STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/31/2025

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 IN00465696 and IN00465582. Intake IN00465696 - No deficiencies related to the allegations are cited. Intake IN00465582 - State deficiencies related to the allegations are cited at R0090. Survey date: October 31, 2025 Facility number: 014034 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 12, 2025.	R 0000		
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6)	R 0090	*Submission of*	11/14/2025

	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate		*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 # R 090** **Plan of Correction for Tag R090 – Administration and Management**	

record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on record review and interview, the facility failed to ensure a complete and thorough investigation was conducted following an incident involving a resident who self-administered medications and required hospitalization. This deficient practice resulted in an incomplete investigation and failure to ensure adequate protection and oversight for all (42) residents who self-administered medications within the facility. (Resident C)

Findings included:

Resident C's clinical record was

Regulation Cited:410 IAC 16.2-5-1.3(g)(1-6)

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident C was on Leave of Absence at the hospital after the occurrence. The day the resident became stable at the hospital, the Executive Director/Administrator (ED) and Director of Nursing (DON) went to discuss the incident and the potential cause of the behavior leading to the emergency visit. She received emotional support and discussed the need to report any variances of her moods to clinical and/or management as well as concerns to the Administrator.

Investigation was performed by DON of incident and reported results to the ED within 24 hours of the incident, and the DON submitted

	reviewed on 10/31/25 at 11:34 a.m. Diagnoses included major depressive disorder, congestive heart failure, anxiety disorder, chronic pain syndrome, post traumatic stress disorder, rheumatoid arthritis, and borderline personality disorder. Current physician orders included clonazepam (anti-anxiety) 0.5 milligrams (mg) take one half tablet daily at 2:00 p.m. (prescription pending), pregabalin 75 mg give one capsule two times a day for rheumatoid arthritis, tofacitinib 5 mg two times a day for rheumatoid arthritis, oxycodone 10 mg one tablet every six hours as needed for pain, sertraline 100 mg one tablet one time a day for major depressive disorder, and trazodone 150 mg one half tablet at bedtime for insomnia. A Medication Self-Administration Safety Screen, performed on 6/3/25, indicated the resident was able to self-administer medications unsupervised. A Medication Self-Administration Safety Screen, performed on 9/3/25, indicated the resident was able to self-administer medications unsupervised. A progress note, dated 10/20/25 at 11:11 a.m., indicated Certified		an incident report to the State. The DON being part of the incident reported names of the staff members involved and what occurred to the ED. PCC notes were verified regarding the occurrence. Written statements of the incident were not requested due to the DON being directly involved therefore did not request written statements. It was determined the resident acted on her own and no other residents were impacted by Resident C's actions. **2.How will the facility identify other residents who may have been affected by the same deficient practice?** • The determination by the ED and DON that Resident C acted on her own and no other residents were impacted by Resident C's	

Nursing Assistant (CNA) 2 checked on Resident C because the resident had not used her call light that morning, which was unusual. When CNA 2 entered the resident's room, she found Resident C lying in bed, unresponsive. 911 was called, and vital signs were obtained.

Resident C's heart rate was within normal ranges, but her oxygen saturation was 44%. Normal oxygen saturation should be between 95% to 100%. Staff elevated the head of the bed and performed a sternal rub. Emergency Medical Services (EMS) arrived, placed oxygen on the resident, and transferred her to the hospital.

A progress note, dated 10/20/25 at 4:00 p.m., indicated 10/19/25 staff reported the resident was out of her room and seemed fine. On 10/20/25, staff found Resident C's medications for 10/20/25 and 10/21/25 were gone. The hospital was notified, and the medication list was reviewed by the hospital's case manager. No diagnoses were provided, and no toxicology screen had been performed at that time.

A progress note, dated 10/22/25 at 11:59 a.m., indicated the facility spoke with the hospital case manager who reported Resident C's ventilator settings were low and the plan was to

actions.

- State findings provided the insight that all self-administered residents needed assessed due to the isolated incident of Resident C. Forty-two self-administered residents reside in our community. All will be assessed for behaviors and capability to self-administer their medications.
- A full review of incident reports from the past 60 days will be conducted by the ED, DON or an assigned responsible party to identify any other residents who may have experienced lack of written documentation.

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

- All staff will receive mandatory in-service training

	wean her off the ventilator for neurological testing. A progress note, dated 10/29/25 at 6:18 p.m., indicated Resident C returned to the facility from the hospital. During an interview with the Director of Nursing (DON) on 10/31/25 at 12:11 p.m., she indicated CNA 2 found Resident C unresponsive and notified QMA 3. On her way to the resident's room, QMA 3 alerted the DON. The DON retrieved a bag valve mask (or Ambu-bag, used to assist in breathing). The resident was unresponsive but did have a pulse. QMA 3 called 911 after checking Resident C's pulse and oxygen saturation. On the day of the incident, the DON discovered Resident C had (apparently) taken two days' worth of medication. The DON notified EMS and locked the remaining medications in Resident C's cabinet. She had concerns about Resident C and could not be certain the resident would not try to harm herself again. All residents who self-administered medications were provided with a locked cabinet in their apartments. She had not evaluated or assessed other residents who self-administered medications to ensure they were safe and/or not at risk for drug overdose or who displayed suicidal ideations. No written statements		• on reporting practices for incidents and the need for formal written documentation when interviewing individuals involved. • The facility's incident reporting policy will be reviewed with all staff via in-service training. **4.How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?** • The Administrator or designee will conduct weekly audits of all incident reports for documentation in PCC, interviews performed, and written statements are uploaded into PCC for document tracking for 90 days. • The Quality Assurance and Performance Improvement (QAPI) committee will review audit results monthly and address staffing concerns	

	were obtained from staff involved in the incident. During an interview with QMA 3 on 10/31/25 at 12:45 p.m., she indicated CNA 2 called and reported Resident C was foaming at the mouth. QMA 3 went immediately to the resident's room, telling the DON she needed help in Resident C's room. QMA 3 found the resident in bed, unresponsive, with foam coming from the mouth. She checked Resident C's vitals and called 911 right away. The resident appeared to be having a seizure. QMA 3 tried a sternal rub and Resident C's eyes opened briefly. QMA 3 was not asked to provide a written statement regarding the incident. During an interview with CNA 2 on 10/31/25 at 12:54 p.m., she indicated Resident C had not used her call light at all on the day of the incident, which was unusual. CNA 2 went to the resident's room to check on her and found Resident C unresponsive and foaming from her mouth. The CNA raised the head of the bed and called QMA 3 for help. CNA was not asked to provide a written statement regarding the incident. A review of residents who self-administered medications, provided by the Administrator on 10/31/25 at 12:46 p.m.,		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 December 2, 2025. **The facility respectfully requests a paper compliance review.** **Tag R090 – Administration and Management** **Regulation Cited:410 IAC 16.2-5-1.3(g)(1-6)**	

indicated 42 residents self-administered their medications.

A facility document, titled "incident Reporting Policy", provided by the Administrator on 10/31/25 at 12:46 p.m., indicated the following: " ...What to report on the ISDH Incident Reporting System - 2. The Follow Up Report information should include the following - a. Results of the investigation. b. Interventions implemented, or corrective action taken. c. Method in which facility will continue to monitor efficacy of plan/interventions ...."

This citation relates to Intake IN00465582.

Based on record review and interview, the facility failed to ensure a complete and thorough investigation was conducted following an incident involving a resident who self-administered medications and required hospitalization. This deficient practice resulted in an incomplete investigation and failure to ensure adequate protection and oversight for all (42) residents who self-administered medications within the facility. (Resident C)

Findings included:

Resident C's clinical record was reviewed on 10/31/25 at 11:34 a.m. Diagnoses included major

depressive disorder, congestive heart failure, anxiety disorder, chronic pain syndrome, post traumatic stress disorder, rheumatoid arthritis, and borderline personality disorder.

Current physician orders included clonazepam (anti-anxiety) 0.5 milligrams (mg) take one half tablet daily at 2:00 p.m. (prescription pending), pregabalin 75 mg give one capsule two times a day for rheumatoid arthritis, tofacitinib 5 mg two times a day for rheumatoid arthritis, oxycodone 10 mg one tablet every six hours as needed for pain, sertraline 100 mg one tablet one time a day for major depressive disorder, and trazodone 150 mg one half tablet at bedtime for insomnia.

A Medication Self-Administration Safety Screen, performed on 6/3/25, indicated the resident was able to self-administer medications unsupervised.

A Medication Self-Administration Safety Screen, performed on 9/3/25, indicated the resident was able to self-administer medications unsupervised.

A progress note, dated 10/20/25 at 11:11 a.m., indicated Certified Nursing Assistant (CNA) 2 checked on Resident C because

	the resident had not used her call light that morning, which was unusual. When CNA 2 entered the resident's room, she found Resident C lying in bed, unresponsive. 911 was called, and vital signs were obtained. Resident C's heart rate was within normal ranges, but her oxygen saturation was 44%. Normal oxygen saturation should be between 95% to 100%. Staff elevated the head of the bed and performed a sternal rub. Emergency Medical Services (EMS) arrived, placed oxygen on the resident, and transferred her to the hospital. A progress note, dated 10/20/25 at 4:00 p.m., indicated 10/19/25 staff reported the resident was out of her room and seemed fine. On 10/20/25, staff found Resident C's medications for 10/20/25 and 10/21/25 were gone. The hospital was notified, and the medication list was reviewed by the hospital's case manager. No diagnoses were provided, and no toxicology screen had been performed at that time.			

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During an interview with the Director of Nursing (DON) on 10/31/25 at 12:11 p.m., she indicated CNA 2 found Resident C unresponsive and notified QMA 3. On her way to the resident's room, QMA 3 alerted the DON. The DON retrieved a bag valve mask (or Ambu-bag, used to assist in breathing). The resident was unresponsive but did have a pulse. QMA 3 called 911 after checking Resident C's pulse and oxygen saturation. On the day of the incident, the DON discovered Resident C had (apparently) taken two days' worth of medication. The DON notified EMS and locked the remaining medications in Resident C's cabinet. She had concerns about Resident C and could not be certain the resident would not try to harm herself again. All residents who self-administered medications were provided with a locked cabinet in their apartments. She had not evaluated or assessed

other residents who self-administered medications to ensure they were safe and/or not at risk for drug overdose or who displayed suicidal ideations. No written statements were obtained from staff involved in the incident.

During an interview with QMA 3 on 10/31/25 at 12:45 p.m., she indicated CNA 2 called and reported Resident C was foaming at the mouth. QMA 3 went immediately to the resident's room, telling the DON she needed help in Resident C's room. QMA 3 found the resident in bed, unresponsive, with foam coming from the mouth. She checked Resident C's vitals and called 911 right away. The resident appeared to be having a seizure. QMA 3 tried a sternal rub and Resident C's eyes opened briefly. QMA 3 was not asked to provide a written statement regarding the incident.

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	regarding the incident. A review of residents who self-administered medications, provided by the Administrator on 10/31/25 at 12:46 p.m., indicated 42 residents self-administered their medications. A facility document, titled "incident Reporting Policy", provided by the Administrator on 10/31/25 at 12:46 p.m., indicated the following: " ...What to report on the ISDH Incident Reporting System - 2. The Follow Up Report information should include the following - a. Results of the investigation. b. Interventions implemented, or corrective action taken. c. Method in which facility will continue to monitor efficacy of plan/interventions ...." This citation relates to Intake IN00465582.			

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) DATE11/24/2025