STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/27/2026

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 a State Residential Licensure Survey. Survey dates: May 26 and 27, 2026 Facility number: 014034 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 29, 2026.	R 0000		
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.	R 0042	*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*	06/02/2026

	Based on observation, record review, and interview, the facility failed to ensure the most recent State Survey results were readily available to residents and the public. Finding includes: During an observation, on 5/26/26 at 4:24 p.m., a State Survey results binder was setting on a table in the lounge near the main entrance door to the facility. A review of the binder's contents indicated the binder lacked annual survey results completed 5/16/25 and Intake investigation surveys completed 10/2/25, 12/24/25, 1/28/26 and 4/17/26. During an observation, on 5/27/26 at 1:22 p.m., the State Survey results binder near the main entrance door lacked survey results completed on the following dates: 5/16/25, 10/2/25, 12/24/25, 1/28/26, and 4/17/26.		*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.* **R 042** **410 IAC 16.2-5-1.2(P) Resident Rights-Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • All residents/visitors will have the right and access to annual survey results and intake investigations. The Executive Director/Administrator (ED) will review this. • The Executive Director/Administrator (ED) and Director of Nursing or designee will	

	During an interview, on 5/27/26 at 1:49 p.m., Receptionist 3, after reviewing the State Survey results binder, indicated the binder lacked survey results dated 5/16/25, 10/2/25, 12/24/25, 1/28/26, and 4/17/26. The State Survey results binder near the main entrance was the only place the survey results were accessible to residents and visitors. During an interview, on 5/27/26 at 1:55 p.m., the Administrator indicated he was unaware all survey results were required in the State Survey results binder. He typically printed the survey results and gave them to the receptionist to place in the binder. He did not verify the survey results were placed in the binder and accessible to residents and visitors for surveys dated 5/16/25, 10/2/25, 12/24/25, 1/28/26, and 4/17/26.		verify accuracy of current annual survey results/intake investigation to ensure all residents/visitors have access to the information. **2. How will the facility identify other residents who may have been affected by the same deficient practice?** • The Executive Director/Administrator (ED) will advise 100% of residents, that required Survey Binder information is up to date and accessible if they wish to read. • The Executive Director/Administrator (ED) will report to the Interdisciplinary team at weekly management meeting (L10) for review of quality improvement. • **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • • The Executive Director/Administrator or designee will monitor and document accordingly a weekly audit of survey binder to ensure all required	

			documentation remains current for viewing. • Executive Director/Administrator (ED) will report to the Quality Assurance and Performance Improvement (QAPI) committee monthly for areas of quality improvement. • The Executive Director/Administrator (ED) will report to the Interdisciplinary team at weekly management meeting (L10) for review of quality improvement and compliance. **4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?** • The Executive Director/Administrator , Director of Nursing or designee will review and document weekly once Survey Binder has been audited. • Quality Assurance and Performance Improvement (QAPI) committee will review State Survey Binder	

			monthly and address concerns and provide training as needed. **5. By what date will the systemic changes be completed?** • All corrective actions and systemic changes will be completed by June 25, 2026. •	
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure staff did not work with expired certification for 1 of 5 staff reviewed for employee records. (Home Health Aide [HHA] 4)	R 0118	• ***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***	06/02/2026

	Finding includes: Employee records were reviewed on 5/27/26 at 11:57 a.m. HHA 4's certification indicated it expired on 4/19/26. A facility schedule for 5/17/26 through 5/30/26, provided by the DON after entrance conference, indicated HHA 4 worked and provided resident care on 5/17/26, 5/18/26, 5/22/26, and 5/25/26. During an interview, on 5/27/26 at 3:05 p.m., the Administrator indicated he was unaware HHA 4's certification was expired. All employees without valid certification should not work until their credentials were up to date. A current facility policy, revised 8/28/18, titled "License or Credential Verification," provided by the Administrator on 5/27/26 at 3:58 p.m., indicated the following: " ...Silver Birch Living requires all staff that require licensing or certification to have current and unencumbered licensing or certification or other authorization to practice in the state(s) in which they work ...Each employee is responsible for renewing his/her certification/license to present to supervisor/department manager with a copy for his/her employee file. The supervisor must verify		***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.*****R 118** **410 IAC 16.2-5-1.4(c) Personnel – Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • All facility employee records will be audited by the Business Office Manager • Executive Director/Administrator (ED) will verify accuracy of audit and address needed updates immediately with the BOM Business Office Manager. **2. How will the facility identify other residents who may have been affected by the same deficient practice?**	

	the credentials are current before placing in file ...Employees with expired credentials will not be permitted to work in a credentialed role until new and valid credentials are in file or the employee has presented a written verification of renewal from the credentialing entity. Employees who fail to maintain valid license/certification as required by the position, will be placed on administrative leave for a period not to exceed 30 days and/or receive disciplinary action up to and including termination if valid licensure/certification cannot be produced within the 30-day timeframe."		• The Business Office Manager will review HHA #4 timesheet to determine which residents received care while the HHA #4 license was expired. • The Business Office manager will conduct and document review of clinical documentation for the period of time HHA #4 worked with an expired license to ensure no negative impact on resident care or safety. • The Executive Director/Administrator (ED) will review HHA #4 timesheet and care of residents during the time of expired license to ensure health; safety and no negative outcomes occurred. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • The Business Office Manager will review auditing system for all employee files for valid licensing and establish ongoing tracking for monitoring license expirations. • The Business Office	

			Manager will implement an alert within tracking system to identify upcoming license expiration/renewal. • The Business Office Manager will report to Executive Director/Administrator (ED) for review and weekly management meeting (L10) team on upcoming expiration/renewals. • The Business Office Manager will report to the Quality Assurance and Performance Improvement (QAPI) committee monthly for areas of quality improvement. **4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?** • The Executive Director/Administrator and Business Office Manager or designee will review and document weekly auditing of licensure within ongoing tracking. • The Executive Director/Administrator and Business Office	

			Manager will ensure alerts are accurate, functional, and documented accordingly. • The Executive Director/Administrator , Business Office Manager and weekly management team (L10) will verify accuracy of Business Office Mangers audits. • Quality Assurance and Performance Improvement (QAPI) committee will review licensure updates monthly and address concerns and provide training as needed. **5. By what date will the systemic changes be completed?** • All corrective actions and systemic changes will be completed by June 25, 2026.	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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:	R 0217	*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*	06/02/2026

	(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 involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to		*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.* **R 217** **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 112 will have their service plan evaluated by the Director of Nursing and reviewed by the Executive Director/Administrator (ED) to include a signature by the resident, or resident's	

	ensure service plans were signed by the resident or their representative for 1 of 7 residents reviewed for service plans. (Resident 112) Finding includes: Resident 112's clinical record was reviewed on 5/26/26 at 1:41 p.m. Medical diagnoses included pneumonia, nicotine dependence, and depression. An 11/9/25, Level of Care assessment indicated the resident was cognitively intact. The record lacked a service plan signed by the resident or resident representative. During an interview, on 5/27/26 at 11:05 a.m., the DON indicated there was not a signed service plan for Resident 112. On 5/27/26 at 3:05 p.m., the Administrator indicated all service plans should be signed by the resident or their representative. A current facility policy, revised 1/1/23, titled "Service/Care Plan", provided by the DON on 5/27/26 at 4:33 p.m. indicated the following: " ...2. The service/care plan and any revisions shall include a signature or other authentication by Silver Birch and by the resident, or resident's		representative, documenting agreement on the services to be provided. • The Executive Director/Administrator (ED) and Director of Nursing or designee will verify updated service plans including resident, or residents' representative signature. **2. How will the facility identify other residents who may have been affected by the same deficient practice?** • The Director of Nursing or Designee conducted a 100% audit of all current resident records. To identify any other residents who may have been affected by the same deficient practice of not having a signed service plan. • The Director of Nursing will report to Executive Director/Administrator (ED) findings and review for quality improvement. • Executive Director/ Administrator (ED) will review the audit of current resident service plans for 100% accuracy to include resident signatures with each service plan of	

	representative, documenting agreement on the services to be provided ...."		completion. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • The Director of Nursing will explicitly require that all resident service plans be signed and dated prior to implementation. • All staff will be in serviced at the next monthly meeting (June 2026) regarding the mandatory signature on all service plans. • Executive Director/Administrator (ED), Director of Nursing or designee will review service plans and confirm signatures after each designated service plan. • Quality Assurance and Performance Improvement (QAPI) committee will review monthly for areas of quality improvement.	

			4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? • The Executive Director/Administrator, Director of Nursing or designee will conduct weekly audits of all service plans for resident signatures for 90 days. • Quality Assurance and Performance Improvement (QAPI) committee will review signed service plans monthly and address concerns and provide training as needed. **5. By what date will the systemic changes be completed?** • All corrective actions and systemic changes will be completed by June 25, 2026.	
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3)	R 0299	*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*	06/02/2026

(3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy.

Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed and addressed by the medical provider for 1 of 7 residents reviewed for pharmacy reviews. (Resident 72)

Finding includes:

Resident 72's clinical record was reviewed on 5/27/26 at 10:41 a.m. Diagnoses included chronic kidney disease stage 3 and neuromuscular dysfunction of the bladder.

Current orders included oxybutynin chloride (overactive bladder) extended release 24 hour 5 milligrams (mg) tablet- give one tablet by mouth daily (5/8/26) and solifenacin (overactive bladder) 10 mg tablet - give one tablet by mouth daily (1/24/24).

A discontinued order included oxybutynin chloride 5 mg tablet - give one tablet by mouth daily (9/12/25). The order was discontinued on 5/8/26.

A 9/18/25, "Pharmacy Consultation Report," indicated

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.

R 299

410 IAC 16.2-5-6(c)(3) Pharmaceutical Services – Noncompliance

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

- Resident 72 will have their pharmaceutical services/ recommendations

	the resident had two prescriptions for urinary incontinence that may represent a duplication of therapy. The medications included: oxybutynin 5 mg - take one tablet by mouth once daily and solifenacin 10 mg - take one tablet by mouth once daily. Recommendation: Assess the patient's needs and verify if able to eliminate one of these drugs. The response was incomplete and lacked provider acknowledgement. The resident's clinical record lacked any responses by the medical provider to the 9/18/25 pharmacy recommendation. During an interview, on 5/27/26 at 4:48 p.m., the DON indicated she was uncertain why the clinical record lacked a response to the pharmacy recommendation on 9/18/25 because she was not employed with the facility during that time. All pharmacy recommendations should be acted upon with a response. A current facility policy, dated 4/11/18, titled " CONSULTANT PHARMACY SERVICES," provided by the DON on 5/27/26 at 4:32 p.m., indicated the following: "Policy: Pharmaceutical services are to be available for the purpose of providing residents with prescription and nonprescription		evaluated by the Director of Nursing and reviewed by the Executive Director/Administrator (ED) to include physician notification/signature and documented accordingly. • The Executive Director/Administrator (ED) and Director of Nursing or designee will verify residents receiving pharmacy recommendations quarterly that were faxed to the physician, signed and documented. **2. How will the facility identify other residents who may have been affected by the same deficient practice?** • The Director of Nursing or designee conducted a 100% audit of all current resident pharmacy recommendations on May 29, 2026. To identify any other residents who may have been affected by the same deficient practice. • The Director of Nursing will report to Executive Director/Administrator (ED) findings and review for quality improvement. • Executive Director/ Administrator (ED) will	

	drugs. A licensed pharmacist is to be retained as a Consultant to coordinate, supervise and review the community's pharmaceutical services... Procedure: ...2. At minimum, the Agreement requires the pharmacy provider to: ...g. Provide drug information and consultation to the community's staff regarding such drugs as may be ordered...."		review the audit of current resident pharmacy recommendations for 100% accuracy to include physician notification, signature, and recommendation. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • The Director of Nursing will monitor and document accordingly incoming pharmacy recommendations including but not limited to date, time, physician information and fax confirmation. • The Director of Nursing after receiving from pharmacy quarterly, will provide follow up to all pharmacy recommendations daily until a timely response has been received by the physician. • All staff will be in serviced at the next monthly meeting (June 2026) protocol of pharmacy recommendations, fax machine use and monitoring for physician reply.	

- Executive Director/Administrator (ED), Director of Nursing or designee will review pharmacy recommendations and communication with physicians to ensure physician response in a timely manner.
- Quality Assurance and Performance Improvement (QAPI) committee will review monthly for areas of quality improvement.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?

- The Executive Director/Administrator, Director of Nursing or designee will conduct weekly audits of all service plans for resident signatures for 90 days and quarterly thereafter.
- Quality Assurance and Performance Improvement (QAPI) committee will review pharmacy recommendations monthly and address concerns and provide training as needed.

5. By what date will the

			systemic changes be completed? • All corrective actions and systemic changes will be completed by June 25, 2026.	

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) DATE06/11/2026