STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 467228 and 467464. Intake 467228 - State deficiencies related to the allegations are cited at R0217. Intake 467464 - No deficiencies related to the allegations are cited. Survey dates: January 27 and 28, 2026 Facility number: 014034 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 30, 2026.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	*Submission of this plan of correction does not*	02/02/2026

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be		*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.* **Provider: 014034** **Intake 467228, 467464** **Completed January 28, 2026**	

	involved in identification and documentation of the services to be provided. Based on observation, interview, and record review, the facility failed to ensure service plans were developed and revised to mitigate falls for 3 of 3 residents reviewed for falls (Resident B, Resident D, and Resident E). Findings included: 1. Resident B's clinical record was reviewed on 1/27/26 at 9:54 a.m. Diagnoses included malignant neoplasm of liver, hydrocephalus, chronic pain, and age-related osteoporosis without current pathological fracture. Her Level of Service Assessment/Evaluation, dated 11/19/25, indicated she was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and she had a dementia diagnosis and/or significant memory loss combined with behaviors, such as wandering. Her progress notes indicated she had the following falls: On 12/12/25 at 12:24 p.m., she rolled out of bed. Her post fall, Morse Fall Risk		**Prefix Tag # R 217** **Plan of Correction for Tag R 217 – Administration and Management** **Regulation Cited:410 IAC 16.2-5-2(e)(1-5)** **Evaluation - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident B, D, and E will have their service plans evaluated by the Director of Nursing (DON) and reviewed by the Executive Director/Administrator (ED) to ensure steps were noted on interventions to mitigate risk of further falls if needed. •	

	Assessment, dated 12/12/25, indicated she was at a high risk for falling. On 12/18/25 at 7:18 a.m., the QMA found Resident B on the floor. Resident B indicated that she must have rolled out of bed. Her clinical record lacked a Morse Fall Risk Assessment for the 12/18/25 fall. On 1/27/26 at 12:01 p.m., she reported that she was sleeping, rolled out bed, got herself up, and back into bed. Her post fall, Morse Fall Risk Assessment, dated 1/27/26, indicated she was at a high risk for falling. Resident B's clinical record lacked interventions to mitigate falls in her service plan. 2. Resident D's clinical record was reviewed on 1/28/26 at 9:44 a.m. Diagnoses included pain in left ankle and joints of left foot, muscle weakness, and difficulty in walking.		The Executive Director/Administrator (ED) and Director of Nursing (DON) or designated person will verify updated service plans and notations are put in PCC incident follow up reports of the service plan review and interventions steps to mitigate risk of further falls. **2.How will the facility identify other residents who may have been affected by the same deficient practice?** • Director of Nursing (DON) or designated person will review residents that have fallen in the last 60 days to determine if service plans revisions are needed, Morse Fall Risk Assessment was completed, steps of mitigation of risk of falls noted and education to residents of prevention was completed.	

	His Level of Service Assessment/Evaluation, dated 9/24/25, indicated he was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and he had no memory impairment. His progress notes indicated he had the following falls: On 11/5/25 at 12:55 p.m., his brother witnessed the resident walking into the bathroom and tripped over his foot when turning to the toilet and fell into the wall. He sustained a skin tear to his right hand. His post fall, Morse Fall Risk Assessment, dated 11/5/25, indicated he was at a high risk for falling. On 12/27/25 at 7:21 a.m., he was transferring from his bed to his wheelchair, lost his balance, and fell to the floor. His post fall, Morse Fall Risk Assessment, dated 12/27/25, indicated he was at moderate risk of falling. On 12/31/25 at 9:08 p.m., he activated his call light and reported to nursing staff that he was getting his pajamas from the closet, lost his balance, and fell to the floor.		• Director of Nursing (DON) will report to Executive Director of findings and review for quality improvement. • Executive Director/Administrator (ED) will review incident report from the last 30 days to ensure service plans that needed updates, completed Morse Fall Risk Assessment, mitigation of risk of falls, and education to residents of prevention was completed and noted in incident reports. **3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • Reporting of falls, resident fall prevention education techniques, and fall risk communication requirements will be reviewed at	

	His post fall, Morse Fall Risk Assessment, dated 12/31/25, indicated he was at a high risk for falling. His fall service plan, revised on 3/13/24, indicated he had balance issues, poor safety awareness, and weakness. His intervention, dated 5/26/23, indicated to remind him to call for assistance. His fall service plan lacked updated interventions to mitigate risk of further falls. 3. Resident E's clinical record was reviewed on 1/28/26 at 11:05 a.m. Diagnoses included dementia in other diseases classified elsewhere, chronic pain, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her Level of Service Assessment/Evaluation, dated 9/19/25, indicated she was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and she had a dementia diagnosis and/or significant memory loss combined with behaviors, such as wandering. Her progress notes indicated he had the following falls: On 12/9/25 at 9:56 p.m., she		all clinical huddle meetings for two weeks starting February 16, 2026. • An in-service training regarding the reminder of Stop and Watch protocol, fall incident reporting policy and communication for falls will be administered in the full staff meeting in February. • Executive Director/Administrator (ED) and Director of Nursing (DON) or designated person will follow up within 24 hours of notification of falls to ensure service plans are updated as needed and incident reports completed after each fall. • Executive Director/Administrator (ED) and Director of Nursing (DON) or designated person verify that 72 hours of nursing checks are implemented, request a UA from the PCP and therapy orders as needed for residents with reoccurring falls and all residents that fall are educated on fall	

	slid out of her recliner and was sitting on the floor. Her post fall, Morse Fall Risk Assessment, dated 12/9/25, indicated she was at a high risk for falling. On 1/7/26 at 11:58 a.m., she reported that she was in her closet and lost her footing while turning around causing her to fall into a chair that was sitting near her closet. She sustained a laceration with swelling and bruising to her left inner thigh, bruising to her right breast and side, and bruising to both shoulders. She was educated on the importance of wearing proper footwear and her alert pendant. Her post fall, Morse Fall Risk Assessment, dated 1/7/26, indicated she was at a high risk for falling. On 1/18/26 at 8:10 p.m., she reported at 7:45 a.m. that she had a fall while she held a towel over her right eyebrow. She sustained a deep laceration to her right eyebrow and was sent to the emergency room. Her post fall, Morse Fall Risk Assessment, dated 1/18/26, indicated she was at a high risk of falling. On 1/25/26 at 7:09 p.m., she lost her balance and fell to her		prevention such as call light use, asking for assistance, proper footwear, correct mobility devices, • Director of Nursing (DON) will ensure implement 4-hour checks during waking hours for the first 24 hours and that the checks are noted in PCC. • Quality Assurance and Performance Improvement (QAPI) committee will review monthly for areas of quality improvement. • Executive Director/Administrator (ED) with the Quality Assurance team will add a formalized education program for residents after first fall and more in depth for individuals that are falling more often **4.How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?**	

knees in her apartment.

Her post fall, Morse Fall Risk Assessment, dated 1/25/26, indicated she was at a high risk of falling.

Her fall service plan, dated 7/1/24, indicated she had balance issues and weakness. Her interventions, dated 7/1/24, were call for assistance, proper footwear, ambulate with walker, and physical therapy.

Her fall service plan lacked updated interventions to mitigate risk of further falls.

During an interview, on 1/28/26 at 1:42 p.m., CNA 6 indicated resident fall interventions were probably located in the nurse's office.

During an interview, on 1/28/26 at 1:45 p.m., the DON indicated if a new fall intervention was needed, it would be located in the resident's service plan, and on the CNA tasks in the electronic health record. Falls were recorded on the nurse's board in the nursing office and reported in the shift change huddle.

During an interview, on 1/28/26 at 1:50 p.m., HHA 7 indicated she would find new fall interventions in the electronic health record, shift huddles and resident's names that needed

- The Executive Director/Administrator or designee will conduct weekly audits of all fall incident reports for documentation in PCC for document tracking for 90 days.
- The Quality Assurance and Performance Improvement (QAPI) committee will review audit results monthly and address staffing concerns and/or provide training as needed.

5.By what date will the systemic changes be completed?

- All corrective actions and systemic changes will be completed by February 20, 2026.

The facility respectfully requests a paper compliance review.

extra checks located on the board in the nursing office.

During an interview, on 1/28/26 at 3:11 p.m., CNA 8 indicated new fall interventions were discussed in the shift change huddle.

A current facility policy, titled "Fall Prevention & Management" dated 7/2024, and provided by the DON on 1/28/26 at 3:38 p.m., indicated the following: "...Policy...It is the responsibility of all Community employees to minimize the potential for resident fall events through early detection of risk, deployment of person-centered interventions, ongoing monitoring, and prompt action...b. Upon and Following Move In... iv...1. The resident's individualized service plan is reviewed and updated by the Community's licensed nurse, as needed and/or if needed biannually, post fall event, and/or with significant change in condition...d. Resident Fall Events...ii...8. Reviewing and updating the resident's individualized service plan, if needed...."

This citation relates to Intake 467228.

Based on observation, interview, and record review, the facility failed to ensure service plans were developed and

Tag R 217 – Administration and Management

Regulation Cited:410 IAC 16.2-5-2(e)(1-5)
Evaluation - Deficiency

revised to mitigate falls for 3 of 3 residents reviewed for falls (Resident B, Resident D, and Resident E).

Findings included:

1. Resident B's clinical record was reviewed on 1/27/26 at 9:54 a.m. Diagnoses included malignant neoplasm of liver, hydrocephalus, chronic pain, and age-related osteoporosis without current pathological fracture.

Her Level of Service Assessment/Evaluation, dated 11/19/25, indicated she was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and she had a dementia diagnosis and/or significant memory loss combined with behaviors, such as wandering.

Her progress notes indicated she had the following falls:

On 12/12/25 at 12:24 p.m., she rolled out of bed.

Her post fall, Morse Fall Risk Assessment, dated 12/12/25, indicated she was at a high risk for falling.

On 12/18/25 at 7:18 a.m., the QMA found Resident B on the floor. Resident B indicated that she must have rolled out of bed.

Her clinical record lacked a Morse Fall Risk Assessment for the 12/18/25 fall.

On 1/27/26 at 12:01 p.m., she reported that she was sleeping, rolled out bed, got herself up, and back into bed.

Her post fall, Morse Fall Risk Assessment, dated 1/27/26, indicated she was at a high risk for falling.

Resident B's clinical record lacked interventions to mitigate falls in her service plan.

2. Resident D's clinical record was reviewed on 1/28/26 at 9:44 a.m. Diagnoses included pain in left ankle and joints of left foot, muscle weakness, and difficulty in walking.

His Level of Service Assessment/Evaluation, dated 9/24/25, indicated he was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and he had no memory impairment.

His progress notes indicated he had the following falls:

On 11/5/25 at 12:55 p.m., his brother witnessed the resident walking into the bathroom and tripped over his foot when turning to the toilet and fell into the wall. He sustained a skin tear to his right hand.

His post fall, Morse Fall Risk Assessment, dated 11/5/25, indicated he was at a high risk for falling.

On 12/27/25 at 7:21 a.m., he was transferring from his bed to his wheelchair, lost his balance, and fell to the floor.

His post fall, Morse Fall Risk Assessment, dated 12/27/25, indicated he was at moderate risk of falling.

On 12/31/25 at 9:08 p.m., he activated his call light and reported to nursing staff that he was getting his pajamas from the closet, lost his balance, and fell to the floor.

His post fall, Morse Fall Risk Assessment, dated 12/31/25, indicated he was at a high risk for falling.

His fall service plan, revised on 3/13/24, indicated he had balance issues, poor safety awareness, and weakness. His intervention, dated 5/26/23, indicated to remind him to call for assistance.

His fall service plan lacked updated interventions to mitigate risk of further falls.

3. Resident E's clinical record was reviewed on 1/28/26 at 11:05 a.m. Diagnoses included dementia in other diseases classified elsewhere, chronic pain, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

Her Level of Service Assessment/Evaluation, dated 9/19/25, indicated she was disoriented to point of no longer able to function independently three or more days a week or part of everyday for a seven-day period, and she had a dementia diagnosis and/or significant memory loss combined with behaviors, such as wandering.

Her progress notes indicated he had the following falls:

On 12/9/25 at 9:56 p.m., she slid out of her recliner and was sitting on the floor.

Her post fall, Morse Fall Risk Assessment, dated 12/9/25, indicated she was at a high risk for falling.

On 1/7/26 at 11:58 a.m., she reported that she was in her closet and lost her footing while turning around causing her to fall into a chair that was sitting

near her closet. She sustained a laceration with swelling and bruising to her left inner thigh, bruising to her right breast and side, and bruising to both shoulders. She was educated on the importance of wearing proper footwear and her alert pendant.

Her post fall, Morse Fall Risk Assessment, dated 1/7/26, indicated she was at a high risk for falling.

On 1/18/26 at 8:10 p.m., she reported at 7:45 a.m. that she had a fall while she held a towel over her right eyebrow. She sustained a deep laceration to her right eyebrow and was sent to the emergency room.

Her post fall, Morse Fall Risk Assessment, dated 1/18/26, indicated she was at a high risk of falling.

On 1/25/26 at 7:09 p.m., she lost her balance and fell to her knees in her apartment.

Her post fall, Morse Fall Risk Assessment, dated 1/25/26, indicated she was at a high risk of falling.

Her fall service plan, dated 7/1/24, indicated she had balance issues and weakness. Her interventions, dated 7/1/24, were call for assistance, proper footwear, ambulate with walker,

and physical therapy.

Her fall service plan lacked updated interventions to mitigate risk of further falls.

During an interview, on 1/28/26 at 1:42 p.m., CNA 6 indicated resident fall interventions were probably located in the nurse's office.

During an interview, on 1/28/26 at 1:45 p.m., the DON indicated if a new fall intervention was needed, it would be located in the resident's service plan, and on the CNA tasks in the electronic health record. Falls were recorded on the nurse's board in the nursing office and reported in the shift change huddle.

During an interview, on 1/28/26 at 1:50 p.m., HHA 7 indicated she would find new fall interventions in the electronic health record, shift huddles and resident's names that needed extra checks located on the board in the nursing office.

During an interview, on 1/28/26 at 3:11 p.m., CNA 8 indicated new fall interventions were discussed in the shift change huddle.

A current facility policy, titled "Fall Prevention & Management" dated 7/2024, and provided by the DON on

	1/28/26 at 3:38 p.m., indicated the following: "...Policy...It is the responsibility of all Community employees to minimize the potential for resident fall events through early detection of risk, deployment of person-centered interventions, ongoing monitoring, and prompt action...b. Upon and Following Move In... iv...1. The resident's individualized service plan is reviewed and updated by the Community's licensed nurse, as needed and/or if needed biannually, post fall event, and/or with significant change in condition...d. Resident Fall Events...ii...8. Reviewing and updating the resident's individualized service plan, if needed...." This citation relates to Intake 467228.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJoe Collins	TITLEAdministrator	(X6) DATE02/12/2026