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	01/19/2024

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

(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 the Investigation of Complaints IN00422063 and IN00425471. Complaint IN00422063-No State deficiencies related to the allegations are cited. Complaint IN00425471-State deficiencies related to the allegations are cited at R64. Unrelated deficiencies are cited at R29, R53, R52 and R245. Survey dates: January 18 and 19, 2024 Facility number: 014137 Residential census: 115 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 30, 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 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: Tony Stewart, Executive Director Silver Birch of Kokomo.	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity during incontinence care and failed to ensure a resident's	R 0029	div="" Prefix Tag # R 029 **1 What corrective action(s)**	02/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tony	stewart	02/25/2024

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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	preference for how she wanted to be checked for incontinence was recognized for 1 of 3 residents reviewed for respect and dignity. (Resident G) Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 12/29/2023, indicated on 12/28/23 in the evening time, CNA 6 was providing incontinence care for Resident G. The CNA asked if she was dry, which the resident indicated "Yes," then CNA 6 put his hands down her brief and checked her private area. CNA 6 proceeded to check the resident after she had told the CNA she was dry. The clinical record for Resident G was reviewed on 1/18/24 at 3:22 p.m. The diagnoses included, but were not limited to, anxiety disorder, chronic congestive heart failure, type II diabetes mellitus, and insomnia. The resident had a service plan, dated 1/6/21, which indicated she was incontinent of her bladder. The resident had a service plan, dated 4/22/21, which indicated the resident had no memory loss. The resident had a service plan, dated 6/28/23, which indicated the resident required physical assistance from staff to change incontinence product as needed. A progress note, dated 12/29/23 at 12:07 p.m., indicated Resident G reported to the Executive Director (ED) and the Director of Nursing (DON) an employee touched her peri area inappropriately when checking for incontinence.		**will be accomplished for those residents found to have been affected by the deficient practice:** /p> **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:** The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. No other residents were identified of having potential to be affected in this review. **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;** Staff will be in-serviced **1-3-2024** on resident monitoring and response to adverse behavioral expressions. Resident conduct, as noted within the Resident Residency Agreement, will be reviewed at the Resident Council Meeting. At every resident council meeting resident's rights and abuse will be reviewed at every monthly meeting to identify any	

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	During an interview, on 1/18/24 at 12:45 p.m., the DON indicated a CNA should not place his or her hand in a resident's brief to check to see if the resident was wet. During an interview, on 1/18/24 at 3:32 p.m., Resident G indicated, on 12/28/23, she was not treated with respect and dignity and her preferences on how she wanted to be checked for incontinence was "violated." She indicated CNA 6 came into her room and after the CNA transferred her to the bed, CNA 6 asked if she was wet. She indicated to the CNA she was not wet, then the CNA proceeded to place his hand under the blanket, then inside her brief through the side of it, by her thigh. CNA 6 "actually" touched her private area with the CNAs fingers at the vaginal opening but did not penetrate her vagina. She felt "violated, worthless and dirty" after the incident was over. The resident was observed sitting in her apartment. She spoke with her head down and she would make eye contact on occasion. During a phone interview, on 1/19/24 at 3:15 p.m., CNA 6 indicated, on 12/28/23 at approximately 10:30 p.m., the CNA went into Resident G's apartment to check if she was dry. At that time, CNA 6 visually checked the bed pad and used his right index finger and thumb to pinch the brief up to see if she was wet. He also, visually checked the yellow line on the brief to verify she was dry. She was on her left side with her knees bent toward her chest when he checked her for incontinence.		concerns. Our Guardian program where staff is assigned to all residents will interview 5 residents on weekly basis with a questionary form concerning resident rights and abuse and forward to QAPI committee for review. **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:** The Director of Nursing & Wellness, Executive Director, and/or designee, will participate in a daily huddle with staff to determine if enhanced resident monitoring due to adverse behavioral expressions are necessary and/or to ensure staff timely, prompt response to any adverse behavioral expressions exhibited by residents; The interviews will be conducted with (5) residents and occur weekly for four weeks, biweekly for four weeks, then monthly for 6 months. Interviews will be reviewed at the Community's Monthly Quality Assurance (QA) Committee Meeting. The QA Committee will determine if continued interviews are necessary following this sequence.	

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			5 By what date the systemic changes will be completed: Systematic changes will be in effect by 2/12/2024. The facility respectfully requests a paper compliance review.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from physical abuse, related to another resident physically abusing him in the gazebo in front of three witnesses for 1 of 6 residents reviewed for abuse. (Residents C and D). The deficient practice resulted in Resident D being taken to the hospital for evaluation and treatment after the abusive incident occurred. He had a bruise to his head, chest and back. Findings include: A document, titled "Indiana State Department of Health Survey Report System," dated 12/1/23, indicated Resident C hit and knocked down Resident D, then Resident C "bumped" Resident D with his electrical wheelchair when he was on the ground. Resident D had a bruise to his head, chest and back. Resident C was discharged from the facility following the incident.	R 0052	Prefix Tag # R 052 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Following the reported incident, Community leadership took prompt, immediate action to ensure the safety of all Community residents and staff. . In consideration of the Community's response to the incident, Resident C has expressed that he feels safe and does not want to leave the Community. 2 How the facility will identify other residents having the	02/12/2024

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	1. The clinical record for Resident C was reviewed on 1/18/24 at 2:20 p.m. Diagnoses included, but were not limited to, generalized anxiety disorder, chronic obstructive pulmonary disease, hypertension, and chronic pain. The resident had a service plan, dated 1/7/22, which indicated he exhibited inappropriate behaviors such as taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patterns. The resident had a service plan, dated 11/8/22, which indicated he had a problem with his cognition. He demonstrated inappropriate judgement related to safety and displayed deficits in judgement. The resident had a service plan, dated 11/8/22, which indicated he had a problem with his mobility. He required reminders to use his assistive device if seen without it and he ambulated independently. A progress note, dated 11/10/23 at 9:37 p.m., indicated his Oxycontin ER (narcotic pain medication) 15 mg (milligrams) tablet was held due to the resident appeared intoxicated, smelled like alcohol, and slurred his words. A progress note, dated 11/12/23 at 5:02 p.m., indicated Resident C and another resident was arguing in his apartment. The other resident was asked to leave his apartment to deescalate the situation. A progress note, dated 12/1/23 at 7:19 p.m., indicated Resident C was in the gazebo and smelled of alcohol. Witnesses indicated this		potential to be affected by the same deficient practice and what corrective action will be taken: The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. No other residents were identified of having potential to be affected in this review. 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; Staff will be in-serviced on **1-3-2024** resident monitoring and response to adverse behavioral expressions. Resident conduct, as noted within the Resident Residency Agreement, will be reviewed at Resident Council Meeting. At every resident council meeting resident's rights and abuse will be reviewed at every monthly meeting to identify any concerns. Our Guardian program where staff is assigned to all residents will audit 5 residents on weekly basis with a questionary form concerning resident rights and abuse and forward to QAPI committee for review. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	resident pushed another resident down, was hitting on him, and running into him with his electric wheelchair. He was yelling in the hallway being uncooperative. He indicated to the police he did not hit the other resident, then in the next breath, he indicated "I would run him over with my chair." He and his son received emergency discharge paperwork and he left the community. A progress note, dated 12/1/23 at 7:51 p.m., indicated the resident was discharged from the facility and his medication was sent with him. 2. The clinical record for Resident D was reviewed on 1/18/24 at 2:45 p.m. The diagnoses included, but were not limited to, hypotension, type II diabetes mellitus, dementia, schizophrenia, psychosis, and major depressive disorder. The resident had a service plan, which addressed his cognition. He had mild to moderate disorientation or difficulty recalling and retaining information, so he required cueing. He received mental health services. A progress note, dated 12/1/23 at 6:59 p.m., indicated the Director of Nursing (DON) was notified by Resident V, that Resident D was in the gazebo on the ground and another resident was "beating on him." The DON went outside to the gazebo and found the resident on the ground on his left side. He was assisted up to a standing position, steadied, and given his walker. When asked what happened, Resident D indicated he got pushed down on the ground by another resident. Witness statements indicated Resident D was pushed to the ground, hit and Resident C ran into him with his electric wheelchair. He was sent to the Emergency room for evaluation and treatment.		i.e., what quality assurance program will be put into place: The Director of Nursing & Wellness, Executive Director, and/or designee, will participate in a daily huddle with staff to determine if enhanced resident monitoring due to adverse behavioral expressions are necessary and/or to ensure staff timely, prompt response to any adverse behavioral expressions exhibited by residents; The interviews will be conducted with (5) residents and occur weekly for four weeks, biweekly for four weeks, then monthly for 6 months. Interviews will be reviewed at the Community's Monthly Quality Assurance (QA) Committee Meeting. The QA Committee will determine if continued interviews are necessary following this sequence. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 2/12/2024. This Community respectfully requests a paper compliance review.	

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	During an interview, on 1/18/24 at 12:14 p.m., Resident D indicated, on 12/1/23 in the evening, he was in the gazebo outside sitting down when Resident C, who had been drinking alcohol came up to him "trying to pick a fight with me." Resident C kept telling him to hit him as he pointed to his jaw. Resident D indicated to Resident C he was not going to hit him. As Resident D was standing up to leave the gazebo, Resident C hit him in the upper body with his electric wheelchair. Resident D indicated he hit Resident C in the jaw with his fist, then he went back inside and told the front desk girl that Resident C hit him with his electric wheelchair, so he hit him back. He indicated Resident C "was always rowdy when he was drinking." Resident D was observed sitting in his apartment in a chair. He was observed to be of a small frame stature. During an interview, on 1/19/24 at 1:04 p.m., Resident V indicated, on 12/1/23 at approximately 5 p.m., Resident C was "drunk" when he was out in the gazebo. At that time, he was trying to pick a fight with all the men in the gazebo. When Resident D came out to the gazebo and sat down, Resident C started picking a fight with him. Resident D got up to leave the gazebo and Resident C knocked him down on the ground and "started ramming him with his electric wheelchair." Resident V indicated Resident D tried to pick fights when he was drunk or "high on his dope." Resident D did not do anything to Resident C during any of the time he was in the gazebo, not even hit him back. During an interview, on 1/19/24 at 1:22 p.m., Resident W indicated, on 12/1/23, he was not sure of the time, Resident D was outside sitting in the gazebo when Resident C was hitting Resident D in			

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	the head and kicking him. Resident C was "drunk." Resident D did not do anything to Resident C to bring the fight on. During an interview, on 1/19/24 at 1:30 p.m., Resident X indicated on 12/1/23 in the evening time, Resident C was "drunk really bad." Resident D was minding his own business when Resident C started yelling at him to hit him in his right cheek. Resident C began hitting Resident D while he was sitting up in a chair, then Resident D's seat turned over and he fell on the ground. When Resident D fell on the ground, Resident C got him blocked in with his electric wheelchair between the chair he was sitting on and the wall and he began kicking and hitting Resident D. Resident D was trying to cover his head, but Resident C kept hitting him in the head. He indicated a bunch of people from inside came out to the gazebo, then the fight was over. During an interview, on 1/19/24 at 2:45 p.m., the DON indicated, on 12/1/24 at approximately 5 p.m., she was approached by Resident V, who indicated Resident C was "beating on" Resident D in the gazebo. When she arrived at the gazebo, she found Resident D laying on the ground on his left side in the doorway of the gazebo. He had abrasions to his left back and left side of his head. Resident D indicated he was on the ground because Resident C pushed him onto the ground. Resident C was sitting in his electric wheelchair at that time, and he had been drinking alcohol. A current policy, titled "Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated 2/1/2020 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "Purpose: Each resident has the right to be free from abuse...Residents must not be subjected to abuse			

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	by anyone including but not limited to...other residents...Policy: Residents have the right to be free from physical abuse...Definitions: Abuse is the willful infliction of injury, unreasonable confinement, Intimidation or punishment with resulting physical harm, pain...Physical abuse includes hitting, slapping, pinching and kicking...Prevention ...The community identifies, corrects, and Intervenes in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. This includes Features of the physical environment that may make abuse...more likely to occur, such as secluded areas of the facility...The supervision of staff to identify inappropriate behaviors such as using derogatory language...."			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse by a staff member related to the resident being spoken to by the staff member in a derogatory and threatening manner for 1 of 6 residents reviewed for verbal abuse. (Resident E) Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 12/18/23, indicated CNA 4 was yelling obscenities at Resident E. The employee was terminated. The clinical record for Resident E was reviewed on 1/18/24 at 4:21 p.m. The diagnoses included, but were not limited to, hypothyroidism, depression, hypertension, and polyneuropathy.	R 0053	Prefix Tag # R 53 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Employee who was reported to verbally escalate was terminated. Resident E was assessed, and resident expressed felt safe in the Community and denied any other occurrences and/or concerns. Incident was noted to be isolated in nature. 2 How the facility will identify other residents having the potential to be affected by the	02/12/2024

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	A service plan, dated 7/13/23, addressed the problem the resident had to have staff administer her medications to her. A document, titled "Team Member Progressive Discipline Form," dated 12/20/23, indicated CNA 4 was terminated for misconduct. The incident occurred on 12/18/23 at approximately 5:30 a.m. The resident reported she approached Qualified Medication Aide (QMA) 7 and requested pain medication be given to her. CNA 4 interrupted the resident indicating QMA 7 was unable to give the resident her pain medication at that time, due to it was not time to be given. The resident requested QMA 7 speak to her directly, then CNA 4 raised her voice at the resident and was repeatedly yelling obscenities at her. She made the statement to the resident she was "lying trash." When the resident indicated she was calling the corporate office, CNA 4 indicated to the resident "F*** you." QMA 7 repeatedly attempted to calm CNA 4 down and have her step back into the office, but her attempts failed. QMA 7's witness statement collaborated with the resident's complaints. CNA 4's employment with the facility was terminated in light of her actions toward the resident due to misconduct. During an interview, on 1/19/24 at 12:44 p.m., Resident E indicated, on 12/18/23 at approximately 5 a.m., she was talking to QMA 7 regarding her pain and thyroid medication being taken together. CNA 4 indicated her doctor told her she could take it with food, and she was unable to get her pain medication at that time. She asked QMA 7 to come out of the breakroom, so she had some privacy with her to discuss her medications. QMA 7 came out of the breakroom into the hallway and was discussing her medication with her when CNA 4 came to the break room door and indicated		same deficient practice and what corrective action will be taken: The Community reviewed every current resident's record to determine which residents, if any, could be affected by the alleged deficient practice; no other residents were discovered with potential to be affected. The Executive Director/Designee in-serviced residents on Resident Rights and Abuse on @-9, 2-10, and 2-12-2024 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; All staff were re-educated, via an in-service, on 7/5/2023 and 8/1/2023 by the Executive Director and/or Director of Nursing & Wellness on Resident Rights and the Abuse Policy. New employees will be educated on Resident Rights and the Abuse Policy. The Executive Director, or designee, will review Resident Rights, Abuse Policy, and the importance of prompt reporting of concerns during the date Resident Council Meeting. Residents rights abuse will be reviewed at our monthly staff meetings for next 6 months and our Guardian program where staff is assigned to all residents will audit 5 residents on weekly basis with a questionary	

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	Resident E was "lying trash." Resident E indicated to CNA 4 she was being unprofessional, and she was contacting the corporate office, then CNA 4 indicated to the resident "F*** you, F*** you." CNA 4 started coming out of the break room while pulling both her pant legs up with both her hands as if "she was getting ready to start fighting." QMA 7 told CNA 4 to go back into the breakroom as the resident was going back to her room as QMA 7 instructed her to do. Resident E was observed in her apartment sitting in her electric wheelchair during the interview. During a phone interview, on 1/19/24 at 1:34 p.m., CNA 4 indicated, on 12/18/23 between 4 a.m. and 5 a.m., she was sitting in the breakroom with QMA 7. Resident E was outside the breakroom screaming she needed her pain medication because her daughter gave it to her at that time. QMA 7 attempted to explain to the resident she was unable to get her pain medication at that time and the reasons why, when the resident indicated "You n***** b****I was not talking to you." She continued to scream "You people, you people and you n***** b****." The resident continued to say, "hurtful and disrespecting things about my race," so she closed the breakroom door while asking the resident who she was referring to when she indicated "You people." At that time, Resident E continued to say hurtful and disrespecting things about her race. She indicated she got emotional with the resident at that time, and she would take whatever consequences came her way. During an interview, on 1/19/24 at 4:22 p.m., QMA 7 indicated Resident E came to the QMA office doorway on 12/18/23 between 5:20 p.m. and 5:30 p.m., requesting her pain pill. She indicated to the resident she was unable to give her the pain		form concerning resident rights and abuse and forward to QAPI committee for review. 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: Effective 2/12/2023, the ED or designee will interview 5 residents and interview 3 staff members weekly to ensure resident rights are upheld and residents are free from neglect. The interviews will be conducted with (5) residents and occur weekly for four weeks, biweekly for four weeks, then monthly for 6 months. Interviews will be reviewed at the Community's Monthly Quality Assurance (QA) Committee Meeting. The QA Committee will determine if continued interviews are necessary following this sequence. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by 2/12/2024. The facility respectfully requests a paper compliance review.	

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		A. BUILDING 00 B. WING	01/19/2024

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	medication due to it was not time yet. Then CNA 4 started interrupting QMA 7 and Resident E's conversation. CNA 4 indicated to the resident it was not time for her to receive her pain medication and she was placing QMA 7's job in jeopardy by asking for her pain medication early. She was also telling the resident about how her doctor ordered her thyroid medication. QMA 7 asked CNA 4 to stay in her place as a CNA. CNA 4 began to raise her voice and the resident asked QMA 7 to go out to the hallway, so she was able to talk to her privately. CNA 4 called the resident "lying trash and a b****." Then CNA 4 indicated to the resident "F*** you. F*** you." QMA 7 was talking with the resident outside the office in the hallway when CNA 4 came out of the office, while pulling up both her pant legs with her hands like she was "going to fight the resident." She instructed CNA 4 to get back into the office, then took Resident E to her room to talk with her. The only thing Resident E indicated was "you people and my meds." QMA 7 indicated she assumed Resident E was referring to the nurses and QMA's when she indicated "you people and my meds." Once QMA 7 explained to the resident why she was unable to receive her pain medication at the time she was asking, the resident was okay with her answer and was not arguing with her. A current policy, titled "Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated 2/1/2020 and provided by the Director of Nursing (DON) on 1/18/24 at 2:17 p.m., indicated "Purpose: Each resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone including but not limited to...facility staff...Policy: Residents have the right to be free from verbal abuse...Definitions...Verbal abuse includes the use of oral, written or gestured language that willfully			

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	includes disparaging, and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples Include threats of harm, saying things to frighten a resident...Prevention...The community identifies, corrects, and Intervenes in situations in which abuse...is more likely to occur...The supervision of staff to identify inappropriate behaviors such as using derogatory language...."			
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure residents were free from misappropriation of property related to their narcotic medications were not kept safe from a staff member who diverted the narcotic medications and the facility failed to follow their narcotic count policy and procedure for accounting for their residents' narcotics for 2 of 2 residents being reviewed for misappropriation of property. (Residents H and J) Findings include: A document, titled "Indiana State Department of Health Survey Report System," dated 1/4/24, indicated on 1/4/24 during the 6:00 a.m., narcotic count the staff discovered there was 15 Oxycodone tablets and three Norco tablets unaccounted for.	R 0064	Prefix Tag # R 64 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident H and J controlled medications were reviewed to ensure that there were no discrepancies between medications on hand and the Controlled Substance Count Forms. Resident H and J's respective primary care providers were notified. Resident H and J controlled medication(s) were replaced by the Community. Incident was noted to be isolated in nature.	02/12/2024

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	A statement typed by QMA 8, dated 1/4/24 at 10:47 a.m., was reviewed. QMA 8 indicated she counted the cart on 1/3/24, with QMA 3. QMA 3 counted the two and four cart narcotic box with QMA 8. She and QMA 3 did not count the one and three cart or the insulin cart narcotic boxes. On 1/4/24, she and QMA 9 counted the insulin narcotic box, when they discovered a card of 15 Oxycodone tablets missing. QMA 7 and the QMA 9 recounted the insulin cart narcotic box and discovered there were three 5 mg Hydrocodone tablets missing from a bottle. QMA 8 indicated the insulin cart narcotic box was used as an overflow narcotic box to place narcotics which were to be destroyed. A statement handwritten by LPN 5, dated 1/4/24, was reviewed. LPN 5 indicated she passed medications on the first floor. At one point, QMA 3 approached LPN 5 to ask her about two residents' medications, she and QMA 3 looked in the insulin cart narcotic box and they were unable to find the medications. QMA 3 indicated she did not think anyone counted the insulin cart narcotic box and those medications were there for someone to take. She indicated to LPN 5 to look at all the narcotics in the narcotic box. LPN 5 indicated to QMA 3 that yes, the narcotics were kept locked up and they were counted. She noticed Resident J's narcotic card in the drawer at that time. She remembered Resident J did her own medications, so the nursing staff kept her narcotic card until she needed it for the next time she ran out. She indicated Resident H had several narcotic medications in the insulin cart narcotic box as well. During an interview, on 1/18/24 at 12:45 p.m., the Director of Nursing (DON) indicated there was a discontinued narcotic card and three narcotic		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: The Community audited all residents' controlled substances to ensure that medications on hand were reconciled against Controlled Substance Count Forms and that there were no discrepancies discovered. 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; Community Qualified Medication Aides and Licensed Nurses were educated on the Controlled Substance Policy and the Medication Disposal Policy on **1-4-2024 and 1/15/2024** by the Director of Nursing & Wellness. The DONW, or designee, will monitor the Controlled Substance Count Forms routinely as described below. 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: The Director of Nursing & Wellness or designee will review the Medication Audit Report for	

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	tablets missing from the insulin cart narcotic box, on the morning of 1/4/24. The discontinued narcotics were being kept in the insulin cart narcotic box until the facility received more drug busters (a container which destroys medication by dissolving the medication). The overflow narcotics were also kept in the insulin cart narcotic box. The narcotic box was to be counted at the change of each shift just like the other two narcotic boxes were counted. The day shift nurse and LPN 5 counted the insulin narcotic box at the change of the afternoon shift on 1/3/24. LPN 5 remembered Resident J's narcotic card being in the narcotic box at the beginning of her shift. She worked passing medications to the residents on the first floor until 6 p.m. She had the narcotic keys for the insulin narcotic cart while she was on duty. The other staff members who were QMAs may have had to get overflow narcotics out of the insulin cart, but they would have gotten the keys off LPN 5. QMA 3 was left at the facility as the only person able to administer medications for two hours and she had possession of all the carts and narcotic keys. During a phone interview, on 1/18/24 at 3:07 p.m., QMA 3 indicated, on 01/04/24, she counted the narcotic boxes for the second and fourth floor carts when she came onto her shift, then when the QMA who was working on the third floor left at 6 p.m., she counted that narcotic box with her. She did not count the other narcotic boxes with the nurse working on the first floor, who also had the insulin cart because the nurse left without counting the carts. She left the cart keys on the table in the QMA room. She and LPN 5 pulled a Hydrocodone 5-325 mg tablet from the drawer for a resident who came back from the hospital because her family did not pick her pain medication up. When QMA 8 came into work on		the next (3) months to ensure medications are being administered as prescribed and are properly documented; the frequency of the audits are as follows: daily for (2) weeks, weekly for (4) weeks, and monthly for 6 months. Any opportunities will be addressed by the Director of Nursing & Wellness or designee. Findings from audit will be reviewed by the QA Committee to determine if compliance is met. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by2/12/2024. The facility respectfully requests a paper compliance review.	

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	1/3/24, for the midnight shift, she refused to count carts one and three and the insulin cart with her, so she "figured" if something was wrong with the count on those carts, then that QMA would be responsible for the problem, not her. QMA 3 indicated she did not take the missing narcotics from the insulin cart. During an interview, on 1/19/24 at 2:45 p.m., the Director of Nursing (DON) indicated if a medication was signed off on the Electronic Medication Record, that meant the person signing off administered the medication. QMA 3 was responsible for the second and fourth floors, on 01/03/24. A nurse and a QMA stayed over until 6:00 p.m., to assist her with the medication passes on the first and third floors. The narcotics in carts one and three, two and four and the insulin cart were only counted at the morning change over shifts, on 1/3/24 and 1/4/24. There was no evidence the medication carts were counted on the afternoon and night shifts for 1/3/24 and 1/4/24, according to the narcotic count log sheet. The DON indicated there were no signatures on the narcotic count log sheet except for the dayshift nursing staff on 1/3/24 and 1/4/24. The following records were reviewed: 1. Resident H's record was reviewed on 1/19/24 at 4:45 p.m. Diagnoses included, but were not limited to, major depressive disorder, chronic kidney disease stage III, dementia, fibromyalgia, and cerebral infarction. A document, titled "Narcotic Count Sheet," dated 12/7/23, indicated the resident had Hydrocodone-APAP (Acetaminophen) 5-325 mg (milligrams). The directions indicated to give the resident one tablet every six hours as needed.			

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	During an interview, on 1/19/24 at 2:45 p.m., the DON indicated Resident H's "Narcotic Count Sheet" indicated three tablets were missing from the insulin cart narcotic box, on 1/4/24, at the dayshift change of shift narcotic count. She had no idea what happened to those three missing tablets. 2. Resident J's record was reviewed on 1/19/24 at 4:54 p.m. Diagnoses included, but were not limited to, pain in the knee, unilateral primary osteoarthritis of the right knee, anxiety disorder, and hypertension. A document, titled "Narcotic Count Sheet," dated 10/6/23, indicated the resident had Oxycodone-APAP 5-325 mg tablets. The directions indicated to give the resident one tablet every six hours as needed for seven days. According to the Narcotic Count Sheet, the narcotic should have been discontinued on 10/14/23. During an interview, on 1/19/24 at 2:45 p.m., the DON indicated Resident J's Oxycodone-APAP entire narcotic card was missing from the insulin cart narcotic box, on 1/4/24, at the dayshift change of shift narcotic count. A current policy, titled "Narcotic Storage Policy," dated 8/11/18 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "Policy: All drugs in schedules 2 and 3 controlled substances are to be stored under DOUBLE lock, such as in Narc (Narcotic) box on a medication cart, or in a locked refrigerator in a locked medication room. All drugs in schedules 4 and 5 controlled substances are to be stored in the locked medication cart and under DOUBLE lock if ordered PRN (as needed) ...."			

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	A current policy, titled "Medication Disposal Policy," dated 8/11/18 and provided by the Executive Director (ED) on 1/18/24 at 2:34 p.m., indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedure: Disposal of outdated, discontinued, recalled medications shall occur no longer than several days after the discontinuation. Disposal of controlled medications is 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 Narcotic Count Sheet is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides. Some medications may be eligible for return to the dispensing pharmacy for credit...It is advised to return all bubble packs with more than three pills left to the supplying pharmacy. Medications in bottles should be destroyed on-site according to the above procedure." A current policy, titled "Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated 2/1/2020 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "Purpose: Each resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone including but not limited to...facility staff...Policy: Residents have the right to be free...misappropriation of property...Definitions: Misappropriation of resident property is the			

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	deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...Prevention...The community identifies, corrects, and Intervenes in situations in which...misappropriation of resident property is more likely to occur...The supervision of staff to identify inappropriate behaviors...." A current policy, titled "Medication Administration Program Policy," dated 3/24/21 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "Policy: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the state's administrative rules and regulations and orders from the physician. Procedure...Residents receiving medication assistance will have a. Medication stored in a manner prohibiting access by other residents. b. Documentation of the medication name, dose, time taken by resident. c. Documentation of refusals or inability to take medication according to the prescription...The community Executive Director and/or Director of Health and Wellness will ensure adequate professional oversight of the medication administration program. The elements of an approved medication administration system are as follows...Documentation in the medication record is complete and accurate a. Resident receives medications as prescribed. b Subscriber's orders for discontinued medications are maintained. c. Medication record is correctly noted with signatures and explanations for missed medications noted properly...6. Narcotics, outdated, or discontinued medications are accounted for and disposed of properly...." A current policy, titled "Controlled Substance			

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	Medication & (and) Verification During Shift Change Policy," dated 1/25/23 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "...Procedure: 1. At the change of shift, the oncoming and off-going staff person jointly verify controlled substance medications and the associated quantity of controlled medications or "count" that are securely stored in the designated double lock container, including discontinued or expired medications awaiting destruction. 2. The off-going staff person will read the individual Controlled Substance Count Form(s) while the oncoming person completes a verification of medication and quantity or "count" of the controlled medications. The "count" or quantity, of medication available is compared to the Controlled Substance Count Form during completion...3. Upon completion of the verification of medication and quantity or "count", the Controlled Substance Count Form is filled out including the date, time, quantity on hand along with the ongoing and off-going staff member signatures and the date/time of medication and quantity verification." This citation relates to Complaint IN00425889.			
R 0245 Bldg. 00	410 IAC 16.2-5-4(e)(5) Health Services - Offense (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure insulin (used to treat high blood sugars) was administered by licensed or certified personnel for 11 of 12 residents reviewed for injectable medications. (Residents K, L, N, O, P, Q, R, S, T, U and H) Findings include:	R 0245	Prefix Tag # R 245 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The following Residents names were given to the surveyor upon	02/12/2024

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	A document, titled "Indiana State Department of Health Survey Report System," dated 1/4/24, indicated on 1/5/24, Qualified Medication Aide (QMA) 3 was working at the facility through an agency company. She administered insulin to residents in the facility. When she was asked if she was insulin certified, she stated "Yes, I am insulin certified." The facility was unable to verify there was a Qualified Medication Aide (QMA) insulin certification on the Indiana State License Verification site. QMA 3 indicated she was going to provide her QMA insulin certification, but she was unable to. The following residents' records were reviewed at the date and time indicated, to check if their insulins were administered by QMA 3 or another staff member: 1. Resident K's record was reviewed on 1/19/24 at 2:02 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, major depressive disorder, and chronic atrial fibrillation. The Electronic Medication Administration Record (EMAR), dated 1/1/24 to 1/31/24, indicated he had an order written for Lantus Solostar Insulin 100 units (U)/milliliter (ml). Inject 50 units subcutaneous (sub-q) every evening at 5:00 p.m., for type II diabetes mellitus. QMA 3's initials were documented in the signature box on the EMAR for the date of 1/3/24 at 5:00 p.m., at the appropriate medication administration time. 2. Resident L's record was reviewed on 1/19/24 at 2:12 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, chronic atrial fibrillation, atherosclerotic heart disease, and osteoarthritis.		inquiry based on the self-reportable; K, L, N, O, P, Q, R, S, T, U and H; insulin records were reviewed to ensure that all medication is administered per provider orders by appropriate qualified team member (i.e. QMA, licensed nurse). No other medication was found to be administered improperly and no adverse health events were noted. The respective providers for the previously noted residents were notified; no additional orders received. This incident involved an agency/contract QMA who will not be returning to the Community and was isolated to the identified agency/contract QMA. 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: The Community audited all resident medication records to identify any potential residents who could be affected; no additional residents were discovered. 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; All QMAs and licensed nurses were in-service on Insulin Administration Policy on **1-11-2024**. All new QMA/LPNS	

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	The EMAR, dated 1/1/24 through 1/31/24, indicated he had an order written for Lantus Solostar Insulin 100 U/ml. Inject 20 units sub-q at bedtime at 8:00 p.m., for type 2 diabetes mellitus. QMA 3's initials were documented in the signature box on the EMAR for the date of 1/3/24 at 8:00 p.m., at the appropriate medication administration time. 3. Resident N's record was reviewed on 1/19/24 at 2:30 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus with diabetic retinopathy, hypertension, and pain. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to, the following medication orders: a. Lantus Solostar 100 U/ml. Inject 18 U at bedtime at 8:00 p.m., for type II diabetes mellitus with diabetic retinopathy. b. Insulin Lisp 100 U/ml Kwik pen. Inject sub-q per sliding scale (SS) three times daily at 7 a.m., 12 p.m. and 5 p.m. QMA 3's initials were documented in the signature box on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 4. Resident O's record was reviewed on 1/19/24 at 2:55 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus with diabetic polyneuropathy and diabetic peripheral angiopathy without gangrene, anxiety disorder, peripheral vascular disease, and pulmonary fibrosis. The EMAR, dated 1/1/24 through 1/31/24,		will continued to be educated on insulin administration during initial orientation. The DONW, Business Office Manager (BOM), or designee, will review credentials prior to shift for new employee(s) and/or contract staff and, thereafter, routinely. 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: Effective 2/12/2024, the DONW, BOM, or designee will conduct daily audits for the next (3) months to ensure medications are being administered as prescribed and are properly documented; the frequency of the audits are as follows: daily for (2) weeks, weekly for (4) weeks, and monthly for 6 months. Any opportunities will be addressed by the Director of Nursing & Wellness or designee. Findings from audit will be reviewed by the QA Committee to determine if compliance is met. 5. By what date the systemic changes will be completed: Systematic changes will be in effect by2/12/2024. The facility respectfully requests a paper compliance review.	

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		A. BUILDING 00 B. WING	01/19/2024

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	included, but were not limited to the following orders: a. Basaglar Kwik pen insulin 100 U/ml. Inject 65 units sub-q at bedtime at 8:00 p.m., for type II diabetes mellitus. b. Novolog FlexPen insulin 100 U/ml. Inject 5 units sub-q three times a day with meals at 8:00 a.m., 2 p.m. and 5 p.m., with carbohydrates (carbs) plus her blood sugar SS. If the meal has no carbs do not administer insulin. Use the blood sugar sliding scale if her blood sugar is high (above 150) for type II diabetes mellitus with hyperglycemia. c. Novolog FlexPen 100 U/ml. Inject per SS three times daily before meals at 8 a.m., 2 p.m. and 8 p.m. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 5. Resident P's record was reviewed on 1/19/24 at 3:37 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus with diabetic neuropathy, hypertension, pain, and polyneuropathy. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Humalog Kwik pen insulin 100 U/ml. Inject 18 units sub-q three times a day before meals at 8 a.m., 12 p.m. and 4 p.m. Hold if nothing by mouth ordered or blood glucose less than 110 for type II diabetes mellitus. b. Humalog Kwik pen insulin 100 U/ml. Inject per SS with meals at 8 a.m., 12 p.m. and 4 p.m.			

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	QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 6. Resident Q's record was reviewed on 1/19/24 at 3:45 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, chronic pain syndrome, hypertension, and congestive heart failure. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Lantus Solostar insulin 100 U/ml. Inject 20 units sub-q at bedtime at 8 p.m., related to diabetes mellitus. b. Novolog FlexPen insulin 100 U/ml. Inject per SS. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 7. Resident R's record was reviewed on 1/19/24 at 3:56 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, chronic pain syndrome, inflammatory polyarthropathy, and congestive heart failure. The EMAR, dated 1/1/24 through 1/31/24, indicated an order for Humalog Kwik pen insulin 100 U/ml. Inject per SS three times a day before meals sub-q at 8 a.m., 12 p.m. and 4 p.m. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times.			

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	8. Resident S's record was reviewed on 1/19/24 at 4:07 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, anxiety disorder, chronic pain, and hypertension. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Humalog Kwik pen insulin 100 U/ml. Inject three times a day per SS at 8 a.m., 2 p.m. and 8 p.m. b. Lantus Solostar insulin 100 U/ml. Inject 22 units sub-q at bedtime at 8 p.m. Hold for a blood sugar less than 110 related to diabetes mellitus. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 9. Resident T's record was reviewed on 1/19/24 at 4:16 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, chronic pain, anxiety disorder, major depressive disorder, and generalized edema. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Humalog Kwik pen insulin 100 U/ml. Inject 6 units sub-q twice a day with lunch and dinner at 12 p.m. and 4 p.m. Hold if resident was not allowed to have anything by mouth or if blood glucose is less than 110 related to type II diabetes mellitus. b. Humalog Kwik pen insulin 100 U/ml. Inject per SS twice a day at 12 p.m. and 4 p.m.			

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	c. Lantus Solostar 100 U/ml. Inject 26 units sub-q at bedtime at 8 p.m., related to diabetes mellitus. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 10. Resident U's record was reviewed on 1/19/24 at 4:38 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus with diabetic polyneuropathy, hypertension, and major depressive disorder. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Humalog Kwik pen insulin 100 U/ml. Inject per SS at bedtime at 8 p.m. b. Lantus Solostar 100 U/ml. Inject 26 units sub-q at bedtime at 8 p.m. related to type II diabetes mellitus. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. 11. Resident H's record was reviewed on 1/19/24 at 4:45 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, major depressive disorder, anxiety disorder, and epilepsy. The EMAR, dated 1/1/24 through 1/31/24, included, but were not limited to the following orders: a. Humalog Kwik pen insulin 100 U/ml. Inject 8 units sub-q three times daily before meals at 8			

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	a.m., 12 p.m. and 8 p.m., related to type II diabetes mellitus. b. Humalog Kwik pen insulin 100 U/ml. Inject per SS three times a day with meals at 8:00 a.m., 12 p.m. and 5 p.m. c. Lantus Solostar 100 U/ml. Inject 30 units sub-q twice daily at 8 a.m. and 8 p.m., related to type II diabetes mellitus with diabetic neuropathy. QMA 3's initials were documented in the signature boxes on the EMAR for the date of 1/3/24, at the appropriate medication administration times. During an interview, on 1/18/24 at 11:38 a.m., the Executive Director (ED) indicated QMA 3 gave insulin to residents on the evening shift of 1/3/24, without being certified. She was an employee of an agency company, not a facility employee. During an interview, on 1/18/24 at 12:45 p.m., QMA 3 indicated she administered insulin to residents, but she was unable to produce her QMA insulin certification. During an interview, on 1/19/24 at 2:45 p.m., the Director of Nursing (DON) indicated if a medication was signed off on the Electronic Medication Administration Record (EMAR), it meant the person signing off the medication administered the medication. QMA 3 was responsible for the second and fourth floors on the evening shift of 01/03/24. During an interview, on 1/19/24 at 5:10 p.m., the ED indicated he called the facility where QMA 3 supposedly took her QMA insulin certification course, and he was told she had not attended the			

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	QMA insulin certification course at that facility. A current policy, titled "Resident Policy: Medication Management Program," undated and provided by the DON on 1/18/24 at 2:17 p.m., indicated "Purpose: The purpose of this Policy is to share the Resident Medication Management Policy which includes services that are available to our Community residents as it relates to Medication Management...Medication Program & Service Offerings...2. Medication Administration Program: Our Community offers medication management services for all residents needing or requesting this support. A licensed nurse or qualified medication aide will administer medications, as ordered by the resident's provider, for residents who are receiving medication administration services...d. Insulin Administration: House Bill 1652, passed in 2019, allows (certified) qualified medication aides (QMA's) to administer insulin. According to Senator Busch, 'HB [House Bill] 652 allows registered nurses to delegate the task of injecting insulin. [...].' The leadership of your Community has carefully considered the utilization of Qualified Medication Aides for insulin administration as we believe this additional support allows staff to concentrate on the areas that best optimize your care. If you require insulin administration, a trained, certified qualified medication aide may be completing this administration...." A current policy, titled "Medication Administration Program Policy," dated 3/24/21 and provided by the DON on 1/18/24 at 2:17 p.m., indicated "POLICY: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance			

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	with the state's administrative rules and regulations and orders from the physician. PROCEDURE ...The community Executive Director and/or Director of Health and Wellness will ensure adequate professional oversight of the medication administration program. The elements of an approved medication administration system are as follows ...Written policies related to medication assistance and administration are followed by licensed nurses and Qualified Medication Aides (QMA's) within their scope of practice...5. Documentation in the medication record is complete and accurate ...c. Medication record is correctly noted, with signatures and explanations for missed medications noted properly, d. Medication is available to the resident in a correct and timely manner. 6. Narcotics, outdated, or discontinued medications are accounted for and disposed of properly...."			