

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/01/2026
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 408 S WASHINGTON STREET, KOKOMO, , 46901			
(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. This visit included the Investigation of Intakes 471561 and 471566. Intake 471561 - No deficiencies related to the allegations are cited. Intake 471566 - State deficiencies related to the allegations are cited at R52. Survey dates: August 31 and September 1, 2026 Facility number: 014137 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 8, 2026.	R 0000	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 correction for this survey. Please find 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 Tony Stewart, Executive Director, Silver Birch of Kokomo.		

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R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure residents were provided with an environment which promoted their quality of life for 2 of 2 residents reviewed for respect and dignity. (Resident B and C) Findings include: During an interview, on 9/1/26 at 10:12 a.m., Resident B indicated Dietary Aide 3 was disrespectful and rude during a meal and had told anyone who talked to "shut up". During an interview, on 9/1/25 at 10:20 a.m., Resident C indicated Dietary Aide 3 was disrespectful in the dining room, had repetitively stated "I'm over this" and would not acknowledge residents when something was requested. A facility written statement, dated 7/28/26, Resident B indicated Dietary Aide 3 told several residents to shut up. A facility written statement, dated 7/28/26, Resident C	R 0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents B and C were assessed and experienced no adverse effects related to the occurrence. Their needs and rights will continue to be monitored by facility staff. How will you 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 to be affected by the deficient practice. The dietary aide involved will be counseled and educated regarding residents' rights, dignity and respect, respectful communication, customer service expectations, and appropriate conduct during meal service. The employee will be expected to demonstrate appropriate and respectful interactions with residents at all times. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All dietary staff will be educated regarding residents' rights,	09/10/2026
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indicated Dietary Aide 3 had not acknowledged Resident C's request after 3-4 times and had kept saying "I'm so over this place, I'm so over this place". A facility typed statement, dated 8/3/26, indicated Dietary Aide 3 was in the dining room cleaning and verbally expressed frustrations out loud in front of residents. A facility written statement, undated, Dietary Aide 3 indicated she was in the dining room cleaning and verbally venting out loud and repetitively said shut up, shut up. A notice of leave, dated 7/29/26, indicated Dietary Aide 3 had been placed on administrative leave pending an investigation. A job description, signed by Dietary Aide 3 on 3/4/26, indicated "...The Server ensures a pleasant and comfortable dining experience for all residents and visitors through quality customer service to address questions and concerns...Greets residents and guests, presents the menu, makes suggestions and answers questions...Strong customer service...." A facility statement of residents' rights received from the Executive Director on 9/1/26 at 10:32 a.m., indicated "...Each	dignity and respect, respectful communication, customer service expectations, and appropriate behavior and conduct during meal service. Staff will be reminded that all residents are to be treated with consideration, courtesy, respect, and recognition of their individual preferences and dignity. Education will be incorporated into ongoing staff training and reinforced as needed based on observations, concerns, or identified trends. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Dietary Manager/designee will conduct weekly random observations of meal service for four (4) weeks to monitor dietary staff interactions with residents and ensure respectful communication, appropriate conduct, and compliance with residents' rights and dignity. Following the initial four (4) weeks, monitoring will be completed monthly for three (3) months. Any concerns identified during the monitoring process will be addressed immediately, with	
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	Resident shall have the right to...Be treated at all times with consideration, respect and recognition of their dignity and individuality...."		additional education and/or counseling provided as indicated. The results of the audits will be reviewed, reported, and trended for compliance through the facility communities QAPI Committee for a minimum of six (6) months. Continued monitoring or additional corrective action will be implemented if compliance is not sustained. Responsible Person: Dietary Manager / Executive Director / Designee Completion Date: 9/20/2026	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from	R 0052	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The resident was assessed and received appropriate follow-up care related to the identified wound. The resident's condition and wound status will continue to be monitored by nursing staff, with treatment and follow-up provided as indicated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be	09/10/2026

neglect, when a resident with chronic wounds had a new wound observed by clinical staff which was not immediately reported or assessed by a licensed nurse for 1 of 3 residents reviewed for neglect. (Resident B) This deficient practice resulted in Resident B obtaining an infection in the wound and required hospital treatment. Findings include: During an interview, on 8/31/26 at 1:53 p.m., Qualified Medication Aide (QMA) 2 indicated Resident B came to her with a bloody right foot. She was unsure what day. She indicated she cleaned up his foot and wrapped it with gauze. It had stopped bleeding and she was unsure how he hurt his foot. She did not document the incident in the clinical record. During an interview, on 8/31/26 at 2:02 p.m., the Director of Nursing (DON) indicated she was not aware of an injury to Resident B's right foot until 8/13/26. The incident was said to occur on the bus, on 8/7/26, although Resident B told several varying stories on how the injury happened. The facility did not address wounds or dressing changes for anything which required more than a Band-Aid. Staff were not equipped to	taken? All residents have the potential to be affected by the deficient practice. A review will be completed to identify residents with new wounds, injuries, bleeding, or other changes in condition to ensure that appropriate notification, assessment, intervention, and documentation were completed. Any concerns identified during the review will be addressed immediately, and appropriate follow-up care and additional education will be provided as indicated. All clinical and QMA staff will be re-educated on the Change in Condition policy, including the requirement to immediately report new wounds, bleeding, injuries, and other changes in condition to the licensed nurse/on-call nurse and document the event in the clinical record. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	
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perform those duties. The facility Nurse Practitioner (NP) had been seeing Resident B and changing the dressings on his feet. The Nurse Practitioner saw Resident B every Monday and Wednesday. Resident B took himself to the hospital, on 8/18/26, for pain in his foot.

The clinical record for Resident B was reviewed on 8/31/26 at 10:45 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral vascular disease, congestive heart failure, diabetes, and diabetic foot ulcer.

There was no documentation in the clinical record about a new wound to Resident B's foot, the incident which caused the injury, or a licensed staff member or the facility nurse practitioner had been notified of the new wound when it occurred and the QMA wrapped it in gauze.

A Nurse Practitioner (NP) visit note, dated 8/10/26 at 2:00 p.m., indicated Resident B had a deep laceration at the base of the right 3rd toe on the bottom extending almost all the way around the toe. The resident reported his toe was run over by another resident's electric wheelchair on the bus last week. The NP removed the

All clinical and QMA staff will receive education regarding the Change in Condition policy and the facility's expectations for timely recognition and reporting of changes in resident condition.

Education will emphasize the immediate reporting of new wounds, injuries, bleeding, and other changes in condition to the licensed nurse/on-call nurse, as well as timely nursing assessment, appropriate interventions, notification of the physician/responsible party when indicated, and complete documentation in the clinical record.

Staff will be reminded that changes in condition must be reported promptly to ensure residents receive timely assessment and appropriate care.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

dressing, and the foot had a strong bacterial odor. The wound was cleansed with mild soap and water, iodine was applied liberally to the toes and laceration, and the foot was dressed with a Silversorb pad (antimicrobial wound dressing), gauze, kerlix and an ACE bandage. The NP would reassess the wound in 2 days on his visit.

An NP visit note, dated 8/12/26 at 3:30 p.m., indicated Resident B reported the laceration of the 3rd and 4th toes on the right foot extended down to the bone where the toes meet the sole of the foot. The wound hurt with treatment, but the pain was mild to moderate. The NP performed wound care to the laceration. The toes were cleansed with wound cleanser, dry skin was scrubbed with rolled gauze, iodine was applied to the laceration, a thin layer of bacitracin (first aid antibiotic) ointment was applied, and the toes were wrapped with kerlix gauze and an ACE wrap. His next follow-up would be in 7 days.

A podiatry physician visit note, dated 8/13/26 at 2:30 p.m., indicated Resident B had a new wound on his right foot. The patient indicated the facility looked at it and wrapped it, but he had not received any

The DON/designee will audit new wounds, injuries, and change-in-condition documentation weekly for four (4) weeks to verify timely notification, nursing assessment, appropriate follow-up, and complete documentation.

Following the initial four (4) weeks, the DON/designee will conduct monthly audits for three (3) months.

Any identified deficiency will be corrected immediately, and additional education and/or counseling will be provided as indicated.

The results of the audits will be reviewed, reported, and trended for compliance through the communities QAPI Committee for a minimum of six (6) months. Continued monitoring or additional corrective action will be implemented if compliance is not sustained.

Responsible Person: Director of Nursing / Designee

Completion Date: 9/20/2026

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antibiotics and the foot was painful. The skin assessment for the right foot indicated varied pigmentation, laceration wound across the bottom of toes 3 to 5, redness, swelling, and drainage was noted. Diagnoses included, but were not limited to, laceration of the right foot and cellulitis (skin infection) of right foot. Clindamycin (an antibiotic) was prescribed at 300 milligrams (mg), three times a day, for 10 days for cellulitis.

A nursing progress note, dated 8/13/26 at 5:00 p.m., indicated Resident B went to the Director of Nursing (DON) office to drop off paperwork from his podiatrist appointment. He told the DON he had an infection in the cut on the bottom of his right foot, and the doctor prescribed an antibiotic which needed to be started as soon as possible. The DON asked him how and when he got the wound on the bottom of his foot and he indicated it happened while on an outing a week ago. His foot got stuck between his wheelchair and another resident's wheelchair while trying to exit the bus. Resident B indicated someone put a band-aid on it but he was not sure who.

A progress note, dated 8/18/26 at 12:21 p.m., indicated Resident B was admitted to the hospital for pain and possible

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	right toe amputation. A hospital physician history and physical note, dated 8/20/26 at 2:08 a.m., indicated Resident B went to the emergency room (ER) because he was concerned when he took his dressing off his right foot, his 5th toe was blue and dusky. The resident was started on intravenous (IV) antibiotics in the ER and imaging was completed. The results were consistent with cellulitis and tissue swelling of the right foot. There was no clear evidence of osteomyelitis (infection in the bone). However, the results did show peripheral artery disease (decreased blood flow to the legs) with a blockage on the right leg causing ischemia (tissue death from not enough blood flow) to the 5th toe. Due to these results, a specialist was called and the resident was transferred to another hospital for a higher level of care to receive a procedure in which they attempt to reopen the artery and improve blood flow to the foot/toe. During an interview, on 8/31/26 at 1:26 p.m., the hospital social worker indicated Resident B said he was involved in an incident on the facility bus where his foot was stuck between 2 wheelchairs. Resident B indicated his foot did			
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not get proper care at the facility.

During an interview, on 8/31/26 at 2:22 p.m., the facility NP indicated he was monitoring Resident B's foot wounds. He had a chronic diabetic ulcer on his left foot he was treating 2 times a week. He had also observed the new wound on his right foot. It was a laceration located under the 2nd and 3rd toe with approximated edges. He indicated he cleaned it well, applied bacitracin, and wrapped it.

During an interview, on 9/1/26 at 11:45 a.m., QMA 4 indicated if a resident had a new bleeding wound, staff should apply pressure to stop the bleeding and notify the nurse to assess the resident.

During an interview, on 9/1/26 at 12:21 p.m., QMA 2 indicated if a resident had an open bleeding wound, staff would apply pressure, then notify the on-call nurse, which was normally the DON. Staff were supposed to document any occurrence in the progress notes in the clinical record and inform the DON. Staff were not equipped to take care of a bleeding open wound and should send residents out to the emergency room if a nurse was not available.

A facility job description, titled

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	"Qualified Medication Assistant (QMA)", dated 12/30/24 and signed by QMA 2, indicated "...reports all unusual or unexpected resident conditions or expressions to supervisor...reports on the condition of residents to the Wellness Team and documents in the electronic health record the assistance provided to residents...." A current facility policy, titled "Change in Condition", dated 12/2025 and received from the DON on 9/1/26 at 1:36 p.m., indicated "...all community employees are responsible for promptly reporting any suspected change in condition to the community licensed nurse and/or the community licensed nurse on call for further review and evaluation...." This citation relates to Intake 471566.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on interview and record	R 0273	R 273 - Food and Nutritional Services / Meal Temperature Logs Finding: The facility failed to maintain complete meal temperature logs. What corrective action(s) will be accomplished for those residents found to have been	09/10/2026

review, the facility failed to ensure meal temperature logs were maintained and kept up to date for 1 of 1 kitchen reviewed for meal temperature logs. This deficient practice had the potential to affect 103 of 103 residents who received food from the kitchen.

Findings include:

During a record review, on 8/31/26 at 10:10 a.m., the meal service temperature log had missing documentation for temperatures for the following months:

1. March 2026 had missing food temperatures for 3 out of 93 meals
2. April 2026 had missing food temperatures for 3 out of 90 meals.
4. May 2026 had missing food temperatures for 8 out of 93 meals
5. June 2026 had missing food temperatures for 6 out of 90 meals
6. July 2026 had missing food temperatures for 8 out of 93 meals.

During an interview, on 8/31/26 at 10:26 a.m., the Dietary Manager indicated the temperature recordings should

affected by the deficient practice?

Residents experienced no adverse effects related to the occurrence. Meal service and food safety practices will continue to be monitored to ensure residents receive food that is served at appropriate temperatures.

How will you 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 to be affected by the deficient practice. A review of meal temperature logs will be completed to identify any missing or incomplete temperature documentation.

All dietary staff will be re-educated on the Food Temperature policy and the requirement to record food temperatures at the beginning and end of each meal service.

The Dietary Manager/designee will ensure temperature logs are readily available and completed for every meal service. Any missing or incomplete documentation identified will be addressed immediately with the staff member responsible, and additional education will be

have been documented prior to serving the meals and it was not. The documentation was not completed due to a high turnover rate of staffing in the kitchen.

A current facility policy, titled "Food Temperature", dated as revised 1/20/20 and received from the Dietary Manager on 8/31/26 at 10:26 a.m., indicated "...Foods should be served at proper temperatures to ensure food safety and palatability...Record reading on Food Temperature Chart at beginning of the service line and end of the service line. If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperatures...."

provided as needed.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

All dietary staff will receive education regarding the Food Temperature policy and the facility's expectations for accurate and complete meal temperature documentation.

Staff will be reminded that food temperatures must be obtained and documented at the beginning and end of each meal service. The Dietary Manager/designee will ensure the appropriate temperature logs are available at each meal service and that staff understand their responsibility for completing the required documentation.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Dietary Manager/designee will review meal temperature logs weekly for four (4) weeks to verify that temperatures are documented completely for each meal service.

Following the initial four (4)

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weeks, the Dietary Manager/designee will review meal temperature logs monthly for three (3) months to ensure continued compliance.

Any missing or incomplete documentation will be addressed immediately with the staff member responsible, and additional education and/or counseling will be provided as indicated.

The results of the audits will be reviewed, reported, and trended for compliance through the communities QAPI Committee for a minimum of six (6) months. Continued monitoring or additional corrective action will be implemented if compliance is not sustained.

Responsible Person: Dietary Manager / Designee

Completion Date: 9/20/2026

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
SIGNATUREAntonio Stewart

TITLEExecutive Director

(X6) DATE09/18/2026