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	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF KOKOMO	408 S WASHINGTON STREET KOKOMO, IN 46901

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00378962, IN00384360, IN00385474, IN00386619, and IN00388939. Complaint IN00378962 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384360 - Unsubstantiated due to lack of evidence. Complaint IN00385474 - Unsubstantiated due to lack of evidence. Complaint IN00386619 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00388939 - Unsubstantiated due to lack of evidence. Survey dates: September 12, 13, 14 and 15, 2022 Facility number: 014137 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 26, 2022.	R 0000	We respectfully request a desk review of the following plan of correction to the survey conducted at Silver Birch of Kokomo on 9-15-2022. This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of correction is submitted to meet the requirements established by the state and federal law. Silver Birch of Kokomo desires that this Plan of Correction be considered the facility's Allegation of Compliance effective Oct 8, 2022.	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required			

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

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	immunizations. Based on interview and record review, the facility failed to have the residents' assistance animals examined and ensure the animals had the required immunizations for 5 of 8 assistance animals reviewed for periodic veterinary examinations and required immunizations (Residents D, K, L, V, and AA). Findings include: During the entrance conference interview on 9/12/2022 at 12:15 p.m., the Executive Director (ED) indicated there were residents living in the facility who had assistance animals living with them. At that time, the facilities pet policy and the residents' animals' examinations, and vaccine records were requested. The examination and vaccination records for 6 of the 8 assistant animals were provided by the ED on 9/14/22 at 10:04 a.m. At that time, the ED indicated there were 4 of the 8 animals whose examinations and required vaccinations that were not up to date. Resident D's cat had been taken home two months ago when she was hospitalized, then sent to a rehabilitation facility. The other 3 animals had remained in the facility. 1. Resident D's cat was last examined and given her required vaccinations on 3/1/2019. The cat's examination was due on 2/29/2020. The required vaccinations were due on 2/28/2022. The cat was taken home by the family two months ago when the resident was admitted to the hospital. 2. Resident K's cat was last examined and given his required vaccinations on 1/13/2021. The cat's examination and required vaccination was due on 1/13/2022. The cat remained in the facility.	R 0151	R 151 Sanitation and Safety Standards What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident D's pet was examined by veterinarian on (9/30/2022) and received needed immunizations. Resident K's pet was examined by veterinarian on 9/19/2022) and received needed immunizations. Resident L's pet was examined by veterinarian on (9/29/2022 and received needed immunizations. Resident V's pet was examined by veterinarian on (9/17/2022) and received needed immunizations. Resident AA's pet was not examined by veterinarian on because the resident no longer resides in the facility. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	10/08/2022

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	3. There was no examination or vaccination paperwork provided for Resident L's dog. A paper provided with a list of the assistant animals who were and were not up to date on their vaccinations provided by the ED on 9/14/2022 at 10:04 a.m., indicated her dog was not up to date on the dog's examination and vaccinations. 4. There was no examination or vaccination paperwork provided for Resident V's dog. A paper provided with a list of the assistant animals who were and were not up to date on their vaccinations provided by the ED on 9/14/2022 at 10:04 a.m., indicated her dog was not up to date on the dog's examination and vaccinations. 5. Resident AA's cat was last examined and given his required vaccinations on 9/13/2022. The survey entrance date when the examination and required vaccination information was requested was on 9/12/2022. The information was not received from the ED until 9/14/2022 at 10:04 a.m. A current policy titled, "Assistance Animal Policy," with revised date 2/1/2020, provided by the ED on 9/12/2022 at 1:25 p.m., indicated, "...Definitions ...'Assistance Animal' means either a Service Animal or an Emotional Support Animal...Identification of Assistance Animal by Prospective Resident If the Resident has a Service Animal, Resident shall...3. Provide evidence of all immunizations and vaccinations as required...."		As a means of quality assurance all residents with records have been audited, all have received their immunizations and immunization records are in residents' administrative files located in Executive Director's office. What measures will be put into place or what systematic changes make to ensure that the deficient practice does not recur. The Eligibility Coordinator (EC) has been re-educated on company policy regarding pets residing in the community and informing new residents with pets about annual immunization requirements and needed documentation. Pet immunization records will be obtained by Director or and will be placed in administrative file. All new admissions will provide proof of their pets' immunizations prior to or at the time of move in. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality	

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			assurance program will be put into place. Coordinator or will audit residents' administrative files for pet immunization records one (1) time monthly for three (3) months, then biannually in January and July, and any findings will be addressed at the time of discovery. Audit findings will be reported to the QAPI Committee monthly ongoing due to continued acceptance of new residents. AOC date 10/8/2022 and on-going.	
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.			

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	(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 interview and record review, the facility failed to ensure residents' weights were obtained semiannually for 6 of 7 residents reviewed for weights (Residents H, J, C, B, G and E), and failed to ensure medication self-administration assessments were completed timely for 2 of 2 residents reviewed for self-medication administration (Residents G and E). Findings include: 1. The record for Resident H was reviewed on 09/13/2022 at 1:56 p.m. Diagnoses included, but were not limited to, insomnia, anxiety disorder, multiple sclerosis, chronic pain, and anemia. Resident H had a documented weight on 07/02/2021 and did not have another documented weight until 08/12/2022. 2. The record for Resident J was reviewed on 09/13/2022 at 2:45 p.m. Diagnoses included, but were not limited to hypertension, anxiety, major depressive disorder, and pain. The resident was admitted on 02/23/2021. The only documented weight in Resident J's record was on 08/11/2022. 3. The record for Resident C was reviewed on 09/13/2022. Diagnoses included, but were not limited to, hypertension, chronic gout, and pain. The resident was admitted on 05/20/2021 and discharged on 04/01/2022.	R 0216	R-216 Evaluation Non-compliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident G was assessed for the ability to self-administer medications ordered on (9/13/2022) and service plan updated accordingly. Resident E Resident no longer is a resident at the facility. Resident B was weighed on (10/5/2020) and service plan has been updated Resident C was weighed on (10/5/2020) and service plan has been updated Resident E no longer is a resident at the facility. Resident G was weighed on (10/5/2020) and service plan has been updated	10/08/2022

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	Resident C had a documented weight on 05/20/2021 and on 07/02/2021 and did not have another documented weight before she discharged. 4. The record for Resident B was reviewed on 09/14/2022 at 3:05 p.m. Diagnoses included, but were not limited to atrial fibrillation, major depressive disorder, chronic pain, mild cognitive impairment, and type 2 diabetes mellitus. Resident B had a documented weight on 05/17/2021 and did not have another documented weight until 08/12/2022. 5. The record for Resident G was reviewed on 09/12/2022 at 2:30 p.m. Diagnoses included but were not limited to hypothyroidism, type 2 diabetes mellitus, and major depressive disorder. Resident G had a documented weight on 07/02/2021 and did not have another documented weight until 08/12/2022. Resident G had a "Medication Self-Administration Safety Screen" dated as signed on 09/13/2022. During an interview, on 09/14/2022 at 3:00 p.m., the Director of Health Services indicated the resident's self-administration assessment was due 06/20/2022. It was not signed as completed until 09/13/2022. 6. The record for Resident E was reviewed on 09/12/2022 at 2:50 p.m. Diagnoses included but were not limited to hypertension, dermatitis, insomnia, major depressive disorder, and chronic fatigue.		Resident H was weighed on (10/5/2020) and service plan has been updated Resident J was weighed on (10/5/2020) and service plan has been updated How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit has been completed by the Director of Nursing and Wellness (DONW) to ensure accurate identification of all residents who self-administer any type of medications or treatments. Assessments have been completed and service plans reviewed and updated for each identified resident to reflect medication and/or treatment self-administration. The clinical staff have been educated on resident self-administration, the need to notify the Director of Nursing and Wellness (DONW) should a resident voice a desire to self-administer who had not	

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	Resident E had a documented weight on 10/14/2021 and did not have another documented weight until 08/12/2022. An "Order Summary Report," dated 09/13/2022, indicated this was a list of all Resident E's active physician's orders as of 09/13/2022. The order report had all the resident's medications listed as unsupervised self-administration. The only documented self-medication assessment in the resident's record was dated 7/19/2019. During an interview, on 09/14/2022 at 4:12 p.m., the Director of Health Services indicated the only self-administration was completed on the resident's admission to the facility on 07/19/2019. A new assessment was completed during the survey and the resident's medication were removed from her room. The nursing staff would be administering her medications. During an interview, on 09/14/2022 at 4:14 p.m., the Director of Health Services indicated she had no more weights to provide, and residents were to be weighed on admission and semi-annually. A current facility policy, titled "Weight Monitoring Policy," dated 2/14/20 and received from the Director of Health Services on 9/15/22 at 12:11 p.m., indicated "...It is the policy of Silver Birch Living that all residents will be weighed upon admission and at least semiannually thereafter...." A current facility policy, titled "Self-Medication Program Policy," dated 4/11/18 and received from the Director of Health Services on 9/15/22 at 12:11 p.m., indicated "...Any resident wishing to administer their own medications will be assessed		previously self-administered medications, and to ensure completion of assessment and updating of the service plan. An audit has been completed by the DONW to ensure all residents have a semiannual weight taken, recorded in PCC, and service plans have been updated per policy. The clinical staff have been educated on the importance of obtaining semi-annual weights, recording weights in PCC, and updating service plans for all residents residing in the community. Education was provided by the DONW on (9/13/2020) What measures will be put into place or what systematic changes make to ensure that the deficient practice does not recur. The DONW will audit residents' PCC documentation for Quarterly Medication Self-administration assessments for those residents identified as self-administering ordered medications and/or	

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	by a licensed nurse and self-administration assessment completed to determine resident's ability to self-administer their medications...."		treatments. Audits will be completed weekly for 3 months, then monthly ongoing due to the continued acceptance of new residents. Any findings will be addressed at the time of discovery. The DONW will utilize the weight report from PCC to audit all residents' weights, the date the residents were weighed, and will monitor to ensure all residents are weighed no less than every 6 months. The audits will be completed monthly x 3 months, then quarterly ongoing due to the continued acceptance of new residents. Findings will be addressed at the time of discovery. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DONW will report audit findings of medication self-administration assessment completion to the QAPI committee for review monthly until 100% compliance has been met for 3 consecutive months, then quarterly ongoing due to continued	

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			acceptance of new residents. The DONW will report audit findings of weights obtained at least every 6 months to the QAPI Committee monthly until 100% compliance has been met for 3 consecutive months, then quarterly ongoing due to continued acceptance of new residents. AOC date 10/8/2022 and on-going.	
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 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			

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	resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident's service plans were signed and dated by the resident for 2 of 7 residents reviewed for service plans (Residents E and C). Findings include: 1. The record for Resident E was reviewed on 09/12/2022 at 2:50 p.m. Diagnoses included, but were not limited to hypertension, dermatitis, insomnia, major depressive disorder, and chronic fatigue. A "Level of Service Assessment/ Evaluation," dated as effective 06/24/2022, was electronically signed by the Admissions Wellness Nurse on 07/11/2022. The service plan was not signed or dated by the resident or the resident representative. During an interview on 09/14/2022 at 4:35 p.m., the Director of Health Services indicated she could not locate a signed service plan for Resident E and the resident should have signed it when it was completed. 2. The record for Resident C was reviewed on 09/13/2022. Diagnoses included, but were not limited to hypertension, chronic gout, and pain.	R 0217	R-217 Evaluation Deficiency Service Plan What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents E's service plan has been reviewed and signed by the resident on (9/22/2022) Residents C's service plan has been reviewed and signed by the resident on (9/10/2022) How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents of Silver Birch of Kokomo are to have a service plan in place, reviewed by the residents, signed & dated by the resident at least upon admission and no less than annually. DONW completed an audit to ensure all service plans have been reviewed and signed by all current residents.	10/08/2022

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	A signed service plan was not located in the resident's record. During an interview, on 09/14/2022 at 4:14 p.m., the Director of Health Services indicated she could not locate a signed service plan for Resident C and the resident should have signed it when it was completed. A current facility policy titled, "Service Plans," dated 6/15/18 and received from the Director of Health Services on 9/15/22 at 12:11 p.m., indicated, "...designee will meet with residents and review their service plans at least annually or if changes are warranted. If both parties agree on the service plan it is to be signed and dated by the resident...."		DONW provided 1:1 education to licensed nurses on the Service Plan Policy & Procedure on (9/22/2022). Nursing Department in-services provided by DONW on 10/3/22 and 10/4/22. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. DONW will audit service plan reviews weekly for 3 months, then quarterly ongoing due to continued acceptance of new residents. Any findings will be addressed at the time of discovery. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DONW will report audit findings to the QAPI Committee monthly until 100% compliance is maintained for 3 consecutive months, then quarterly ongoing due to the continued acceptance of new residents. AOC Date: 10/8/2022 and on-going.	
R 0304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency			

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Bldg. 00	(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to ensure medications were kept secured for 10 of 10 residents' medications randomly observed to be unsecured. (Residents N, P, Q, R, X, S, T, U, V, and W) Findings include: During an observation, on 09/13/2022 at 2:42 p.m., a medication cart on the second floor of the building had medications left unattended on the medication cart and not secured. Observed lying on the cart were the following medications: 1. One medication card for Resident N for levothyroxine (a thyroid medication) 50 mcg (microgram). The card contained 30 tablets. 2. Four medication cards for Resident P for gabapentin (an anticonvulsant or medication to treat nerve pain) 100 mg (milligram). Each card contained 30 capsules for a total of 120 capsules. 3. One medication card for Resident Q for acetaminophen (used to treat mild pain or fever) 325 mg. The card contained 30 slots with 2 tablets in each slot for a total of 60 tablets. 4. Two medication cards for Resident R for acetaminophen 325 mg. Each card contained 30	R 0304	R 304 Pharmaceutical Services Deficiency What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident N's medications were placed in proper storage by licensed staff Resident P's medications were placed in proper storage by licensed staff Resident Q's medications were placed in proper storage by licensed staff Resident R's medications were placed in proper storage by licensed staff Resident S's medications were placed in proper storage by licensed staff	10/08/2022

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	slots with 2 tablets in each slot for a total of 120 tablets. 5. One medication card for Resident X for clonidine (used to treat high blood pressure) 0.1 mg. The card contained 30 tablets. 6. One medication card for Resident S for Zofran (used to treat nausea) 4 mg. The card contained 30 tablets. 7. One medication bottle for Resident T for potassium chloride solution 20 meq/15 ml (milliequivalents per milliliters). The bottle contained 16 fluid ounces. 8. One pack for Resident U for telmisartan-HCTZ (used to treat high blood pressure) 80-25 mg. The pack contained 7 tablets. 9. One medication bottle for Resident V for brimonidine tartrate solution 0.2% (used to treat glaucoma). 10. One medication bottle for Resident W for ketorolac tromethamine solution 0.4% (used to treat eye inflammation). During an interview, on 09/13/2022 at 2:45 p.m., Qualified Medication Aide (QMA) 2 indicated he was unsure who left the medications on the cart unattended. The pharmacy had just made a delivery. The medications belonged inside the cart they were lying on. The cart was for the residents on the fourth floor. During an interview, on 09/13/2022 at 3:15 p.m., the Director of Health Services indicated the pharmacy had just made a delivery and may have left the medications on the cart. Medications were		Resident T's medications were placed in proper storage by licensed staff Resident U's medications were placed in proper storage by licensed staff Resident V's medications were placed in proper storage by licensed staff Resident W's medications were placed in proper storage by licensed staff How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents have the potential to be affected by the alleged deficient practice. QMA 2 was educated on the procedure for receiving medications from the pharmacy delivery and them on 9/13/2022. The DONW provided the education.	

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		A. BUILDING 00 B. WING	09/15/2022

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	not supposed to be left unattended. A current facility policy titled, "Medication Administration Program Policy," dated as revised 03/24/2021 and received from the Director of Health Services on 09/14/2022 at 3:11 p.m., indicated "...Storage of medications is proper, separate from food and toxic chemicals, and accessible only to designated responsible staff or appropriate resident...."		Licensed staff will be educated on the procedure for receiving medications from the pharmacy delivery and them on or before 10/8/22. The DONW provided the education. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. The DONW or will make rounds to observe medication carts and nursing offices for medications not stored properly. The DONW or will record findings on a rounds audit tool 5 times per week x , then weekly for 6 monthsAny findings will be addressed at the time of discovery including staff . How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DONW will be responsible for	

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			ensuring sustained compliance and ongoing education with nursing staff. The DONW will report audit findings and education provided to the QAPI Committee monthly until 100% compliance is met for 3 consecutive months, then quarterly ongoing due to in nursing staff. AOC Date/8/2022.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to administer an annual Tuberculin (TB) screening (to determine if a person had been exposed to Tuberculosis) for 1 of 7 residents reviewed for annual TB screening. (Resident J) Finding includes: The record for Resident J was reviewed on 09/13/2022 at 2:45 p.m. Diagnoses included, but	R 0412	R 412 infection Control Non-Compliance What correct actions will be accomplished for those residents found to have been affected by the deficient practice?	10/08/2022

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	were not limited to, hypertension, anxiety, major depressive disorder, and pain. A chest x-ray was completed for Resident J on 03/02/2021. A first step skin test for TB was completed on 03/07/2021. A second step skin step for TB was completed on 03/21/2021. An annual TB screening was not located for 03/2022. During an interview, on 9/14/2022 at 4:24 p.m., the Director of Health Services indicated there was not an updated annual TB screening for Resident J and one should have been completed in March of 2022. A document titled, "Annual TB Questionnaire," undated and received from the Director of Health Services on 9/15/22 at 12:11 p.m., indicated "...In the past yearly TB tests or chest x-rays were performed; however, recent studies show that they are unnecessary. Instead, this health survey will assist Nursing to monitor possible TB Symptoms...."		TB Screening was completed on Resident J on (9/15/2022) How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The DONW completed an audit to ensure all residents had an Annual TB screening completed. Licensed nurses were re-educated on the policy and procedures for performing TB screenings on all residents once a year. The DONW provided the education on (9/13/2022). What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. The DONW or designee will be responsible re- all nursing staff on the policy and procedure on residents' annual TB screenings.	

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			Going forward Annual TB screenings will be done on current residents in Feb and in Sept. The DONW or designee will audit the missing TB immunization report for residents without an annual TB assessment weekly , then monthly x 3, then quarterly ongoing due to continued acceptance of new residents. Any findings will be addressed at the time of discovery. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. will report audit findings to the QAPI committee monthly until 100% compliance is maintained for 3 consecutive months, then biannually in February and September ongoing due to continued acceptance of new residents. AOC Date/8/2022.	