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	07/17/2024

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 Complaints IN00430442 and IN00435565. Complaint IN00430442 - No deficiencies related to the allegations are cited. Complaint IN00435565 - No deficiencies related to the allegations are cited. Survey dates: July 16 and 17, 2024 Facility number: 014034 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 19, 2024.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joseph Collins	Administrator	08/05/2024

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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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 101 of 101 residents who resided in the facility. Finding includes: A review of the fire drills conducted from 7/1/23 to 7/17/24, indicated the drills were held on the following dates, times, and shifts: a. 9/2/23 at 8:00 p.m. - second shift b. 10/20/23 at 2:53 p.m.- first shift c. 1/12/24 at 12:00 p.m. - first shift d. 1/13/24 at 10:50 a.m. - first shift e. 2/29/24 at 1:05 p.m. - first shift f. 3/27/24 at 8:15 a.m. - first shift g. 5/29/24 at 3:30 p.m. - second shift h. 6/25/24 at 11:20 p.m. - third shift	R 0092	*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 Joe Collins, Executive Director, Silver Birch of Muncie.* Prefix Tag # 0092 1 What corrective action(s) will	08/06/2024

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	The facility lacked fire drills completed in July 2023, August 2023, November 2023, December 2023, and April 2024. From July 2023 to September 2023, only second shift received a fire drill. From October 2023 to December, only first shift received a fire drill. From January 2024 to March 2024, only first shift received fire drills. From April 2024 to June 2024, only second and third shifts received fire drills. During an interview on 7/17/24 at 10:25 a.m., the Environmental Services Manager indicated he was required to conduct fire drills every month and alternating shifts each month. All fire drills were documented in TELS (a tracking system for monitoring scheduled maintenance items). He had provided all of the fire drill documentation he could find and was unable to provide any fire drills for the months of July 2023, August 2023, November 2023, December 2023, and April 2024. In the absence of the Environmental Services Manager, the duties for fire drills should have been delegated to another staff member to ensure they were completed. He was told the fire drills were not completed because the facility lacked an Environmental Services Manager from June 2023 to August 2023 and November 2023 to December 2023. During an interview on 7/17/24 at 11:47 a.m., the Environmental Services Manager indicated the facility followed the Indiana State Department of Health guidelines for fire drills. During an interview on 7/17/24 at 5:40 p.m., the Administrator indicated fire drills were required to be completed monthly rotating shifts. He indicated the facility lacked an Environmental Services Manager for periods of time. He was unable to provide any further completed fire drills.		be accomplished for those residents found to have been affected by the deficient practice: The Executive Director has completed a review of Fire Drill Documentation on 08/01/2024 for fire drill documentation of the potential impact to all residents in our 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: The Executive Director, or designee, will complete an audit of all fire drills to identify the potential impact to all residents. Following, the audit, an additional fire drill/s will be conducted for shifts that did not receive the scheduled drills. An in-service will be performed with the responsible parties on proper rotation of the fire drills. 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. The Executive Director, or designee, will educate the Environmental Service Manager and other managers of the leadership team on the following including, but not limited to proper	

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	A current facility policy, revised 9/10/23, titled "8.06 Fire Safety, Evacuation Plan, Fire Drills," provided by the Environmental Services Manager on 7/17/24 at 1:38 p.m., indicated the following: "Policy: ...8. Fire/evacuation drills for staff and residents should be conducted on a regular schedule and at different times different shifts...."		schedule for conducting of fire drills, appropriate documentation of drills, filing of the documentation and review of applicable regulations within 410 IAC 16.2-5 by August 6, 2024. Additionally, the Executive Director, or designee, will complete routine audits of fire drill logs for drill completion and timeliness 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, or designee, shall complete a review of 100% of all future fire drills to ensure compliance to 410 IAC 16.2-5 and company policy of rotation of shifts and monthly; 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. The Executive Director, or designee, will report to the results of the audits to the Community's Quality Assurance & Performance Improvement Committee and the Regional Maintenance Director. Executive Director, or designee, will update the Quality Assurance	

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			Committee until the Committee determines the area is resolved. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by August 6, 2024. The facility respectfully requests a paper compliance review.	