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	03/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00429392, IN00429688 and IN00429770. Complaint IN00429392- No deficiencies related to the allegations are cited. Complaint IN00429688-State deficiencies related to the allegations are cited at R 0240. Complaint IN00429770-State deficiencies related to the allegations are cited at R 0090. Survey dates: March 13 and 14, 2024 Facility number: 014553 Residential Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 18, 2024.	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 Cathy Vasil, Executive Director, Silver Birch of Cook Road.*	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Vasil	Executive Director	03/29/2024

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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	of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			

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	Based on observation, interview and record review the facility failed to ensure unusual occurrences were reported within 24 hours for 1 of 2 residents reviewed (Resident 4). Findings include: An Indiana Report dated 3/3/25 at 11:52 PM indicated Resident 4's motorized wheelchair had been removed by the facility Executive Director (ED). The report indicated Resident 4's motorized wheelchair would not be returned until they moved out of the facility. The report indicated Resident 4's manual wheelchair was insufficient due to their weakness of 1 arm and 1 leg. On 3/13/24 at 10:10 AM Resident 4 was observed lying in their bed, then transferring themselves to a manual wheelchair. In an interview on 3/13/24 at 10:12 AM, Resident 4 indicated they were weak on their left side due to having had a stroke. Resident 4 indicated they were blind in their left eye. Resident 4 indicated the facility ED had placed their motorized wheelchair into storage because the ED did not like the resident. Resident 4 indicated the ED was trying to force them to move out. Resident 4 indicated it was extremely difficult for them to manage their manual wheelchair. Resident 4 indicated they were being punished because other residents in the facility were over dramatic and made a big deal out of everything. Resident 4 indicated he had occasionally lightly bumped the backs of other residents' wheelchairs with their motorized wheelchair. Resident 4 indicated he knew the names of the other residents, but he did not want to disclose their names. Resident 4 indicated 1 "old lady" reported she would not	R 0090	Prefix Tag # __R090 Administration and Management___ 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 4 experienced no adverse effects due to the finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No other residents were affected and no other unreported events occurred. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DONW will be given access for reporting events in Gateway and will be educated on the reporting process and timelines. QAPI plan has been initiated. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ED will be reviewing all reportable events on a monthly basis during QA meeting until we gain 100% compliance for 6 consecutive months.	04/05/2024

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	speak to them anymore because they had bumped into her chair and she now had back pain. Resident 4 indicated they were being harassed by the ED. Resident 4 indicated the ED wrongfully accused them of buying a gas can. Resident 4 indicated they had won an eviction appeal, but the ED was still trying to evict them. Resident 4 displayed a letter from the facility dated 3/11/24. The letter indicated it was to be considered a 2nd warning prior to eviction. The letter indicated Resident 4 had been involved in an altercation with another resident, viewed pornographic material on the public library computer, damaged the walls behind the reception area, collected urine into 2 large jugs in their room, bought and filled a gas can with cigarette butts and cattails with ill intent and tampering with the temperature control unit. Resident 4 displayed a letter from the facility dated 3/12/24. The letter indicated the resident was invited to a discharge and location conference on 3/20/24 at 11:00 AM. Resident 4's record was reviewed on 3/13/24 at 10:35 AM. Diagnoses included stroke, left sided paralysis\, major depressive disorder and anxiety disorder. Resident 4's current service plan for depression and anxiety dated 2/6/24 indicated the resident received 3rd party psychosocial services within the facility. The target goal was for Resident 4 to have decreased behavior episodes by 12/23/23. Interventions included mediation as necessary to protect the rights and safety of others, validation of feelings, diversion or relation-based redirection and removal from the situation. Resident 4's current service plan dated 8/2/23 for motorized wheelchair indicated the resident rode their motorized wheelchair in the parking lot at		5 By what date the systemic changes will be completed: Systematic changes will be in effect by 4/5/2024. The facility respectfully requests a paper compliance review.	

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	high speeds. The service plan indicated Resident 4 refused to ride on the sidewalk for safety. The target goal was for the resident to have fewer episodes by 12/21/23. Interventions included mediation as necessary to protect the rights and safety of others, validation of feelings, diversion or relation-based redirection, removal from the situation, empathetic listening, attention and opportunities for positive interactions. Resident 4's current service plan for behaviors dated3/3/21 indicated the resident was at risk for behaviors. The target goal was for the resident to not act out in a way that was harmful to self or others by 12/21/23. Interventions included the reporting of behavioral changes from baseline. Resident 4's progress notes dated from October 2023 through March 2024 indicated the resident had requested a gun and a bullet, threatened to break a staff member's neck and had threatened to make an explosive device to blow up the facility. In an interview on 3/13/24 at 11:17 AM, the ED indicated they were aware of Resident 4 requesting a gun and a bullet. The ED indicated the request was not reported due to the resident had denied a suicidal plan. The ED indicated they were unaware of Resident 4 threatening to make an explosive device to blow up the facility. The ED indicated Resident 4 had displayed behaviors such as slamming into the backs of others' wheelchairs, sexual comments to staff, name calling of residents, physical altercations with other residents, verbal threats of physical violence, viewing pornographic material on the public library computers and destruction of the facility with their motorized wheelchair.The ED indicated they had reviewed Resident 4's progress notes. The ED indicated they had been on			

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	vacation during the time Resident 4 threatened to build a bomb and had not been fully aware of the details. The ED indicated Resident 4's threat to blow up the facility should have been investigated and reported The ED indicated they had initiated an in investigation of the incident. A current facility policy dated 8/1/18 provided by the ED on 3/14/24 at 3:03 PM indicated the facility would provide crisis/behavior intervention to ensure safety of all residents and staff. The policy indicated suicidal residents would be immediately transported to the hospital. The policy indicated homicidal threats should be immediately reported to local police authorities. A current facility policy dated 12/10/18 provided by the ED on 3/14/24 at 3:34 PM indicated the facility would inform the Indiana State Department of Health within 24 hours of becoming aware of unusual occurrences that directly threatens the welfare, safety, or health of a resident. The policy indicated occurrences that directly threaten the welfare, safety, or health of a resident included resident to resident verbal abuse and sexual abuse. The policy defined verbal abuse as oral, written and/or gestured language that includes disparaging and/or derogatory terms to residents or their families either directly or within their hearing. The policy defined sexual abuse as sexual harassment, sexual coercion or sexual assault. The policy indicated examples of sexual abuse included harassment, gestures and sharing of pornography. This citation is related to complaint IN00429770.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with			

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	activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review and interview the facility failed to ensure blood pressure was monitored and physician was notified as ordered for 2 of 4 residents reviewed. (Resident 9). Findings include: 1. Resident 9's record was reviewed on 3/14/24 at 9:30 AM. Diagnoses included essential hypertension and edema. Resident 9's current semiannual service plan, dated 9/1/23, indicated the resident had issues with cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) including mild to moderate disorientation, difficulty remembering, and retaining information. Interventions included providing cues and reminders to the resident. A physician's order dated 1/23/24 at 4:58 PM indicated Resident 9 was to receive a 10mg midodrine tablet three times a day as needed for hypotension (low blood pressure) when her systolic blood pressure (the first or top number of your blood pressure) was below 90. In an interview on 3/14/24 at 11:47 AM, Resident 9's daughter indicated she was aware of two times her mother's systolic blood pressure had dropped below 70. Resident 9's Medication Administration Record (MAR) indicated the resident would have her blood pressure and pulse documented when taking her 25mg metoprolol tartrate tablet three	R 0240	Prefix Tag # __R240 Health Services__ 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 9: Had no negative outcome related to finding. Resident 13: Had no negative outcome related to finding. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with ordered blood pressure monitoring and those receiving blood sugar monitoring have the potential to be affected. Review of all other residents with orders completed on 4/3/24 to ensure that proper monitoring and documentation is being completed. No residents have experienced any negative effects. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education was provided to nurses and QMAs on 3/22/24-3/26/24 regarding monitoring and documenting ordered B/Ps and blood sugars. QAPI plan has been initiated.	04/05/2024

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	times a day at 8:00 AM, 2:00 PM and 8:00 PM. Resident 9's Medication Administration Record (MAR) indicated the resident blood pressure and pulse was documented as "NA" on the following days/times: Day Time 2/1/24 8:00 PM 2/2/24 8:00 PM 2/5/24 8:00 PM 2/6/24 8:00 PM 2/9/24 8:00 PM 2/10/24 8:00 PM 2/11/24 8:00 PM 2/12/24 8:00 PM 2/13/24 8:00 PM 2/14/24 8:00 PM 2/15/24 8:00 PM 2/16/24 2:00 PM 8:00 PM 2/18/24 8:00 PM 2/19/24 8:00 PM 2/20/24 8:00 PM 2/21/24 8:00 PM 2/26/24 8:00 PM 2/29/24 8:00 PM 3/5/24 8:00 PM 3/6/24 8:00 PM 3/8/24 8:00 PM 3/10/24 8:00 PM Resident 9's progress notes from 2/1/24 to 3/12/24 did not provide additional information concerning the missing blood pressure and pulse documentation. In an interview on 3/14/24 at 1:50 PM, the Assistant Director of Wellness and Nursing indicated the "NA" on the MAR meant not applicable and the blood pressure and pulse for Resident 9 had not been documented prior to		DON/Designee will audit MARS 2x weekly for 4 weeks and then weekly for 4 weeks then monthly thereafter until 95% compliance met for 3 consecutive months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All issues noted on audits will be addressed immediately. Audits will be reviewed in the monthly QAPI meeting. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 4/5/2024. This Community respectfully requests a paper compliance review.	

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	giving her metoprolol and should have been. A current policy titled, "Medication Administration Program Policy", revised 3/24/21, provided by the Executive Director, indicated documentation on the MAR would be complete and accurate. 2. Resident 13's record was reviewed on 3/14/24 at 10:29 AM. Diagnoses included diabetes mellitus, schizophrenia, and hypertension. A review of physician orders dated 2/3/24 indicated insulin lispro (a fast-acting insulin designed to reduce blood sugar quickly) was ordered to be given according to a sliding scale. The sliding scale orders indicated when a blood sugar value was 401 or greater, 12 units of insulin were ordered to be given and the physician was to be notified. A review of a medication administration record (MAR) indicated the following: On 3/3/24 at 4:43 PM, Resident 13's blood sugar was 441. On 3/8/24 at 10:01 AM, Resident 13's blood sugar was 429. On 3/8/24 at 11:29 AM, Resident 13's blood sugar was 443. On 3/12/24 at 10:00 AM, Resident 13's blood sugar was 410. On 3/12/24 at 5:15 PM, Resident 13's blood sugar was 461. A review of progress notes from 3/3/24 through			

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	3/12/24 did not include any documentation of notification of the physician regarding elevated blood sugar levels. A progress note dated 3/5/24 at 12:01 PM by Nurse Practitioner (NP) 10 did not address a review of Resident 13's diet or management of elevated blood sugars. A progress note dated 3/7/24 at 11:41 AM by NP 10 did not address a review of Resident 13's diet or management of elevated blood sugars. No further notes from NP 10 addressing diabetic care were available for review. In an interview on 3/14/24 at 1:50 PM, the Assistant Director of Nursing indicated staff used a book on the unit to write notifications to the Nurse Practitioner (NP) to review on her next visit and those notifications are thrown away after the NP addressed the concern. She indicated the notification should be recorded in the medical record. During an interview on 3/14/24 at 4:05 PM, the Administrator indicated she was unable to locate a policy pertaining to following physician's orders. This citation is related to complaint IN00429688.			
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.	R 0273	Prefix Tag # __R273 _____	04/05/2024

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	Based on observation, interview, and record review the facility failed to ensure opened food items were labeled and dated and a drip pan was emptied and cleaned in the kitchen. 111 of 111 residents residing in the facility consumed food prepared in the kitchen. Findings include: During an observation and interview on 3/13/24 at 9:15 AM, a reach in cooler in the kitchen contained a tray filled with small, lidded cups filled with a white substance. The cups were not labeled identifying the substance in the containers and no dates were found on the containers or the tray. The Culinary Manager (CM) indicated he thought they were cups of ranch dressing and sour cream. He indicated he was unable to determine the expiration dates because they were not labeled and dated. He indicated the items should have been labeled and dated. A salad station cooler was observed containing a lidded container filled with shredded cheese, a lidded container filled with diced tomatoes, a container of boiled eggs and a container of chopped lettuce. No labels or dates were found on any of the containers. The CM indicated the items should have been labeled and dated. He indicated he was unable to determine the expiration dates because they were not labeled and dated. A flat-top grill's drip pan was observed with several piles of black debris, ranging from golf ball to tennis ball size. About two inches of dark fluid was observed in the bottom of the drip pan. The CM indicated this grill was only used weekly on Sundays. He indicated the drip pan should be		1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this finding. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No residents have experienced any negative effects. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education was provided to kitchen staff on 3/15/24 regarding ensuring that all open food items need to be labeled and dated and the drip pan must be cleaned weekly. QAPI plan has been initiated. Culinary Manager, or designee, will audit open foods for labeling and dating. Culinary Manager, or designee will audit drip pan to ensure it is being cleaned on a weekly basis. These audits will be completed weekly for 4 weeks then monthly thereafter until 100% compliance met for 3 consecutive months. 4 How the corrective action(s)	

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	emptied and cleaned after each use. The CM indicated he could not determine when the drip pan had last been cleaned. In a review of an undated document titled Dietary Cleaning Schedule provided on 3/13/24 at 1:43 PM by the Administrator did not include an expected routine time to empty and clean the grill drip pan. A current policy dated 1/20/20 titled Food Storage provided by the Administrator indicated any opened products should be labeled and dated.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All issues noted on audits will be addressed immediately. Audits will be reviewed in the monthly QAPI meeting. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 4/5/2024. The facility respectfully requests a paper compliance review.	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review the facility failed to ensure diet orders were obtained and reviewed for 4 of 16 residents reviewed (Resident 13, Resident 14, Resident 15, and Resident 16). Findings include: 1) Resident 13's record was reviewed on 3/14/24 at 10:29 AM. Diagnoses included diabetes mellitus, schizophrenia, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of physician's orders did not include a diet order. A review of a medication administration record	R 0275	Prefix Tag # __R275 Food and Nutritional Services___ 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 13: Had no negative outcome related to finding. Resident 14: Had no negative outcome related to finding. Resident 15: Had no negative outcome related to finding. Resident 16: Had no negative outcome related to finding. 2 How the facility will identify other residents having the	04/05/2024

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		A. BUILDING 00 B. WING	03/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(MAR) indicated the following: On 3/3/24 at 4:43 PM, Resident 13's blood sugar was 441. On 3/8/24 at 10:01 AM, Resident 13's blood sugar was 429. On 3/8/24 at 11:29 AM, Resident 13's blood sugar was 443. On 3/12/24 at 10:00 AM, Resident 13's blood sugar was 410. On 3/12/24 at 5:15 PM, Resident 13's blood sugar was 461. According to WebMD.com, possible consequences of sustained high blood sugar levels could include permanent damage to blood vessels that could lead to nerve damage, poor blood flow to extremities and internal organ damage. A progress note dated 3/5/24 at 12:01 PM by Nurse Practitioner (NP) 10 did not address a review of Resident 13's diet. A progress note dated 3/7/24 at 11:41 AM by NP 10 did not address a review of Resident 13's diet. No further notes from NP 10 addressing diabetic care were available for review. 2) Resident 14's record was reviewed on 3/14/24 at 11:18 AM. Diagnoses included diabetes mellitus, morbid obesity due to excess calories and hyperlipidemia. Physician's orders did not include a diet order.		potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Review of all other residents' diet orders completed on 4/3/24 to ensure that every resident has a diet order listed in their chart. No residents have experienced any negative effects. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education was provided to nurses on 3/28/24 regarding ensuring that all residents have a diet order listed in their chart upon move in so that the nurse practitioner can review them. QAPI plan has been initiated. DON/Designee will audit diet orders weekly for 4 weeks then monthly thereafter until 100% compliance met for 3 consecutive months. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All issues noted on audits will be addressed immediately. Audits will be reviewed in the monthly QAPI meeting. 5 By what date the systemic changes will be completed:	

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	Progress note dated 1/11/24 at 10:46 AM, NP 10 indicated Resident 13 was new to the facility and had a recent history of requiring 10 minutes of cardiopulmonary resuscitation. Diet was not addressed in the note. Progress notes from admission to 3/14/24 did not include any notes reviewing Resident 14's diet. 3) Resident 15's record was reviewed on 3/14/24 at 1:10 PM. Diagnoses included chronic kidney disease, stage 3, type 2 diabetes mellitus, and hyperlipidemia. A review of physician's orders did not include a diet order. A physician's order dated 10/23/23 indicated NovoLog (a fast-acting insulin) was ordered to be administered by a sliding scale when blood sugars exceeded desired levels. A review of a medication administration for March 2024 indicated Resident 14 received NovoLog as follows: 3/1/24 at 4:00 PM 2 units for blood sugar 166. 3/2/24 at 4:00 PM 4 units for blood sugar 222. 3/3/24 at 4:00 PM 2 units for blood sugar 173. 3/4/24 at 12:00 PM 2 units for blood sugar 186. 3/4/24 at 4:00 PM 4 units for blood sugar 212. 3/8/24 at 8:00 AM 2 units for blood sugar 159. 3/8/24 at 12:00 PM 4 units for blood sugar 220.		Systematic changes will be in effect by 4/5/24. The facility respectfully requests a paper compliance review.	

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	3/10/24 at 12:00 PM 2 units for blood sugar 169. 3/11/24 at 12:00 PM 2 units for blood sugar 154. 3/12/24 at 4:00 PM 2 units for blood sugar 169. 3/13/24 at 12:00 PM 2 units for blood sugar 174. A review of progress notes did not include any review of Resident 15's diet. 4)Resident 16's record was reviewed on 3/14/24 at 2:24 PM. Diagnoses included type 2 diabetes mellitus, hyperlipidemia, and cerebral infarction. A review of physician's orders did not include a diet order. A review of an order note dated 3/7/24 at 2:16 PM by the Assistant Director of Nursing indicated the order for insulin glargine 25 units twice daily was outside the recommended dose for this medication (higher dose than recommended). A progress note dated 1/30/24 at 10:00 AM indicated Resident 16 had been admitted to the hospital with metabolic acidosis (a complication of diabetes). A review of progress notes from 1/1/24 to 3/24/24 did not include any reviews of Resident 16's diet. In an interview on 3/14/24 at 1:50 PM, the Assistant Director of Nursing indicated diet orders were not needed because using a regular diet was a qualification for admission and the facility did not offer any special diets. A current policy titled Special Diets dated 1/20/20			

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	provided by the Administrator on 3/14/24 at 3:04 PM indicated the facility did not provide special diets. The policy indicated menus offered choices that would usually allow residents to meet nutritional guidelines recommended by their physician. A current policy titled Care of Diabetic Residents dated 8/1/18 provided by the Administrator on 3/14/24 at 3:04 PM indicated all residents should be assessed to determine if the facility could meet their needs.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure clinical documentation related to continuity of care for hospital transfers for 2 of 2 residents reviewed (Resident 7 and Resident 8). Findings include:	R 0354	Prefix Tag # __R354 Clinical Records___ 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 7: Had no negative	04/05/2024

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	1.Resident 7's record was reviewed on 3/13/24 at 2:42 PM. Diagnoses included diabetes, dialysis dependent kidney disease, heart failure and nicotine dependence. A Transfer to Hospital Summary dated 6/22/23 at 4:00 PM indicated Resident 7 was transferred to the hospital for evaluation and treatment of a wound on their 2nd right toe. The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 7/13/23 at 4:00PM indicated Resident 7 was transferred to the hospital for evaluation and treatment of a wound on their 2nd right toe. The summary indicated Resident 7 was taken to the hospital by a friend. The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 8/30/24 at 3:52 PM indicated Resident 7 was transferred to the hospital for shortness of breath. The summary indicated an assessment was completed. The summary indicated Resident 7 was transferred to the hospital by an ambulance. The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 12/20/23 at 9:15 AM indicated Resident 7 had been transferred to the hospital for shortness of breath. The summary indicated Resident 7's vital signs were obtained and a full assessment was completed. The summary indicated an ambulance was called. The summary indicated Resident 7's		outcome related to finding. Resident 8: Had no negative outcome related to finding. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents being transferred out have the potential to be affected. Review of all other residents who were transferred out in the past 30 days will be completed by 4/5/24 to ensure that proper monitoring is being completed and documented. No residents have experienced any negative effects. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education was provided to nurses and QMAs on 3/22/24 – 3/26/24 regarding documenting the resident's condition at the time of transfer. Also re-educated on proper documentation completed with all transfers per regulations/guidance. QAPI plan has been initiated. DON/Designee will audit Transfer Summary weekly for 4 weeks and then monthly thereafter until 95% compliance met for 3 consecutive months. 4 How the corrective action(s)	

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	Primary Care Provider, their sister and the dialysis center were notified.The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 1/21/24 at 8:30 AM indicated Resident 7 was transferred to the hospital for shortness of breath. The summary indicated Resident 7's vital signs were obtained and the resident was transferred by an ambulance. The summary indicated the resident's sister and their Nurse Practitioner (NP) were notified.The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 2/14/24 at8:48 AM indicated Resident 7 had been transferred to the hospital for shortness, wheezing and fluid in the right lung. Resident 7's vital signs were recorded. The summary indicated Resident 7 was transferred to the hospital by an ambulance.The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition. A Transfer to Hospital Summary dated 3/4/24 at 12:30 PM indicated Resident 7 was transferred to the hospital for shortness of breath. The summary indicated a full assessment was performed and the resident's lung sounds were diminished in all lobes. The resident was transferred to the hospital by an ambulance. The summary indicated the NP and the resident's sister were notified. The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All issues noted on audits will be addressed immediately. Audits will be reviewed in the monthly QAPI meeting. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 4/5/24. The facility respectfully requests a paper compliance review.	

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	2. Resident 8's record was reviewed on 3/14/24 at 11:52 AM. Diagnoses included bipolar disorder and hyperlipidemia. A progress note dated 11/8/23 at 8:49 PM indicated Resident 8 was found outside in another resident's motorized wheelchair. The motorized wheelchair was tipped over in the grass. Resident 8 denied pain or discomfort but requested transfer to the hospital due to not feeling right. Resident 8 indicated they did not remember why they were in the wheelchair or where they were going. Resident 8 was transferred to the hospital by an ambulance. A Transfer to Hospital Summary dated 11/10/23 at 9:32 PM indicated Resident 8 had been in another resident's room sitting in the other resident's wheelchair. The summary indicated Resident 8 would not get up. The summary indicated Resident 8 was showing psychiatric behaviors. The summary indicated Resident 8 was transferred to the hospital by an ambulance. The summary indicated an assessment was completed, but the summary lacked documentation of the assessment or the resident's condition In an interview on 3/14/24 at 1:45 PM the Assistant Director of Nursing (ADON) indicated hospital transfer information was documented in the resident progress notes. The ADON indicated they were unable to locate a specific hospital transfer form. The ADON indicated a full assessment, receiving hospital and family notification should be documented in the progress notes. A current facility policy dated 12/10/18 provided by the Executive Director (ED) indicated did not address hospital transfers. The policy indicated a Notice of Transfer required documentation of the			

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	reason for discharge or transfer, the effective date of the discharge and the location to which the resident is being discharged.			
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure relevant documentation pertaining to the release of the resident's remains, personal items and medications for 1 of 2 residents reviewed (Resident 7). Findings include: Resident 7's record was reviewed on 3/13/24 at 2:42 PM. Diagnoses included diabetes, heart failure, nicotine dependence and end stage kidney disease. Resident 7 was receiving dialysis treatments. A progress note dated 3/6/24 at 9:45 PM indicated Resident 7 was found seated on the commode unresponsive. The note indicated Resident 7 did not have a pulse, was not breathing and did not respond physically. The note indicated Resident 7's time of death was 8:05 PM. The note indicated Resident 7's sister was present at the time of death. The note indicated the Nurse Practitioner, hospice provider and funeral home were	R 0357	Prefix Tag # __R357 Clinical Records____ 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 7: Had no negative outcome related to finding. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who have passed away have the potential to be affected. Review of all other residents who have passed away in the past 90 days will be completed by 4/5/24 to ensure that proper monitoring is being completed and documented. No residents have experienced any negative effects.	04/05/2024

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	notified.Resident 7's progress notes did not indicate their remains had been released to the funeral home, their personal items had been released, and did not indicate their medications were released. A Provisional Notification of Death-Burial Transit Permit (document) indicated Resident 7's date and time of death was on 3/6/24 at 8:05 PM. The document did not indicate the time Resident 7's remains had been released to the funeral home. In an interview on 3/14/24 at 11:08 AM the Executive Director (ED) indicated Resident 7's family picked up the resident's belongings later. The ED indicated the facility did not document the release of personal belongings. In an interview on 3/14/24 at 1:10 PM the ED provided a Move In/Move Out Report which indicated Resident 7 had been discharged from medical services on 3/6/24. The ED indicated the discharge documentation could provide proof of the resident's personal items being released to the family. The ED indicated the facility did not require family signatures upon release of personal items. The ED indicated the resident did not have an inventory list. In an interview on 3/14/24 at 1:45 PM the Assistant Director of Nursing (ADON) indicated the release of resident remains should be documented in the progress notes. The ADON indicated death information was not documented in any other area of the resident's record that they were aware of. The ADON indicated the facility did not have an official death form. In an interview on 3/14/24 at 3:20 PM the ED provided a copy of a state regulation. The ED		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education was provided to nurses and QMAs on 3/22/24 – 3/26/24 regarding documenting the release of the resident's remains, personal items, and medications. QAPI plan has been initiated. DON/Designee will audit progress notes in regards to deaths weekly for 4 weeks and then monthly thereafter until 95% compliance met for 3 consecutive months. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All issues noted on audits will be addressed immediately. Audits will be reviewed in the monthly QAPI meeting. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 4/5/24. The facility respectfully requests a paper compliance review.	

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	indicated the state regulation did not specify the exact time and date of the release of resident remains or personal belongings was required. The ED indicated they had no further documentation related to the disposition of Resident 7's personal belongings or their remains. A current facility policy (undated) provided on 3/14/24 at 3:34 PM by the ED indicated the death of a resident would be handled appropriately and professionally by all staff. The policy staff were to follow instructions in the resident file for hospice clients. The policy indicated the staff were to call 911 for non-hospice residents.			