed to wait 2 weeks until another one. The isolation cart did not contain any N95 masks and no signage was on the door.

The clinical record for Resident M was reviewed on 10/15/21 at 10:31 a.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, cardiomyopathy, diabetes mellitus and atrial fibrillation.

Resident M was admitted to the facility on 10/14/21.

A progress note, dated 10/15/21 at 6:19 a.m., indicated the resident admitted from home on 10/14/21. The resident was a new admit and place on Covid quarantine.

B. During an observation on 10/15/21 at 10:51 a.m., a cart containing PPE was noted outside the door. There was no signage in place to indicated the type of isolation precautions. There were no N95 mask in the cart, only gloves and gowns.

During a second observation and interview on 10/15/21 at 12:06 p.m., the isolation cart did not contain any N95 masks and no signage was on the door.

The clinical record for Resident N was reviewed on 10/15/21 at

	11:00 a.m. Diagnoses included, but were not limited to, chronic pain and aftercare. A progress note, dated 10/11/21 at 4:55 p.m., indicated the resident arrived at the facility. The clinical record lacked any mention of isolation or order for isolation. On 10/15/21 at 10:22 a.m., QMA 3 indicated she worked for the facility and has not received any education on Covid. During an interview on 10/15/21 at 10:33 a.m., CNA 4 indicated he was unsure of Resident M's isolation status. He was not sure if she was vaccinated or unvaccinated and he had only recently seen surgical masks and not N95 masks. He indicated the resident would be in isolation for maybe 5 to 7 days. He has not received any education on Covid.			

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a sign on the outside of the residents door or place N95 mask in the isolation carts.

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	During an interview on 10/15/21 at 1:56 p.m., the Nurse Consultant indicated they were unable to find any infection control policies, testing logs books for both residents and staff or tracking of potential infections. She indicated no one had been yet designated to put a sign on the outside of the residents doors or place N95 mask in the isolation carts. The facility was unable to provide a copy of transmission-based precaution restriction. During the exit conference, the Administrator indicated they were unable to provide any information related to Research Electronic Data Capture (REDCap) reporting. This State tag relates to Complaint IN00364663.			

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