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		A. BUILDING 00 B. WING	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455677. Complaint IN00455677 - State deficiencies related to the allegations are cited at R0048. Survey dates: May 15 and 16, 2025 Facility number: 014034 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 22, 2025.	R 0000		
R 0048 Bldg. 00	410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency Based on interview and record review, the facility failed to provide information to ensure a safe continuation of care to the accepting facility following a transfer for 1 of 3 residents reviewed for discharge. (Resident B) Finding includes: Resident B's clinical record was reviewed on 5/15/25 at 1:33 p.m. Diagnoses included multiple sclerosis and chronic pain syndrome. Progress notes dated 3/15/25 at 10:50 a.m. and 3/16/25 at 9:41 a.m. indicated the resident was sent to the Emergency Room (ER) for weakness and inability to bear weight. The record lacked	R 0048	**Prefix Tag # R048** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **The Executive Director/Administrator has completed a review of resident B medical records. The resident currently is not evicted/transferred from our location. Rather, she is temporarily in a rehab that has not improved her level of care which prevents her to return to**	06/14/2025

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

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	evidence of communication with Emergency Medical Services (EMS) or the ER. A hospital physician progress note, dated 3/16/25 at 9:51 a.m., indicated Resident B was admitted because the ER was unable to make contact with the facility and was unable to verify the reasoning for transfer. During an interview on 5/16/25 at 2:11 p.m., the DON indicated all documentation pertaining to transfer or discharge was located in the progress notes. Further information was not provided prior to facility exit on 5/16/25. A current facility policy obtained from the DON on 5/16/25 at 1:50 p.m., titled "Transfer and Discharge Policy", indicated the following: "...Before a transfer or discharge occurs, the Silver Birch Community shall: issue a notice to terminate services using State Form 49669 "Notice of Transfer"; accompanied by State Form 49831 "Notice of Transfer or Discharge Request for Hearing"; place a copy of these notices in the resident's clinical records; and provide copies of these notices to: 1. the resident; 2 A family member of the resident, if known; 3. The resident's legal representative...." This citation relates to complaint IN00455677.		**our Assisted Living, Residential Care, community due to level of care standards for residential care. However, clearer and more precise note entries of status is evident and is an area to improve for this identified resident.** **Identified are scenarios such as her and future temporary transfers like resident B's situation. These are transfers to a hospital then to a rehab with the intent to return to their home at the residential care community and declines or their acuity does not improve to AL regulatory or company policy level of care standards. Potentially these scenarios need an improved process here at Silver Birch of Muncie. The potential area of improvement would be to become more involved in continuity of care and planning for potential transfer due to care needs of the resident.** **The Executive Director/Administrator completed an in-service training on April 4, 2025, with the leadership team to discuss, educate and ensure proper continuity of care planning, documentation, notifications, scheduled meetings, and timelines are completed for current and future residents that are involuntarily and level**	

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			of care transfers. 1.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 Executive Director/Administrator, or designee, will complete an audit, to include 100% of residents the hospital or rehab to identify any residents who are potentially not able to return to the home community. If transfer is immanent or most likely, a care plan meeting as described in regulation R048's process of eviction/transfer should be scheduled. Following this audit, residents identified will be verified for completion of documentation, notifications, care plan scheduled meetings, and adherence to timelines required by State regulations and Silver Birch Living's Lease protocol. Any missing documentation will be completed as applicable.** **The involuntary transfer, discharge or eviction of residents in the future will have updated documentation and proper communication as notable changes of conditions occur. After the Executive**	

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			Director/Administrator's, or designee's, review the transfer documentation throughout the process and will send final documentation to the Regional Operations Manager for their approval prior to final discharge or evection. 1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. **The Executive Director/Administrator will educate the management on the following including but not limited to completion of proper protocol during transfer/discharges that will include scheduling of required meetings, proper communication and notifications to families, providers, and responsible parties, documentation of notifications as well as behaviors in the electronic medical record as well as a review of the applicable regulations within 410 IAC 16.2-5 by performing an in-service to all management that will be involved in transfers/discharges by June 18, 2025.** **Additionally, the Executive Director/Administrator, or**	

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			designee, will complete routine audit of evection documentation prior to planned transfers of residents to other care providers and ensure compliance as note within #4 on this Plan of Correction. 1.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 Executive Director/Administrator, or designee, shall complete a review of 100% of residents who are temporarily transferred to a hospital and then to rehabs for potential need for any involuntary transferred to ensure that proper protocol and regulations are followed including continuity of care. This review will continue monthly for six months. If 100% compliance is not met during the monthly review, the audit will begin again at the previously noted review sequence until there are six consecutive months of 100% compliance.** **Additionally, the Executive Director/Administrator or designee will verify communication for continuation of care with the**	

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			accepting facility that follows transfer/discharge from Silver Birch of Muncie. The verification and communication with the accepting care facility will be documented within the EMR. Executive Director/Administrator, or designee, will report to the Regional Operational Manager, Community's Quality Assurance & Performance Improvement Committee any evection and the and will provide through our operational leadership meetings of eviction updates and status of required protocols to the Quality Assurance Committee until the Committee they determine the process is proper and issue is resolved. 1.By what date the systemic changes will be completed: **Systematic changes will be in effect by June 20, 2025.** **The facility respectfully requests a paper compliance review.**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employees who had been	R 0120	Submission of this plan of	06/14/2025

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	employed for less than one year had six (6) hours of dementia training for 1 of 5 employees reviewed for dementia training. (HHA 4) Finding Includes: Employee record review, completed on 5/16/25 at 10:00 a.m., indicated HHA 4 had completed 30 minutes of dementia training. HHA 4's hire date was 10/18/24. During an interview on 5/16/25 at 10:30 a.m., the Human Resources Manager indicated she was not aware HHA 4 had not completed all the online training tools. Staff working with residents needed to have completed six hours of dementia training within six months of hire. A current facility policy, dated 11/19/19, titled, "Relias System Management", provided by the Human Resources Manager on 5/16/25 at 3:16 p.m., indicated the following: "Silver Birch Living has provided Relias as a training tool for the communities to ensure compliance with state regulations and as an opportunity to enhance skills in different areas." No additional policy was provided by the 4:30 p.m. exit on 5/16/25.		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 Joe Collins, Executive Director, Silver Birch of Muncie. Prefix Tag # R120 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Executive Director/Administrator and Human Resources Manager completed a review of the regulations cited in deficiency of R 120 that included personnel noncompliance of maintaining required training.	

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			Deficiencies were immediately corrected ensuring the individual would not perform service when not properly trained. In-services training sessions regarding regulatory training requirements and maintaining compliance timelines will be conducted with all staff starting May 29 – through June 14. 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 of being impacted by these cited deficiencies. The Executive Director/Administrator performed an in-service training session with the Human Resource Manager on proper protocol on June 05, 2025. The Human Resource Manager or designee will complete an in-service training May 29, 2025, through June 14, 2025, to provide all staff in-service training on all cited finding. The Executive Director/Administrator and or designee will hold staff accountable through coaching,	

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			performance documentation, and addressing issues as identified regarding. The Executive Director/Administrator, Human Resources Manager, or designee will complete a monthly audit of all staff state required courses due for completion and work with department managers and staff to meet training deadlines for compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Executive Director/Administrator will educate the management on the following including but not limited to maintaining the compliance for training requirements by use of proper protocol for training set forth in Silver Birch directives. Additionally, requirements will be reviewed of applicable regulations within 410 IAC 16.2-5 by June 14, 2025. Additionally, the Executive Director/Administrator, or designee, will complete routine audit of training modules to ensure compliance as note within #4 on this Plan of Correction. The Human Resources Manager	

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			and Department Manager will educate staff on completion of required trainings, company policy, and the expectations of compliance for training materials monthly during in-services. 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 Executive Director/Administrator, or designee, shall complete a review of 100% of employee training compliance. This review will continue monthly for six months. If 100% compliance is not met during the monthly review, the audit will begin again at the previously noted review sequence until there are six consecutive months of 100% compliance. Human Resource Manager, or designee, will report to the Community's Quality Assurance & Performance Improvement Committee any approaching/potential training noncompliance issues and will provide through our operational leadership meetings updates and status of required protocols to the Quality Assurance Committee until the Committee determines	

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			the process is proper and issue is resolved. The Human Resources Manager and Department Manager shall complete a review of 100% of staff needing state required trainings each month. Any findings of noncompliance with state required trainings will result in that staff member being removed from the schedule until requirements are met. Systematic changes will be in effect by June 14 The facility respectfully requests a paper compliance review.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to prepare foods under safe and sanitary conditions regarding cleaning kitchen equipment. This deficient practice had the potential to impact 105 of 108 residents who received meals prepared in the kitchen. Finding includes: During a kitchen observation on 5/15/25 at 10:22 a.m., the following concerns were identified: The deep fryer contained dark, opaque, brown oil	R 0273	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	06/14/2025

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	with unidentifiable black particles covering approximately 60 percent of the oil surface. A brown thick residue, approximately two inches in width, was just above the level of the oil on all sides. The left side of the deep fryer was covered with thick yellow and brown baked-on residue. The right side of the range contained thick yellow and brown baked-on residue. A thick, black, baked-on residue covered the right side of the grill, between the grill and the range. During an interview on 5/15/25 at 10:42 a.m., Cook 6 indicated the deep fryer oil was dark brown with floating debris. They had a porter (staff member assigned to additional cleaning duties) who cleaned the deep fryer, changed the oil, and removed the baked on residue on the sides of the oven, grill and deep fryer on a weekly basis. The porter was scheduled on Mondays and Thursdays at 8:00 a.m., but was not at the facility due to filling in for a dietary staff shortage. They last used the deep fryer the morning of 5/15/25. The cooks also had a weekly cleaning schedule. All cleaning tasks were required to be completed and documented on the cleaning log by the end of their shift when it was scheduled on their tour of duty. A review of the weekly cleaning schedule logs located in the kitchen, dated from 3/30/25 to 5/17/25, had multiple cleaning tasks that were left incomplete. During an interview on 5/15/25 at 10:53 a.m., the Dietary Manager indicated the facility had been short staffed for the last three weeks. She tried to fill in as porter in between her own duties since the porter was utilized in other dietary duties. The		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 Joe Collins, Executive Director, Silver Birch of Muncie. Prefix Tag # R273 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Executive Director/Administrator and Culinary Director completed a review of the conditions cited in deficiency of R 273 of cleanliness in the deep-frying area of the culinary kitchen and reviewed the checklist documentation that was cited for fully completed checklist. Deficiencies and cleaning routines were immediately corrected. In-service training will be conducted with the Culinary Director and the culinary staff to educate all individuals of the health implications caused by not following regulations and protocols. The Executive	

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	deep fryer contained dark brown oil and had not been cleaned with an oil change weekly as scheduled. Cleaning tasks should have been completed on the day of the week it was due by the end of their shift. The cooks cleaning schedule logs had not been completed each time the cleaning duties were scheduled. The brown, baked-on residue on the sides of the grill, stove, and deep fryer were not acceptable for kitchen cleanliness. The deep fryer was powered on to prepare lunch on 5/15/25 with black floating debris in the oil because it had not been skimmed since breakfast. Review of the "Porter Weekly Checklist" located in the kitchen and dated from 4/7/25 to 5/15/25 indicated the deep fryer was not cleaned on the following weeks: 4/14/25, 4/28/25, 5/5/25, and 5/12/25. The grill was not cleaned on the following weeks: 4/21/25, 4/28/25, 5/5/25, and 5/12/25. Review of the "Cook Weekly Cleaning Schedule" located in the kitchen and dated from 4/6/25 to 5/17/25 indicated the fryer sides were not degreased on the following weeks: 4/13/25, 4/27/25, 5/4/25, and 5/11/25. The range sides were not degreased on the following weeks: 4/6/25, 4/13/25, 4/20/25, 4/27/25, 5/4/25, and 5/11/25. A current facility policy, revised on 1/20/20 and titled "Dietary Cleaning," provided by the Dietary Manager on 5/15/25 at 11:34 a.m., indicated the following: "Policy: It is our intention to follow all local, state, and federal regulations regarding the cleaning procedure for the dietary department. Procedure: 1. All equipment, food contact surfaces... shall be cleaned: ... d. Whenever contamination may have occurred... 11. Documentation of cleaning must be maintained...."		Director/Administrator, Culinary Director, and/or designee will complete an audit, to include 100% of residents, to identify any residents who were noted as having gastro illnesses in the past two weeks to determine potential impact to the residents of the community. 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 of being impacted by these cited deficiencies. The Executive Director/Administrator performed an in-service training session with the Culinary Director on proper protocol on June 04, 2025. The Culinary Director will complete an in-service training May 29, 2025, through June 14, 2025, to provide all culinary staff one-on-one Inservice training on all cited finding. The Executive Director/Administrator and Culinary Director or designee will hold staff accountable through coaching, performance documentation, and addressing issues as identified regarding proper cleaning schedules, monitoring equipment, and reviewing checklists for all within the department.	

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			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. Culinary Director will develop a step-by-step instruction to cleaning the deep fryer. Once approved this will be posted by the deep fryer for reference. The Culinary Director will educate the culinary team on the following including but not limited to completion of all checklists as required by State regulations and Silver Birch protocol and educate all cooks on instruction for complete understanding of fryer cleaning process, timelines, documentation, and practices. The Executive Director/Administrator and Culinary Director will educate the management on the following including but not limited to proper protocol during observing and maintaining standards within the community including specifics of the cited deficiencies in R 273 and review applicable regulations within 410 IAC 16.2-5 by June 14, 2025. Additionally, the Executive Director/Administrator, or designee, will complete routine audit of cleaning and equipment monitoring protocols and ensure	

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			compliance as note within #4 on this Plan of Correction. 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 Culinary Director will follow up each week to verify the task was completed and will keep task completed records for 6 months. Culinary Director will inspect the deep fryer daily to verify the daily skimming for debris is being done, quality of oil and overall cleanliness of deep fryer. The culinary director will keep task completed records for 6 months. The Executive Director/Administrator, or designee, shall complete a review of 100% of monitoring and cleaning checklist to ensure that proper protocol and regulations are followed. This review will continue monthly for six months. If 100% compliance is not met during the monthly review, the audit will begin again at the previously noted review sequence until there are six consecutive months of 100% compliance. Executive Director/Administrator, or designee, will report to the Regional Operational Manager, Community's Quality Assurance & Performance Improvement Committee any evection and the	

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			and will provide through our operational leadership meetings of eviction updates and status of required protocols to the Quality Assurance Committee until the Committee they determine the process is proper and issue is resolved. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by June 14, 2025. The facility respectfully requests a paper compliance review.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to implement and maintain an infection control program that offered health information to residents regarding immunizations for 3 of 3 residents reviewed for immunizations. (Residents 84, 54, and 66) Finding includes: 1. Resident 84's clinical record was reviewed on 5/15/25 at 2:45 p.m. Diagnoses included congestive heart failure, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). The admission date was 4/17/25. The clinical record lacked historical information for Pneumococcal or COVID-19 vaccinations.	R 0407	Systematic changes will be in effect by June 14, 2025. The facility respectfully requests a paper compliance review. 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	06/14/2025

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	The clinical record lacked any education, offerings, consents, or refusals of the Pneumococcal vaccine or COVID-19 vaccines. A 4/9/25, "Physician's Plan of Care & Orders" form indicated to provide the resident with COVID-19 vaccination as recommended by state and/or Centers for Disease Control and Prevention (CDC) Guidelines and Pneumococcal vaccination as needed. 2. Resident 54's clinical record was reviewed 5/16/25 at 11:00 a.m. Diagnoses included heart failure, type 2 diabetes mellitus, and obesity. The clinical record lacked historical information for Pneumococcal or COVID-19 vaccinations. The clinical record lacked any education, offerings, consents, or refusals of the Pneumococcal vaccine or COVID-19 vaccines. A 5/16/23, "Physician's Plan of Care & Orders" form indicated to provide the resident with COVID-19 vaccination as recommended by state and/or CDC Guidelines and Pneumococcal vaccination as needed.3. Resident 66's clinical record was reviewed on 5/15/25 at 2:15 p.m. Diagnoses included Parkinson's disease, gout, and hypertension. Review of the resident's vaccinations included the following: The resident had historical administrations of Pneumococcal vaccines (unknown series) on 2/23/17 and 3/6/19, prior to admission to the facility.		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 Joe Collins, Executive Director, Silver Birch of Muncie. Prefix Tag # R407 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All Residents will be offered immunizations based on CDC guidelines and educated on benefits of timely immunization. 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: Director of Nursing and Wellness or designee will provide all new and existing residents CDC guidelines for immunizations and immunization table. Education of the benefits of immunizations will be provided to	

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	The clinical record lacked any education, offerings, consents, or refusals of the Pneumococcal vaccine or COVID-19 vaccine since admission on 3/2/23. During an interview, on 5/16/25 at 2:31 p.m., the DON indicated vaccinations were discussed verbally with new residents. The facility offered Influenza, Pneumococcal, Shingles, and COVID-19 vaccinations on admission. The residents who requested to receive vaccinations were provided a consent form to complete. The historical information for each resident was requested from the resident's physician, but was not always received. The DON indicated the facility offered the Influenza vaccination annually. The facility held an annual vaccination clinic and education materials would be posted in different locations throughout the building. There was a consent form provided to the residents who wished to receive the vaccination. The residents were able to request any other vaccination they wanted and the facility would assist them in receiving it. If a resident requested education on any vaccination she would provided them with information from the CDC website. During an interview on 5/16/25 at 3:20 p.m., the DON indicated residents had not been offered any Pneumococcal or COVID-19 vaccines since the last annual survey. During an interview, on 5/16/25 at 3:51 p.m., the Executive Director indicated the facility held a vaccination clinic in September 2024 and had placed multiple CDC vaccination information sheets throughout the facility. The CDC vaccination information included Pneumococcal, COVID-19, and respiratory syncytical virus (RSV). The education materials were available to all		residents. All new residents' providers will be contacted to request immunization records. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Upon move in of new resident, will receive a copy of CDC guidelines for immunizations from the Director of Nursing and Wellness or designee. Director of Nursing and Wellness or designee will document education in electronic med record. Education of residents on yearly influenza/Prenar clinic. Those residents that wish to obtain these vaccinations will fill out and sign vaccine consent those that decline vaccinations will sign a declination sheet and uploaded to EMRs. Covid vaccines will be discussed with residents and when new boosters come out residents will be educated about covid vaccine. The community will post signage about covid vaccines. Residents that wish to have covid vaccine will be scheduled with the PCP or transportation will be provided to an offsite location to obtain vaccination. The Executive Director/Administrator and Director	

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	residents. He indicated the facility had no specific vaccination policy. No additional policy was provided by the 4:30 p.m. exit on 5/16/25.		of Nursing and Wellness will also educate the management on immunization education and immunization offerings and review applicable regulations within 410 IAC 16.2-5 by June 14, 2025. Additionally, the Executive Director/Administrator, or designee, will complete routine audits EMR entries of new residents of education and offerings of immunization and ensure compliance as note within #4 on this Plan of Correction. 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 Executive Director/Administrator, or designee, shall complete a review of 100% of new residents. This review will continue monthly for six months. If 100% compliance is not met during the monthly review, the audit will begin again at the previously noted review sequence until there are six consecutive months of 100% compliance. Executive Director/Administrator, or designee, will report Community's Quality Assurance & Performance Improvement Committee any noncompliance to the education of immunization and offering of immunization events as well as provide the same	

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			information through our operational leadership meetings to our management team. The Quality Assurance Committee will determine the process is proper and issue is resolved. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by June 14, 2025. The facility respectfully requests a paper compliance review.	