STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/19/2023

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SILVER BIRCH OF EVANSVILLE	475 S GOVERNOR STREET EVANSVILLE, IN 47713

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00406683 and IN00408321. Complaint IN00406683 - State deficiencies related to the allegations are cited at R216, R246, R297, R298. Complaint IN00408321 - State deficiencies related to the allegations are cited at R216, R246, R297, R298. Survey dates: May 17, 18, 19, 2023 Facility number: 014238 Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 1, 2023.	R 0000	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus,the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Dee Jolly, Executive Director, Silver Birch of Evansville.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dee Jolly 06/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on interview and record review, the facility failed to perform fire drills every six months in conjunction with the local fire department. Findings include: On 5/18/23 at 9:09 A.M., the facility log of fire drills was reviewed and lacked an invitation to the fire department from March 2022 until March 2023. During an interview on 5/18/23 at 9:15 A.M., the maintenance supervisor indicated the fire department was invited annually in March of every year. During an interview on 5/19/23 at 11:15 A.M., the DON (Director of Nursing) indicated the facility did not have a written policy related to fire drills but followed the state requirements.	R 0092	No Residents Noted All Residents are encouraged to participate in Fire Drills. The Executive Director, or designee, shall attempt to hold the fire and disaster drill in conjunction with the local fire department at least every six (6) months. The Vice President for Operations will train the Executive Director and Environmental Services Director related to the protocol for fire and disaster drills in conjunction with the local fire department. The Executive Director, or designee, will audit and ensure that the invitation is sent out to the local Fire Department at least every (6) months. The Executive Director, or designee, will report when the letter is distributed and the response to the Safety Committee.	07/01/2023

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			The facility respectfully requests a paper compliance review.	
R 0188 Bldg. 00	410 IAC 16.2-5-1.6(l) Physical Plant Standards - Noncompliance (l) The facility shall have a nourishment station for supplemental food service separate from the resident's unit. Based on observation and interview, the facility failed to have a nourishment station for supplemental food service separate from the resident's unit for 3 of 3 days of survey. Findings include: 1. During confidential interviews with residents in the dining room on 5/17/23 at 12:30, they indicated they get a good meal about once a week. They are only allowed 2 cups of coffee or tea at meals; no coffee is served at the evening meal or available at other times of the day. 2. During confidential interviews with residents in the dining room on 5/19/23 at 8:10 A.M., residents complained the food was often cold and they didn't get enough to eat. One resident indicated she had asked for toast and yogurt this morning and was still waiting for her food when everyone else at the table had been served and finished eating. Another resident complained that staff would not bring her meal to her room if she is not feeling well because she was not on "the list". The residents complained they could only get second servings after everyone, including the staff, had eaten, and that the kitchen often ran out of food. Food was not available other than during the meal times. 3. During confidential interviews with residents in the dining room on 5/19/23 at 8:20 A.M., one	R 0188	Specific Residents not identified; confidential interviews. Silver Birch is committed to providing quality culinary services and offering our Residents ongoing opportunities to voice concerns related to quality of food, food menu, and overall dining service. During the month of May, we conducted the Pinnacle Resident Satisfaction Survey and obtained the collaborated results for ninety “90” of our residents. Areas of concern will be identified and studied using quality assurance studies. The Executive Director, or designee, shall train the culinary staff and Culinary Director that a nourishment station for supplemental food service separate from the resident’s unit shall be available. The nourishment center shall be set-up in the bistro area and stocked/restocked by the culinary staff. Additionally a Culinary Comment Box is being installed in a central location in close proximity to the Dining area. The Culinary Director, or designee, shall assess the bistro	07/01/2023

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	resident said she had sent her breakfast back over 15 minutes ago because the toast was burnt and had still not received her breakfast. Residents complained there was no salt or pepper on the tables, so you had to ask for it. During an interview on 5/19/23 at 8:35 A.M. with the resident who had sent her food back because of burnt toast, she was sitting outside in the courtyard and complained that she had never gotten her breakfast at all. No other food was available until the next meal. 4. On 5/19/2/3 at 11:15, the facility administrator indicated they have no policy for residents to obtain second servings of food or additional drinks at meals. There was no observed nourishment station set up or stocked daily for resident use.		area to ensure set-up, stock, and restock of the nourishment station three times weekly for two months and thereafter, one time weekly for two months. The facility respectfully requests a paper compliance review.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure thorough assessments for residents were completed and recorded. Semi-annual evaluations including	R 0216	Resident H cannot be remedied as this file has been closed. The Director of Nursing and	07/01/2023

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	weights were not completed for 3 of 7 resident records reviewed. A self-administration of medications evaluation was not completed for 3 of 7 resident records reviewed. (Resident H, Resident J, Resident C, Resident E) Findings include: 1. On 5/17/23 at 10:24 A.M., Resident H's closed clinical record was reviewed. Resident H was admitted 6/24/20 and discharged 2/20/23. Diagnosis included, but was not limited to, COPD (Chronic Obstructive Pulmonary Disease) and anemia. Resident H's physician orders were requested and not provided. The most recent weight documented for Resident H was dated 3/25/22. The clinical record lacked any other weights until the resident was discharged on 2/23/23. 2. During a medication pass on 5/18/23 at 7:40 A.M., Resident J had medications in his room he had bought off the Internet for his Irritable Bowel Syndrome and cold medications. QMA (Qualified Medicine Aide) 3 did not know the medications were at his bedside. During an interview on 5/18/23 at 12:10 P.M., the Assistant Administrator indicated Resident J did not have a self-administration assessment. On 5/18/23 at 12:10 P.M., Resident J's clinical record was reviewed. Diagnoses included, but was not limited to, nontraumatic intracerebral hemorrhage. Resident J's clinical record lacked a self-administration of medication assessment.3.		Wellness (DON-W) will complete a self-administration of medication assessment for Resident J, Resident C, and Resident E. Residents that self-administer medications could be affected by the same deficient practice. The Director of Nursing and Wellness, or designee, will audit the residents that wish to self-administer medications and update their self-administration assessment. The self-administration of medication assessment will be updated every six months or upon notable changes of conditions. The Vice President for Clinical Services, or designee, will train the licensed nurses on completion of self-administration of medication assessment. The Director of Nursing and Wellness will train all clinical staff to look for over the counter medications within resident apartments to ensure they are approved to self-administer. The Director of Nursing and Wellness, or designee, will audit the residents that wish to self-administer medications and update their self-administration assessment. The Director of Nursing and Wellness (DON-W), or designee, shall complete an audit of the self-administration assessments every month to ensure that every	

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	During an interview on 5/17/23 at 9:10 A.M., Resident C indicated that she had medications in her room. During an interview on 5/19/23 at 9:40 A.M., Resident C indicated she self administers the Vitamin D3 tablet and Fluticasone-Salmeterol inhaler and they were kept in a drawer next to the refrigerator in her room. On 5/19/23 at 11:35 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension and atrial fibrillation. Resident C was admitted on 12/31/20. Current physician's orders included, but were not limited to, the following: Monthly weight and vitals every 4 weeks on Mondays related to hypertension, started 2/1/21 Fluticasone-Salmeterol Aerosol Powder Breath 250/50 mcg(microgram)/dose inhale 1 puff orally two times a day with unsupervised self-administration, dated 8/16/21 Vitamin D3 tablet give 1 capsule by mouth daily with unsupervised self-administration, dated 8/16/21 Resident may keep specified medication(s) at the bedside: vitamin D3 and inhalers, dated 6/13/22 The last weight documented in the resident's medical record was 6/20/22. Resident C's last self administration of medication evaluation was dated 4/10/22. 4. On 5/18/23 at 9:22 A.M., Resident E's clinical records were reviewed. Resident E was admitted on 8/13/21.		resident is completed every six months or upon change of condition; the audit tool will be forwarded to the Executive Director for review. The Director of Nursing and Wellness (DON-W), or designee, shall complete an audit of the self-administration assessments every month to ensure that every resident is completed every six months or upon change of condition; the audit tool will be forwarded to the Executive Director for review. The Director of Nursing and Wellness (DON-W), or designee, shall complete an audit of the self-administration assessments every month to ensure that every resident is completed every six months or upon change of condition; the audit tool will be forwarded to the Executive Director for review. The facility respectfully requests a paper compliance review.	

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	Diagnosis included but were not limited to, essential hypertension, diabetes, acute on chronic diastolic (congestive) heart failure and other chronic pain. Current physician orders include but were not limited to, "Resident may have one day's supply of medication left with resident at a time to take throughout the day" dated 4/17/23. Resident E's clinical record lacked a medication self administration evaluation. A current list of residents who self medicate was provided on 5/17/23 at 11:52 A.M., by the Assistant Administrator and indicated Resident H, Resident J, Resident C, Resident E were not on that list. During an interview on 5/19/23 at 9:47 A.M., QMA 12 indicated Resident E kept one day at a time of all his medications including pain medications in his room. She did not know if he kept his medications in the locked box in his room. She indicated the QMAs signed out all the medications on Resident E's MAR (medication administration record) that they had been given even though they were left in his room for the whole day. During an interview on 5/19/23 at 10:00 A.M., the DON (Director of Nursing) indicated Resident E had an order to keep a days worth of medications with him and did not keep his pain meds in a locked drawer. During an interview on 5/18/23 at 1:28 P.M., QMA 12 indicated she was not sure how often the residents needed to be weighed and indicated if the resident's chart did not include a weight then			

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	one had not been taken. During an interview on 5/18/23 at 1:44 P.M., the DON indicated if a resident had a specific order to be weighed it should be followed otherwise residents should be weighed every 6 months. At that time she also indicated residents that self administer medication should have a current self administration of medication evaluation completed. On 5/19/23 at 10:08 A.M., a current policy for self administration of medication was requested and not made available during the survey. On 5/19/23 at 11:15 A.M., a current Weigh Monitoring policy, dated 2/14/20, indicated " ... all residents will be weighed upon admission and if at least [sic] semiannually, thereafter ... The results will be documented in the resident record." On 5/19/23 at 11:15 A.M., a current non-dated Medication Management Program policy was provided, and indicated "If prospective or current resident request to independently manage medications, a Self-Assessment of Medication Administration is completed by licensed nurse ... this assessment is completed upon admission and thereafter on a routine basis and as needed ... it will determine that a resident can safely manage their medications ... " This Residential tag relates to Complaint IN00408321 and Complaint IN00406683.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure service plans were reviewed and signed by the resident or responsible party for 5 of 6 residents reviewed. (Resident C, Resident D, Resident E, Resident B, Resident F) Findings include: 1. On 5/17/23 at 11:35 A.M., Resident C's clinical record was reviewed. The most recent service plan was dated 1/13/23. It was not signed by the resident or representative.	R 0217	It is the policy of Silver Birch Living that each resident will have a service plan that is developed based on their Level of Service Assessment/Evaluation, semi-annual evaluation reviews, and/or changes in resident needs. The DONW or designee will review the service plan with the Resident C, Resident D, Resident E, Resident B, and Resident F, changes will be made, if needed, and the identified parties will sign	07/01/2023

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	During an interview on 5/18/23 at 9:10 A.M., Resident C indicated she did not know what a service plan was and to her knowledge, she had not signed one. 2. On 5/17/23 at 10:24 A.M., Resident D's clinical record was reviewed. Diagnoses included, but was not limited to, anxiety disorder. The current service plan, dated 1/19/2023, lacked a resident or resident representative signature.3. On 5/18/23 at 9:22 A.M., Resident E's clinical records were reviewed. A service plan dated 4/19/23 lacked a signature from the resident or resident's representative. 4. On 5/17/23 at 10:00 A.M., Resident B's clinical records were reviewed. A service plan dated 5/17/23 lacked a signature from the resident or resident's representative. 5. On 5/17/23 at 11:56 A.M. , Resident F's clinical records were reviewed. A service plan dated 8/9/22 lacked a signature from the resident or the resident's representative.		and date. A 100% audit will be completed of all service plans for current residents. If the service plan has not been reviewed and/or signed by the resident, a review will be initiated by the DONW or designee. The Executive Director will re-educate all nursing staff on the policy on or before 06/26/23. The DONW or designee will audit service plans for 6 months and/or until 100% compliance has been determined from QAPI meetings. The DONW or designee will audit care plans for 6 months and/or until 100% compliance has been determined from QAPI meetings (2 times/week; for the next two months, 1 time/week for the following two months, and 1 time/month for two months thereafter. The facility respectfully requests a paper compliance review.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (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			

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	documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure the QMAs (Qualified Medication Aides) obtained authorization by a licensed nurse for the administration of a PRN (as needed) medication for 4 of 7 resident records reviewed. (Resident B, Resident C, Resident D, Resident E) Findings include: 1. On 5/17/23 at 10:00 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 2/3/23. Diagnosis included, but were not limited to, pain in right leg, acute kidney failure, polyosteoarthritis, anxiety disorder, dorsalgia, and intervertebral disc degeneration, lumbar region. Current physician orders included, but were not limited to the following: oxycodone/APAP (a narcotic pain medication) 10/325 1 tablet every 4 hours prn, with a start date of 4/17/23 and ended 5/16/23. oxycodone/APAP 10/325 1 tablet every 4 hours prn, with a start date of 5/16/23. Resident B's MAR (medication administration record) for the month of May 2023 indicated a QMA administered the following prn medication: oxycodone-APAP (Acetaminophen) 10/325 mg on 5/1/23 at 7:36 P.M., 5/5/23 at 1:26 P.M. and 5/18/23 at 10:35 P.M. The MAR lacked documentation that a licensed nurse authorized the administration of those medications. Resident B's MAR for April 2023 was requested and not received. Progress notes lacked documentation that a licensed nurse authorized the QMA to administer	R 0246	Resident B, Resident C, and Resident D experienced no adverse reactions to the PRN medications received without documented authorization. Authorization will continue to be obtained and, in turn, documented for all PRN medications prior to administration. All residents that receive medications administered by Qualified Medication Aides are at risk of receiving PRN medications without authorization by a licensed nurse or physician. Authorization will be obtained for all PRN medications prior to administration and documented in the progress notes or administration notes. Qualified Medicaid Aides (QMAs) and Licensed Nurses will be educated on their responsibilities to obtain authorization before administering a PRN medication from a licensed nurse or physician, documenting said authorization, and observation of symptoms in the resident progress notes, the Residential Regulation 0246 Health Services Deficiency 420 IAC 16.2-5-4C(6), and the Medication Administration Program Policy. The 24-hour report will be utilized by the Director of Nursing and Wellness (DONW) or designee to determine any residents that	07/01/2023

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	oxycodone-APAP (Acetaminophen) 10/325 mg on 5/1/23, 5/5/23 and 5/18/23. 2. On 5/19/23 at 11:35 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension and pain. Resident C was admitted on 12/31/20. Current physician's orders included, but were not limited to, the following: Tramadol 50 mg (milligram) give 50 mg by mouth every 8 hours as needed for moderate pain, ordered 1/20/22 A May 2023 Narcotic sheet for Tramadol 50 mg provided by QMA 12 on 5/18/23 at 1:28 P.M., was reviewed and indicated Resident C was given Tramadol 50 mg by a QMA on the following dates: 5/9/23 at 11:30 P.M. 5/10/23 at 8:30 A.M. 5/10/23 at 8:00 P.M. 5/11/23 at 9:00 A.M. 5/11/23 at 3:05 P.M. 5/12/23 at 9:00 A.M. 5/12/23 at 5:00 P.M. 5/13/23 at 7:00 A.M. 5/13/23 at 8:00 P.M. 5/14/23 at 7:00 A.M. 5/14/23 at 8:00 P.M. 5/15/23 at 7:00 A.M. 5/15/23 at 7:00 P.M. 5/16/23 at 7:00 A.M. 5/16/23 at 8:00 P.M. 5/17/23 at 7:00 A.M. 5/17/23 at 8:00 P.M. 5/18/23 at 9:50 A.M. Resident C's May 2023 MAR was reviewed and indicated Resident C was given Tramadol 50 mg on 5/18/23 at 9:48 A.M. There were no other doses		received PRN medications and ensure that authorizations were obtained and documented. The 24-hour report will be monitored daily for 2 weeks and weekly for 4 weeks to assure compliance with seeking, receiving, and documenting authorization provided by a licensed nurse or physician. Audits of administered PRN medications will continue after the initial six (6) weeks and shall be completed no less than two (2) times monthly by the Director of Nursing and Wellness, or designee. The Director of Nursing and Wellness will report to the Community's Quality Assurance Committee and Executive Director any concerns with compliance ongoing. The facility respectfully requests a paper compliance review.	

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	documented. Resident C's clinical record lacked documentation that a nurse authorized the QMA to give the PRN narcotic. 3. On 5/17/23 at 10:24 A.M., Resident D's clinical record was reviewed. Diagnoses included, but not limited to, anxiety disorder, unspecified, peripheral vascular disease, unspecified, and pain in unspecified joint. Current physician orders included, but were not limited to, oxycodone/APAP- 10/325 one tablet every 4 hours as needed for pain. Progress Notes from 5/1/23 to 5/17/23 indicated a QMA administered oxycodone to Resident D on the following dates: 5/17/23 7:21 P.M. 5/1723 9:47 A.M. 5/16/23 3:49 P.M. 5/16/23 11:37 A.M. 5/16/23 8:20 A.M. 5/15/23 7:24 P.M. 5/15/23 5:27 P.M. 5/14/23 8:16 A.M. 5/12/23 12:00 P.M. 5/11/23 5:12 P.M. 5/11/23 1:59 P.M. 5/11/23 8:13 A.M. 5/10/23 5:22 P.M. 5/9/23 4:22 P.M. 5/8/23 9:01 P.M. 5/8/23 5:05 P.M. 5/8/23 1:06 P.M 5/3/23 12:03 A.M. 5/2/23 11:39 A.M. 5/2/23 7:26 A.M. 5/1/23 7:38 P.M. The progress notes lacked documentation that the			

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	oxycodone given to Resident D by a QMA was authorized by a licensed nurse. Resident D's MAR from 5/1/23 until 5/17/23 indicated a QMA administered oxycodone to Resident D on the following dates: 5/17/23 7:21 P.M. 5/17/23 9:47 A.M. 5/16/23 3:59 P.M. 5/16/23 11:3 A.M. 5/16/23 8:23 A.M. 5/15/23 7:24 PM 5/15/23 5:27 P.M. 5/14/23 816 AM. 5/13/23 no documentation 5/12/23 1200 P.M. 5/11/23 512 P.M. 5/11/23 1:59 P.M. 5/11/23 8:13 A.M. 5/10/23 5:22 P.M. 5/9/22 4:20 P.M. 5/8/23 9:01 P.M. 5/8/23 5:05 P.M. 5/8/23 1:00 P.M. 5/5/23 no documentation 5/3/23 12:23 A.M. 5/2/23 11:39 A.M. 5/2/23 7:26 A.M. 5/1/23 7:38 P.M. The MAR lacked documentation that the oxycodone given to Resident D by a QMA was authorized by a licensed nurse. Resident D's MAR for April 2023 was requested and not provided. During an interview on 5/18/23 at 7:32 A.M., QMA 3 indicated if a PRN narcotic medication is administered by a QMA, they must obtain			

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	authorization from a nurse prior to administration. During an interview on 5/18/23 at 1:28 P.M., QMA 12 indicated she verbally checks with a nurse to give PRN (as needed) narcotics but doesn't document it in the residents clinical record. She also indicated she had assessed the effectiveness of medications after they were administered. During an interview on 5/18/23 at 1:44 P.M., the DON indicated that a QMA should get permission from her or another nurse, document it, and the nurse should follow up and be the one assessing the effectiveness of the medication. At that time, she indicated that sometimes she doesn't have time to document that she assessed the residents condition after a PRN medication was given by a QMA. On 5/19/23 at 11:15 A.M., the Administrator provided a current Medication Administration Program Policy, revised 3/24/21, which indicated "Written policies related to medication assistance and administration are followed by licensed nurses and Qualified Medication Aides (QMAs), within their scope of practice" "Qualified Medication Aide Scope of Practice" was retrieved on 5/22/23 from the Indiana Government website. The Scope of Practice included, but was not limited to the following: "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the			

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	facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident 's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty" This Residential tag relates to Complaint IN00408321 and Complaint IN00406683.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to maintain all food preparation and serving areas in accordance with state and local sanitation and safe food handling standards for 2 of 3 kitchen observations. Findings include: The tour of the kitchen and dining area began on 5/17/23 at 9:00 A.M. with the dietary manager. The dietary manager had 8 shoulder-length dreadlocks hanging out of her hairnet, as well as the hair around her face. Dietary staff 15 had a beard but no beard cover. Observed the food preparation surfaces in the kitchen with crumbs, drips, and smears.	R 0273	No individual residents were noted. The dietary hygiene policy and dietary cleaning policy will be followed to ensure that all local, state, and federal regulations are being followed to prevent any and all residents from being affected by deficient practice. Culinary staff will be in-serviced by the Executive Director, or designee; in-service topics shall include: daily/weekly/monthly cleaning schedule, proper handwashing, proper storage of food, proper labeling procedures for cooler/freezer/dry stock, and proper uniforms including hairnets and beard covers.	07/01/2023

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	Observed the cleaning supply closet, which was dirty in all the places where the wall and floor meet; there were paper scraps, plastic bottle caps, and a roll of plastic bags on the floor under the shelves. The floor in the dry food storage room was dirty around the edges. There was Panko crust mix in a bin, labeled 2/10/23 and labeled to be used by 3/10/23. There was a bag of crispy fried onions open not dated, a bag of potato chips open not dated, 2 bags of dry noodles opened not dated. Observed two handwashing sinks in the kitchen. One had a chair pushed in front of it, the other had a serving cart pushed in front of it. During the tour, only 1 dietary staff was observed washing their hands. Observed the temperature on the dishwasher while it was in use. The wash temperature was 119 degrees F, the rinse was 170 degrees F. Dietary manager indicated they did not have a user manual for the dishwasher. The backsplash next to the dishwasher was sticky and covered with dried food drips. A user manual for the Champion dishwasher model dh5000t was found on the internet, which indicated the wash temperature needed to be a minimum of 150 degrees F. Observed 4 square vent covers on the ceiling that were covered with a brownish substance. In the reach-in refrigerator, there was honey mustard salad dressing open not dated, 2 trays of ramekins with cottage cheese and dessert covered with cling wrap but no date. The door to the walk-in freezer was standing wide open. The shelves were covered with frost. The		A service call shall be placed to our third-party vendor to diagnose and repair the wash temperature of the dishwasher. While onsite, general maintenance of the unit will be conducted to troubleshoot any additional concerns. The Culinary Director will review daily/weekly/monthly cleaning schedules and audit the cleanliness of the dietary department no less than three (3) times a week for four weeks, once (1) a week for four weeks, and bi-weekly for eight (8) weeks. Additionally, the Culinary Director will observe the dining room and kitchen during meal service and food preparation to ensure proper handwashing and use of hairnets/beard covers is taking place. This will be audited three (3) times a week for four weeks, once (1) a week for four weeks, and bi-weekly for eight (8) weeks. The Culinary Director will complete a walk-thru of the cooler, freezer, and dry stock areas to ensure that all food is properly stored and follow proper labeling procedures. The walk-thru audit shall occur no less than three (3) times a week for four weeks, once a week for four weeks, and bi-weekly for eight (8) weeks. The Culinary Director will complete temperature audits of the dishwasher wash and rinse cycles no less than three (3)	

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	frost had to be scraped off the thermometer before the temperature was visible. There was a bag of chicken breasts open not dated, a bag of bacon wrapped in clear wrap that was not dated. In the walk-in refrigerator there was a bag of Canadian bacon open not dated. The grill was greasy with food spills on it. On the countertop by the sink next to the grill there was a dirty white plastic container with greasy kitchen tools with dried food and stained cloths on them. The oven and oven door were greasy inside, with a layer of crumbs in the rubber gaskets. Observed a small black box under the table that held the food slicer. Dietary staff indicated it was a rodent trap. No rodents were observed during the tour. The rolling cart that is used for moving the clean dishes to the cabinet was covered with drips; the lower shelf had 3 dirty plastic bins holding used steel wool scrubbers, scraps of paper, a gallon jug of dishwashing liquid, and a spray bottle with liquid in it. The top shelf had 3 stacks of clean bowls and a stack of clean glasses with drinking edge in contact with the unsanitary surface. On 5/18/23 at 12:30, 4 dietary staff were observed were observed in the kitchen with beards and no beard covers. One dietary staff had waist-length dreadlocks hanging out of his hairnet. The hairnet did not cover the front of his hair. At that time, the dietary manager was also observed in the kitchen with shoulder-length dreadlocks hanging out of her hairnet, which also did not cover the front of her hair.		times a week for four weeks, once a week for four weeks, and bi-weekly for eight (8) weeks. The facility respectfully requests a paper compliance review.	

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	The DON provided the facility dietary hygiene policy on 5/19/23 at 11:15 A.M. The policy indicated that the facility intends to follow all local, state, and federal regulations as they relate to the hygiene of the staff working in the dietary department. Specifically, the policy indicated that employees must keep hair from contacting exposed food, clean equipment, utensils, and linens. Exposed hair must be covered with a hairnet, hat, beard-net, etc. The DON provided the facility dietary cleaning policy on 5/19/23 at 11:15 A.M. The policy indicated that the facility intends to follow all local, state, and federal regulations regarding the cleaning procedures for the dietary department. This included, but was not limited to: 1. cleaning all equipment, food contact surfaces, and utensils whenever contamination may have occurred 2. the floor of the kitchen must be cleaned daily and after each spill or contamination 3. wall surfaces that become splattered during the food preparation process must be cleaned daily.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (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. Based on record review and interview, the facility failed to ensure that pharmaceutical services were available to provide residents with prescribed medications for administration in 3 of 5 residents reviewed. (Resident D, Resident B, Resident C)	R 0297	The Director of Nursing and Wellness (DON-W), or designee, will ensure that pharmaceutical services continue to be available to provide residents of the Community with prescribed	07/01/2023

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	Findings include: 1. On 5/17/23 at 10:24 A.M., Resident D's clinical record was reviewed. Diagnoses included, but was not limited to, anxiety disorder. Current physician orders included, but were not limited to: Dextroamp-amphet (an amphetamine) 10 mg (milligrams) 1 tablet orally one time a day, dated 4/18/23. Resident D's MAR (medication administration record) for the month of May 2023 indicated Dextoamp-amphet was not given on the following dates due to lack of supply: 5/1/23 5/4/23 5/5/23 5/6/23 5/7/23 5/8/23 5/9/23 (progress notes indicated medication was given) 5/10/23 5/12/23 (progress notes indicated medication was given) 5/14/23 (progress notes indicated medication was given) 5/15/23 Resident D's MAR for May 2023 indicated the following dates that Dextroamp-amphet was given: 5/2/23 5/3/23 5/5/23 5/11/23 (progress notes indicated medication was on order that that time) 5/13/23		medications in accordance physician order and in accordance with company policy and procedures and applicable Indiana state law. Residents of the Community receiving pharmaceutical services have the potential to be affected by the alleged noncompliance. The Vice President for Clinical Services, or designee, will re-train the Director of Nursing & Wellness. Following, the Director of Nursing & Wellness will re-train the clinical staff (nurses and QMAs) on the Pharmacy Service Guide (dated January 2022) and appropriate documentation of errors, discrepancies, missing medications. The Director of Nursing and Wellness (DON-W), or designee, will ensure pharmaceutical services are available and prescribed medications are provided to residents of the Community in a timely manner in accordance with company policy and procedures and applicable Indiana state law. A quality assurance monitoring tool will be implement to ensure compliance; the Director of Nursing and Wellness (DON-W), or designee, will monitor daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds	

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	On 5/18/23, at 10:00 A.M., the DON (Director of Nursing) indicated Resident D had went "a couple" of weeks without the Dextroamp-amphet due to waiting on a prior authorization for the medication and other issues related to the pharmacy. On 5/18/23 at 1:02 P.M., the Assistant Administrator provided a delivery sheet that indicated Dextroamo-Amphet 10 mg, for Resident D was delivered on 5/15/23, and contained 14 total pills.2. On 5/17/23 at 10:00 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 2/3/23. Diagnosis included, but were not limited to, anxiety disorder and convulsions. Physician orders included, but were not limited to: clonazepam 0.5 mg 1 tablet two times a day for anxiety, dated 5/16/23 clonazepam 0.5 mg 1 tablet two times a day related to unspecified convulsions, dated 1/31/23 clonazepam 1 mg 1 tablet orally two times a day for anxiety, dated 5/16/23 Resident B's electronic MAR from 5/1/23 through 5/18/23 indicated the following dates clonazepam 0.5 mg with a start date of 5/16/23 was administered: 5/16/23 (2 doses) 5/17/23 (1 dose) 5/18/23 (1 dose) Resident B's electronic MAR from 5/1/23 through 5/18/23 indicated the following dates clonazepam 0.5 mg with a start date of 1/31/23 was administered: 5/2/23 (2 doses) 5/3/23 (1 dose at 8:00 P.M.) 5/4/23 (2 doses) 5/5/23 (1 dose at 8:00 P.M.)		compliance has been met. The facility respectfully requests a paper compliance review.	

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	5/6/23 (2 doses) 5/8/23 (2 doses) 5/9/23 (2 doses) 5/10/23 (2 doses) 5/11/23 (1 dose at 8:00 P.M.) 5/12/23 (2 doses) 5/13/23 (1 dose at 8:00 P.M.) 5/14/23 (1 dose at 8:00 P.M.) 5/16/23 (1 dose at 8:00 P.M.) 5/17/23 (1 dose at 8:00 A.M.) Resident B's electronic MAR from 5/1/23 through 5/18/23 indicated the following dates clonazepam 1 mg with a start date of 5/16/23 was administered: 5/16/23 (1 dose at 8:00 P.M.) 5/17/23 (1 dose at 8:00 P.M.) 5/18/23 (1 dose at 8:00 A.M.) Resident B's electronic MAR from 5/1/23 through 5/16/23 indicated the following dates clonazepam 1 mg with a start date of 4/17/23 and d/c (discontinued) date of 5/16/23 was administered: 5/2/23 (2 doses) 5/3/23 (1 dose at 8:00 P.M.) 5/4/23 (2 doses) 5/5/23 (1 dose at 8:00 P.M.) 5/6/23 (2 doses) 5/7/23 (1 dose at 8:00 A.M.) 5/8/23 (2 doses) 5/9/23 (2 doses) 5/10/23 (2 doses) 5/11/23 (1 dose at 8:00 P.M.) 5/12/23 (2 doses) 5/13/23 (2 doses) 5/14/23 (1 dose at 8:00 P.M.) On 5/19/23 at 11:15 A.M., the DON provided Resident B's narcotic inventory sheet for clonazepam 1 mg, dated 5/16/23. The narcotic inventory sheet indicated out of 28 tablets, 2 had			

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	been given on the following dates: 5/17/23 at 12:00 P.M. 5/18/23 at 8:00 A.M. At that time, all other narcotic inventory sheets for Resident B's clonazepam orders were requested and the DON indicated no others could be found. A progress note dated 4/10/23 at 5:20 P.M. indicated "This nurse received email from Case Manager in regard to Resident not getting her clonazepam since arriving to facility. This nurse looking up her documentation, did have upon arrival but only few days due to resident not having facility PCP [Primary Care Provider, in which who did prescribe her first days of admission, until resident decided to go with her previous PCP. Clonazepam has been ordered regularly several times without being filled, this nurse did call Pharmacy but had to leave message and will call again in morning to see why medication has not been refilled and why pharmacy has not reached to PCP for script if that was needed or had they and got no reply. This nurse will also follow up the with Case Manager and resident after speaking with the Pharmacy. Administrator notified." The progress notes lacked a follow-up related to that concern. During an interview on 5/18/23 at 8:43 A.M., Resident B indicated she had been getting her medication on time. She indicated the QMA brought clonazepam every 12 hours. During an interview on 5/19/23 at 11:59 A.M., the DON indicated Resident B only received clonazepam on 5/17/23 and 5/18/23. She indicated she was unsure why Resident B's MAR indicated they received clonazepam on the other days in May. 3. During an interview on 5/18/23 at 9:10			

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		A. BUILDING 00 B. WING	05/19/2023

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	A.M., Resident C indicated she had pain in her left leg that she went to the hospital for a few weeks ago. She indicated she is still having pain. On 5/19/23 at 11:35 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, pain. Resident C was admitted on 12/31/20. Current physician's orders included, but were not limited to, the following: cyclobenzaprine (Flexeril) 5 mg (milligram) tablet give 1 tablet by mouth every 8 hours as needed for pain, ordered 5/9/23 Resident C's May 2023 MAR lacked documentation that Flexeril had been administered. The clinical record lacked documentation of the resident's pain level except for the following dates: 5/18/23 at 9:48 A.M. pain level 5 out of 10 on a scale of 0-10 with 10 being the worst pain 5/18/23 at 5:38 P.M. pain level 4 out of 10 on a scale of 0-10 with 10 being the worst pain 5/18/23 at 8:37 P.M. pain level 0 out of 10 on a scale of 0-10 with 10 being the worst pain Resident C's progress notes indicated the following: 5/5/23 9:38 A.M., "Resident came to this nurse stating her leg was hurting rating an 8 [sic] ... " 5/6/23 10:07 A.M., "Resident came to this nurse stating having [sic] uncontrolled pain and wanting to go out to [hospital name] to be evaluated ..." 5/10/23 12:57 P.M., "This writer contacted [pharmacy name] regarding Flexeril script. Tech stated med [sic] is needing prior authorization. Prescribing MD [medical doctor] has been			

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	notified." Hospital ED (emergency department) notes from 5/6/23 were reviewed and indicated Resident C presented with low back pain that radiated (went) down her left leg. Resident was sent back to the facility with an order for Flexeril 5 mg by mouth 3 times daily as needed for muscle spasms and diagnosed with acute left-sided low back pain with left-sided sciatica. During an interview on 5/18/23 at 1:44 A.M., the DON indicated the Flexeril was ordered in the ED on 5/6/23. After a couple days had passed and the medication was not delivered, she called the hospital to follow up on it and it was sent to the wrong pharmacy. She obtained another prescription from the facility NP (Nurse Practitioner), dated 5/9/23. On 5/10/23 she was notified that the Flexeril needed a prior authorization from her insurance company before it could be dispensed. She indicated that the prescribing practitioner's office was responsible for obtaining that prior authorization and she notified them it was needed. She will usually wait 2 days or so before she contacts the practitioner's office for status of prior authorizations and that a week of waiting on the medication was too long. Her and another nurse were responsible for following up on those but have not had time. This was not a medication they kept in the emergency drug kit at the facility. She indicated that the resident had been getting an ordered pain medication, but to her knowledge they have not been using nonpharmacological methods to help relieve her pain. On 5/19/23 at 11:15 A.M., a current [Pharmacy Name] Pharmacy Service Guide dated 1/22, indicated "...when a discrepancy or error is			

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	discovered or a resident's medication... is missing in the deliver, review the order,...and contact the licensed pharmacy for assistance." On 5/19/23 at 10:08 A.M., a current policy for obtaining medications and prior authorization for medications was requested and not made available during the survey. This Residential tag relates to Complaint IN00408321 and Complaint IN00406683.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (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; (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 record review and interview, the facility failed to ensure the consulting pharmacy reviewed the drug handling and storage practices of the facility, provided consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping, and report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs for 4 of 5	R 0298	The Director of Nursing and Wellness (DON-W), or designee, will ensure that pharmaceutical services are provided as outlined within 410 IAC 16.2-5-6(c)(2). Residents of the Community receiving pharmaceutical services have the potential to be affected by the alleged noncompliance. The Director of Nursing and	07/01/2023

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	residents reviewed for pharmaceutical services. (Resident C, Resident D, Resident F, Resident B) Findings include: 1. On 5/19/23 at 11:35 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, pain. Resident C was admitted on 12/31/20. Current physician's orders included, but were not limited to, the following: Tramadol 50 mg (milligram) give 50 mg by mouth every 8 hours as needed for moderate pain, ordered 1/20/22 A May 2023 Narcotic sheet for Tramadol 50 mg provided by QMA (Qualified Medication Aide) 12 on 5/18/23 at 1:28 P.M., was reviewed and indicated Resident C was given Tramadol 50 mg on the following dates: 5/9/23 at 11:30 P.M. 5/10/23 at 8:30 A.M. 5/10/23 at 8:00 P.M. 5/11/23 at 9:00 A.M. 5/11/23 at 3:05 P.M. 5/12/23 at 9:00 A.M. 5/12/23 at 5:00 P.M. 5/13/23 at 7:00 A.M. 5/13/23 at 8:00 P.M. 5/14/23 at 7:00 A.M. 5/14/23 at 8:00 P.M. 5/15/23 at 7:00 A.M. 5/15/23 at 7:00 P.M. 5/16/23 at 7:00 A.M. 5/16/23 at 8:00 P.M. 5/17/23 at 7:00 A.M. 5/17/23 at 8:00 P.M. 5/18/23 at 9:50 A.M.		Wellness (DON-W), or designee, will ensure that pharmaceutical services are provided as outlined within 410 IAC 16.2-5-6(c)(2). The DONW, or designee, will work directly with the pharmacy consultant to devise a schedule for a review every 60 days to ensure that consulting is completed as contractually agreed upon. The report completed by the pharmacy consultant every 60 days will be reviewed by the DONW, or designee; any areas of opportunity and/or follow up will be addressed by the DONW. The report, along with any areas of opportunity and/or follow up, will be brought to the monthly Quality Assurance Meeting. The facility respectfully requests a paper compliance review.	

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	Resident C's May 2023 MAR (Medication Administration Record) was reviewed and indicated Resident C was given Tramadol 50 mg on 5/18/23 at 9:48 A.M. The clinical record lacked other documentation of administering Tramadol to the resident. 2. On 5/17/23 at 10:24 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, pain in unspecified joint. Current physician orders included, but were not limited to, oxycodone/APAP- 10/325 one tablet every 4 hours as needed for pain. Progress Notes from 5/1/23 to 5/17/23 indicated oxycodone was administrated to Resident D on the following dates: 5/18/23 1:54 P.M. 5/18/23 9:32 A.M. 5/17/23 7:21 P.M. 5/1723 9:47 A.M. 5/16/23 3:49 P.M. 5/16/23 11:37 A.M. 5/16/23 8:20 A.M. 5/15/23 7:24 P.M. 5/15/23 3:27 P.M. 5/14/23 8:16 A.M. 5/12/23 12:00 P.M. 5/11/23 5:12 P.M. 5/11/23 1:58 P.M. 5/11/23 8:13 A.M. 5/10/23 5:22 P.M. 5/10/23 1:32 P.M. 5/10/23 9:30 A.M. 5/9/23 4:28 P.M. 5/8/23 9:01 P.M. 5/8/23 5:05 P.M. 5/8/23 1:06 P.M 5/7/223 1:50 P.M.			

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	5/7/23 9:30 A.M. 5/6/23 10:11 A.M. 5/4/23 1:02 P.M. 5/4/23 8:58 A.M. 5/3/23 11:02 A.M. 5/3/23 12:03 A.M. 5/2/23 11:39 A.M. 5/2/23 7:26 A.M. 5/1/23 7:38 P.M. Resident D's MAR from 5/1/23 until 5/18/23 indicated oxycodone was administered to Resident D on the following dates: 5/18/23 9:32 A.M. 5/18/23 1:54 P.M. 5/17/23 7:21 P.M. 5/17/23 9:47 A.M. 5/16/23 3:59 P.M. 5/16/23 11:37 A.M. 5/16/23 8:20 A.M. 5/15/23 7:24 P.M. 5/15/23 5:27 P.M. 5/14/23 8:16 A.M. 5/13/23 no documentation 5/12/23 12:00 P.M. 5/11/23 5:12 P.M. 5/11/23 1:58 P.M. 5/11/23 8:13 A.M. 5/10/23 5:22 P.M. 5/10/231:32 P.M. 5/10/23 9:30 P.M. 5/9/22 4:28 P.M. 5/8/23 9:01 P.M. 5/8/23 5:05 P.M. 5/8/23 1:00 P.M. 5/7/23 1:50 P.M. 5/6/23 10:11 A.M. 5/5/23 no documentation 5/4/23 1:02 P.M.			

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	5/4/23 8:58 A.M. 5/3/23 11:02 A.M. 5/3/23 12:23 A.M. 5/2/23 11:39 A.M. 5/2/23 7:26 A.M. 5/1/23 7:38 P.M. On 5/18/23 at 4:28 P.M., the Administrator provided a Narcotic Inventory Sheet that was reviewed and indicated Resident D was given Oxycodone 10 on the following dates: 5/1/23 10:00 A.M., 2:00 P.M., 8:00 P.M., and 11:00 P.M. 5/2/23 7:25 A.M., 11:40 A.M., 3:40 P.M., and 7:40 P.M. 5/3/23 12:12A.M., 11:00 A.M., 3:00 P.M., and 7:00 P.M. 5/4/23 9:00 A.M., 1:00 P.M., 5:CPM., and 9:00 P.M. 5/5/23 7:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. 5/6/23 12:30 A.M. 10:00 A.M., 2:00 P.M., 6:00 P.M., and 10:30 P.M. 5/7/23 9:30 A.M., 1:30 P.M., 5:30 P.M., and 9:30 P.M. 5/8/23 7:45 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M 5/9/23 1:00 A.M., 8:00 A.M., 1:00 P.M., 4:30 P.M., and 8:05 P.M., 5/10/23 9:30 A.M.,1:30 P.M., 5:30 P.M., and 9:38 P.M. 5/11/23 8:14 A.M., 1:05 P.M., 4:05 P.M., and 8:30 P.M. 5/12/23 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:30 P.M. 5/13/23 1:30 A.M. (no further documentation provided). Resident D's MAR for April 2023 was requested and not provided.3. On 5/17/23 at 3:28 P.M., the administrator provided a copy of the police report			

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	she made to the Vanderburgh County Sheriff on 12/6/22 at 12:58 P.M. after narcotics were discovered missing from resident F. On 5/19/23 at 9:50 A.M.,, the administrator provided an incident report indicating that on 11/30/22 at 5:30 P.M., 30 Oxycodone 10-325 were unaccounted for. During a review of resident's clinical records on 5/20/23 at 9:00 A.M., the progress notes and additional documentation provided by the administrator on 5/19/23 at 10:15 A.M. indicated the resident had been out of the facility for hospitalization and rehabilitation from 11/14/22 to 12/16/22. During Resident F's absence from the facility, her narcotic sheet and progress notes indicated that Oxycodone 10-325 had been administered on: 12/1/22 at 0400, 0920, 1400, 1600, 1900 12/2/22 at 2400, 0400, 1330, 1400, 1600, 1900 12/3/22 at 0800, 1200, 1600 12/4/23 at 0400, 0800, 1200, 1600, 1900 12/5/22 at 0000, 0400, 0800, 1200, 1600, 2000 12/6/22 at 0000, 0400, 0800, 1200, 1600, 1900 12/7/22 at 0000, 0400, 0800, 1600 12/8/22 at 2400, 0400, 1000, 1400, 1600, 1945 12/9/22 at 2400, 0400, 1600 12/10/22 at 0800, 1200, 1700, 2100 12/11/22 at 0400, 0830 12/12/22 at 2145 12/13/22 at 0000, 0400, 0800, 1200 12/14/22 at 0000, 0400 Resident F returned to the facility on 12/16/22, but was rehospitalized on 1/1/23 till 2/22/23. During this absence, the narcotic sheet and progress notes indicated that Oxycodone 10-325 was administered on: 2/4/23 at 0640, 2130			

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	2/5/23 at 0512 2/13/23 at 2000, 2318 2/14/23 at 0509, 0902 2/17/23 at 2336 2/18/23 at 0512, 2143 2/19/23 at 0514, 2011 2/20/22 at 0248, 0532 Signed delivery sheets from the pharmacy indicated Oxycodone 10-325, also known as Percocet, were delivered to the facility for Resident F on illegible/22/23 Qty 180 illegible/7/23 Qty 120 5/16/23 Qty 180 illegible/17/23 Qty 120 2/22/23 Qty 120 During an interview on 5/18/23 at 9:40 A.M. with the DON, she indicated that QMA's and LPN's are supposed to chart the narcotics they administer on the medication administration record. Charting of narcotic administration on Resident F's MAR was observed to be only occasional. The MAR, progress notes, and narcotic count sheet did not match. On 12/9/22, a controlled drug destruction record indicated 120 Oxycodone 10-325 were destroyed via Drugbuster. Record was co-signed by 2 people. No reason was given for why the drugs were destroyed.4. On 5/17/23 at 10:00 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 2/3/23. Diagnosis included, but were not limited to, pain in right leg, dorsalgia, and low back pain. Current physician's orders included, but were not limited to, the following: oxycodone/acetaminophen 10/325 mg (milligrams)			

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	give 1 tablet orally every 4 hours as needed for pain, ordered 5/16/23. A May 2023 Narcotic inventory sheet for oxycodone/acetaminophen 10/325 mg (sheet was incorrectly labeled hydrocodone/acetaminophen) provided by the DON (director of nursing) on 5/18/23 at 1:30 P.M., was reviewed and indicated Resident B was given medication on the following dates: 5/5/23 at 4:00 P.M. 5/5/23 at 8:00 P.M. 5/6/23 at 8:00 A.M. 5/6/23 at 4:00 P.M. 5/6/23 at 8:00 P.M. 5/7/23 at 7:30 A.M. 5/7/23 at 1:00 P.M. 5/7/23 at 4:45 P.M. 5/7/23 at 8:45 P.M. 5/8/23 at 8:00 A.M. 5/8/23 at 12:00 P.M. 5/8/23 at 4:00 P.M. 5/8/23 at 8:00 P.M. 5/9/23 at 12:00 A.M. 5/9/23 at 7:30 A.M. 5/9/23 at 2:00 P.M. 5/9/23 at 8:00 P.M. 5/9/23 at 12:00 A.M. At that time, all other narcotic inventory sheets for Resident B's oxycodone/acetaminophen administration were requested and the DON indicated no others could be found. Resident B's May 2023 MAR was reviewed and indicated Resident B was given Oxycodone/Acetaminophen 10/325 mg, start date 4/17/23 and discontinued date 5/16/23, on the following dates: 5/1/23 at 7:36 P.M. 5/5/23 at 1:26 P.M.			

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	5/7/23 at 4:43 P.M. 5/7/23 at 8:45 P.M. Resident B's May 2023 MAR was reviewed and indicated Resident B was given oxycodone/acetaminophen 10/325 mg, start date 5/16/23, on the following date: 5/18/23 at 10:35 A.M. Resident B's May 2023 progress notes were reviewed and indicated oxycodone/acetaminophen 10/325 mg was given on the following dates: 5/1/23 at 7:36 P.M. 5/2/23 at 8:30 A.M. 5/5/23 at 1:26 P.M. 5/7/23 at 4:43 P.M. 5/7/23 at 8:45 P.M. 5/18/23 at 10:35 A.M. The medication disposal policy, dated 4/11/18 and revised on 8/11/18 indicated that disposal of controlled medications must be accomplished by pouring into a dissolving medication solution, coffee grounds, or kitty litter, and witnessed by the Executive Director/Director of Health and Wellness and another facility employee approved by the Executive Director to perform this function. A Drug Disposal Record must be completed, which includes the reason for the disposal of the drugs. A current contract from the contracted pharmacy was asked for from the pharmacy but not provided. A checklist of what the nurse consultant would do at a visit was provided and indicated they will review the clinical record to verify narcotic count sheets correspond to the documented administered medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/19/2023

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

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	During an interview on 5/18/23 at 1:44 P.M., the DON indicated RN narcotics that were administered should be documented on both the MAR and on the narcotic sheet. During an interview on 5/19/23 at 1:07 P.M., [pharmacist at pharmacy name] indicated that they took over the facility's pharmacy needs in mid November 2022. He indicated that their staff had not been in the facility to do any services including a review of documentation and audits from the resident clinical records but plan to do them quarterly beginning soon. On 5/19/23 at 10:08 A.M., a current policy for documentation of medication administration was requested and not made available during the survey. This Residential tag relates to Complaint IN00408321 and Complaint IN00406683.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs 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 and interview, the facility	R 0301	No resident was affected by the	07/01/2023

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	failed to ensure the proper storage of medications in 1 of 1 medication storage rooms. A box of labeled and unlabeled pills was found in a box on the floor in the medication storage room. (Medication Storage Room Second Floor) Findings include: On 5/18/23 at 3:23 P.M., a box of resident labeled pills and unlabeled pills were observed on the second story medication room floor. Pills included: Levothyroxine 112 mcg (Micrograms). Buspar XL 300 mg(Milligrams). Lisinopril 20 mg pill. Metformin 1000 mg pill. Prednisone 20 mg pill. Topiramate 25 mg pill. Rosuvastatin 25 mg pill. Asa 81 mg pill. Fluoxetine 40 mg pill. Mag oxide 400 mg pill. Gabapentin 300 mg pill. Ropinirole 2 mg pill. Card of 7 Asa 81mg pills. During an interview on 5/17/23 at 4:09 P.M., the DON (Director of Nursing) indicated she knew the box of medications was on the floor and needed to be destroyed. She also indicated she needed to notify the pharmacy about the medications. A current Medication Storage Policy dated 1/22 was provided on 5/19/23 at 11:15A.M., by the DON indicated " ...medication room-only authorized personnel may have access. The room must remain locked when authorized staff are not in attendance or within visual control ...individual storage bins- must be locked when not attended or within visual range."		deficient practice; the medications discovered were pending destruction following the passing away of a resident (death). All medications pending destruction will be stored in a secured location that only authorized clinical staff members have access to. All medications shall be secured from unauthorized access or destroyed to prevent deficient practice. The Vice President for Clinical Services, or designee, will conduct a training with the DON-W related to securing and destroying all medications to prevent improper storage and potential deviation of medications. In turn, the DON-W will conduct a training will all clinical staff to ensure that all medications remain locked when authorized staff are not in attendance or within visual control; proper disposal of medications will be addressed in the training also. The DONW, or designee, will audit clinical storage rooms and disposal logs for 6 months and/or until 100% compliance has been determined from QAPI meetings (2 times/week; for the next two months, 1 time/week for the following two months, and 1 time/month for two months thereafter. The facility respectfully requests a paper compliance review.	

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