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

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>04/01/2025 |
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| NAME OF PROVIDER OR SUPPLIER<br>SILVER BIRCH OF FORT WAYNE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>7125 S HANNA STREET, FORT WAYNE, , 46816 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: March 31 and April 1, 2025<br><br>Facility number: 014316<br><br>Residential Census: 79<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed April 2, 2025 | R 0000 | Please accept the following as the community's plan of correction. This plan of correction does not constitute an admission of guilt<br>or liability by the facility and is submitted only in response to the<br>regulatory requirement. | |
| R 0029 | Residents' Rights - Deficiency<br><br>410 IAC 16.2-5-1.2(d)<br><br>(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.<br><br>Based on observation and interview, the facility failed to ensure privacy was maintained | R 0029 | R029 Residents' Rights: It is the policy of Silver Birch of<br>Fort Wayne to ensure that privacy is maintained for all residents.<br><br>All resident rooms noted in the deficiency were checked and signage was removed from public view. | 04/28/2025 |

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| | for residents on 4 of 4 floors observed.<br><br>Findings include:<br><br>During a tour on 3/31/25 at 10:18 AM a notice was posted regarding bath-dates, times, when laundry and bed changes would be provided. The notice was posted on the following rooms: 102, 106, 201, 206, 207, 226, 229, 234, 308, 309, 312, 315, 318, 323, 325,326,327, 329, 330, 331, 333, 337, 338, 405, 406, 408, 410, 411, 413, 414, 415, 428, 431, 437, 438. All posted signs were readable to passersby in the hallway.<br><br>During a tour, on 3/31/25 at 10:18 AM a notice was posted regarding pest control treatments during a certain date, and time. The notice indicated when the resident had to vacate the room, and when it would be safe to reenter. The notices were posted on rooms 409, 426, and 433.<br><br>During an interview, on 3/31/25 at 10:32 AM, the Administrator indicated the signs are posted face to the wall, but when residents read them, they often turned them facing the hallway.<br><br>During on interview, on 3/31/25 at 10:52 AM, QMA 1 indicated the receptionist posted the signs and she had only seen them facing outward to the hallway | | All other resident rooms were checked in the building to ensure privacy is being maintained for all residents.<br><br>All staff will be educated on resident rights regarding privacy on or before 4/28/2025.<br><br>A new system will be revised for communication to residents to ensure privacy is maintained. All communication to residents will be confidential and any postings will be kept private by posting with no visible wording to passerby.<br><br>A QAPI plan will be initiated.<br><br>To ensure ongoing compliance, the ADM/Designee will complete weekly audit "POC 2025" (Attachment A) during rounding of the community to ensure no signage is posted that violates resident privacy. Audits will continue until the facility has maintained 100% compliance for three consecutive months. Any identified issues will be addressed immediately. All audits and the QAPI plan will be | |

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| | During an interview, on 3/31/25 at 11:29 AM, the Receptionist indicated she did not place signs on resident doors- only Maintenance did that.<br><br>During an interview, on 3/31/25 at 11:48 AM, the Maintenance Director indicated he posted pest signs only. The bath signs were posted by other persons. He indicated the signs were not violating any HIPPA concern.<br><br>A current facility policy dated 6/15/25, Maintaining Residents' Dignity, Individuality and Privacy. Was provided the Administrator on 4/1/25 at 1:38 PM. The policy indicated..." All members of the nursing staff will treat residents with consideration and respect in order to preserve residents' dignity, individuality, and privacy..."<br><br>Based on observation and interview, the facility failed to ensure privacy was maintained for residents on 4 of 4 floors observed.<br><br>Findings include:<br><br>During a tour on 3/31/25 at 10:18 AM a notice was posted regarding bath-dates, times, when laundry and bed changes would be provided. The notice was posted on the following rooms: 102, 106, 201, 206, 207, 226, 229, 234, 308, 309, 312, 315, 318, 323, 325,326,327, | | reviewed/revised as needed by the IDT in the monthly facility quality meeting.<br><br>Date of compliance: 4/28/2025 | |

329, 330, 331, 333, 337, 338, 405, 406, 408, 410, 411, 413, 414, 415, 428, 431, 437, 438. All posted signs were readable to passersby in the hallway.

During a tour, on 3/31/25 at 10:18 AM a notice was posted regarding pest control treatments during a certain date, and time. The notice indicated when the resident had to vacate the room, and when it would be safe to reenter. The notices were posted on rooms 409, 426, and 433.

During an interview, on 3/31/25 at 10:32 AM, the Administrator indicated the signs are posted face to the wall, but when residents read them, they often turned them facing the hallway.

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| R 0273 | Food and Nutritional Services - Deficiency<br><br>410 IAC 16.2-5-5.1(f)<br><br>(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.<br><br>Based on observation and interview, the facility failed to ensure proper labeling were maintained in kitchen. 79 of 79 residents that resided in facility ate food prepared in the kitchen.<br><br>Findings include:<br><br>During an observation, on 3/31/25 at 8:56 AM, with the Dietary Manager, the following was observed. In the walk-in refridgerator, on a,shelf there was a clear plastic container. The container was half full of a dark syrup like liquid, with a plastic wrap over the top. There | R 0273 | R273 Food and Nutritional Services: It is the policy of Silver Birch of Fort Wayne to ensure that proper labeling is maintained in<br>accordance with state and local sanitation and safe food handling standards.<br><br>All issues identified in the survey have been corrected.<br><br>A complete audit of all food storage areas will be completed by 4/28/2025.<br><br>All dietary staff will be inserviced on or before 4/28/2025 regarding<br>food storage and safety and sanitation standards.<br><br>A QAPI plan has been initiated. | 04/28/2025 |

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| | was not a current date or label to indicate when the liquid was used or when it expired. On a second shelf was an open carton of strawberry topping, with no open date. On a third shelf, there was an open box of sausage. Inside the box was an opened bag. There was no open date on the bag or the box.<br><br>In an interview, on 3/31/25 at 9:00 AM, the Dietary Manager indicated the sausages are supposed to be wrapped, not exposed or open. She indicated all opened items should have opened dates on them.<br><br>During an observation, on 3/31/25 at 9:02 AM, on a self in the walk-in freezer, there was an open bag of French fries with no open date. On a second shelf in the freezer there was a small container with no label or date. The Dietary Manager opened the container and it was ice cream.<br><br>During an observation, on 3/31/25 at 9:06 AM, in the salad cooler, there was an open package of bologna with no open date. The Dietary Manager, indicated the bologna should not be in the salad cooler. In the same cooler there were two open bags of shredded lettuce with no open date. | | To ensure ongoing compliance the DSM will complete the audit tool "POC 2025" (Attachment A) on a weekly basis for 4 weeks, then bi-weekly<br>for 8 weeks, and monthly thereafter until 100% compliance is maintained for three consecutive months. Any identified issues will be addressed immediately.<br>All audits and the QAPI plan will be reviewed/revised as needed by the IDT in<br>the monthly facility quality meeting.<br><br>Date of compliance: 4/28/2025 | |

A current facility policy dated 8/1/18, Receiving Food and Supplies, was provided by the Administrator on 3/31/25 at 11:49 AM. The policy indicated..." food items should be received and handled in accordance with good sanitary practice...all food should be labeled and dated...."

Based on observation and interview, the facility failed to ensure proper labeling were maintained in kitchen. 79 of 79 residents that resided in facility ate food prepared in the kitchen.

Findings include:

During an observation, on 3/31/25 at 8:56 AM, with the Dietary Manager, the following was observed. In the walk-in refridgerator, on a,shelf there was a clear plastic container. The container was half full of a dark syrup like liquid, with a plastic wrap over the top. There was not a current date or label to indicate when the liquid was used or when it expired. On a second shelf was an open carton of strawberry topping, with no open date. On a third shelf, there was an open box of sausage. Inside the box was an opened bag. There was no open date on the bag or the box.

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| R 0356 | Clinical Records - Noncompliance | R 0356 | R356 Clinical Records: It is the policy of Silver Birch of | 04/28/2025 |

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| | 410 IAC 16.2-5-8.1(i)(1-8)<br><br>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:<br><br>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.<br><br>(2) The resident ' s hospital preference.<br><br>(3) The name and phone number of any legally authorized representative.<br><br>(4) The name and phone number of the resident ' s physician of record.<br><br>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.<br><br>(6) Information on any known allergies.<br><br>(7) A photograph (for identification of the resident).<br><br>(8) Copy of advance directives, if available.<br><br>Based on interview and record review, the facility failed to maintain current, updated information for the emergency file book for 5 of 5 residents reviewed. (Resident 4, Resident 5, Resident 13, Resident 14, and Resident 15) | | Fort Wayne to maintain current and updated information for the resident's emergency files.<br><br>Residents #4, #5, #13, #14,and #15 had no adverse effects from the noted deficiency. Emergency files have been updated.<br><br>Emergency files for all residents will be reviewed by 4/11/2025 , and updates will completed as needed.<br><br>System for maintaining resident files will be evaluated and changes implemented to ensure emergency resident files are kept current and updated. Receptionist will keep binder updated with move-ins and transfers out as they occur. Binder will be audited monthly.<br><br>The ADM/Designee will complete the weekly audit tool "POC 2025" (Attachment A) on the resident emergency files for four weeks, bi-weekly for 8 weeks then monthly ongoing until 100% compliance is maintained for 3 consecutive months. Any identified | |

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| | Findings include:<br><br>During a review of the emergency file book on 4/1/25 at 11:25 AM, 5 residents lacked Advance Directive or hospital preference documentation on their emergency file. Residents 4, 5,13, 14, and 15 had no advance directives (code status) or hospital preferences on their emergency file page.<br><br>1) Review of Resident 4's emergency file, indicated no a code status was documented. There was no hospital preference documented for Resident 4 on her emergency file.<br><br>2) Review of Resident 5's emergency file, indicated no a code status was documented. There was no hospital preference documented Resident 5 on his emergency file.<br><br>3) Review of Resident 13's file, indicated no a code status was documented. There was no hospital preference documented Resident 13 observed.<br><br>4) Review of Resident 14's emergency file, indicated no a code status was documented. There was no hospital preference documented for Resident 14.<br><br>5) Review of Resident 15's emergency file, indicated no a | | issues will be addressed immediately. All audits and the QAPI plan will be reviewed/revised as needed by the IDT in the monthly facility quality meeting.<br><br>Date of compliance:4/28/2025 | |

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| | code status was documented. There was no hospital preference documented for Resident 15.<br><br>In an interview, on 4/1/25 at 1:24 PM, the Executive Director (ED) indicated the emergency file book should contain the resident information, family information, physician name and number, hospital preference, advance directive, funeral arrangements if they have them, emergency contacts and diagnosis. The ED indicated the importance of the book was that in case of a disaster or in an emergency any staff member could obtain emergency necessary information for every resident living in the building.<br><br>A current policy titled "Medical Emergency" dated 5/01/2018, was provided by the ED on 4/1/2025 at 1:06PM. The policy indicated ...For residents the following information should be available for emergency medical services upon their arrival:<br><br>1.Resident face<br><br>2.Advance Directive<br><br>3.CPR designated<br><br>4.List of current medication ...<br><br>Based on interview and record review, the facility failed to maintain current, updated information for the emergency | | | |

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| | file book for 5 of 5 residents reviewed. (Resident 4, Resident 5, Resident 13, Resident 14, and Resident 15)<br><br>Findings include:<br><br>During a review of the emergency file book on 4/1/25 at 11:25 AM, 5 residents lacked Advance Directive or hospital preference documentation on their emergency file. Residents 4, 5,13, 14, and 15 had no advance directives (code status) or hospital preferences on their emergency file page.<br><br>1) Review of Resident 4's emergency file, indicated no a code status was documented. There was no hospital preference documented for Resident 4 on her emergency file.<br><br>2) Review of Resident 5's emergency file, indicated no a code status was documented. There was no hospital preference documented Resident 5 on his emergency file.<br><br>3) Review of Resident 13's file, indicated no a code status was documented. There was no hospital preference documented Resident 13 observed.<br><br>4) Review of Resident 14's emergency file, indicated no a code status was documented. There was no hospital | | | |

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| | preference documented for Resident 14.<br><br>5) Review of Resident 15's emergency file, indicated no a code status was documented. There was no hospital preference documented for Resident 15.<br><br>In an interview, on 4/1/25 at 1:24 PM, the Executive Director (ED) indicated the emergency file book should contain the resident information, family information, physician name and number, hospital preference, advance directive, funeral arrangements if they have them, emergency contacts and diagnosis. The ED indicated the importance of the book was that in case of a disaster or in an emergency any staff member could obtain emergency necessary information for every resident living in the building.<br><br>A current policy titled "Medical Emergency" dated 5/01/2018, was provided by the ED on 4/1/2025 at 1:06PM. The policy indicated ...For residents the following information should be available for emergency medical services upon their arrival:<br><br>1.Resident face<br><br>2.Advance Directive<br><br>3.CPR designated | | | |

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| | 4.List of current medication ... | | | |
| R 0409 | Infection Control - Noncompliance<br><br>410 IAC 16.2-5-12(d)<br><br>(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.<br><br>Based on interview and record review the facility failed to ensure 2 of 7 residents reviewed had a physician annual health statement. (Resident 8 and Resident 9)<br><br>Findings include:<br><br>1) Resident 8's record review, began on 4/1/25 at 9:33 AM, indicated his disgnoses included insomnia, diabetes, and major depression. Resident 8 did not have a current annual health statement to indicate he was free from communicable diseases. Resident 8's last written annual health statement was dated 6/10/22.<br><br>2) Resident 9's record review, began on 4/1/25 at 10:24 AM, indicated her diagnosis included muscle weakness, insomnia, anemia, diabetes, anxiety, and major depression. Resident 9 | R 0409 | R409 Infection Control: It is the policy of Silver Birch of Fort Wayne that all residents will have an annual health statement completed by the physician.<br><br>Resident #8 and #9 will be seen by the provider and annual health statement completed.<br><br>All other residents in the community will be audited to ensure that a current annual health statement is present on the clinical record. This will completed by 4/11/2025.<br><br>A QAPI plan has been initiated.<br><br>To ensure ongoing compliance the DON/Designee will complete the audit tool “POC 2025” (Attachment A) on a monthly basis until 100% compliance is maintained for 6 consecutive months. Any identified issues will be addressed immediately. All audits and the QAPI plan will be reviewed/revised as needed by the IDT in the monthly facility quality meeting. | 04/28/2025 |

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| | did not have a current annual physician statement documented to indicate she was free from communicable diseases. Resident 9's physician annual health statement was dated 9/5/23.<br><br>In an interview, on 4/1/25 at 11:02 AM, the Administrator indicated everyone should have a current annual health statement done annually and no more than 12 months old.<br><br>A current policy titled, "Infection Prevention and Control Program" dated 9/15/23, was provided by the Administrator on 4/1/25 at 11:02AM, this policy did not include annual health statements.<br><br>No other policies were provided at the time of exit.<br><br>Based on interview and record review the facility failed to ensure 2 of 7 residents reviewed had a physician annual health statement. (Resident 8 and Resident 9)<br><br>Findings include:<br><br>1) Resident 8's record review, began on 4/1/25 at 9:33 AM, indicated his disgnoses included insomnia, diabetes, and major depression. Resident 8 did not have a current annual health statement to indicate he was free from communicable diseases. Resident 8's last | | Date of compliance: 4/28/2025 | |

written annual health statement was dated 6/10/22.

2) Resident 9's record review, began on 4/1/25 at 10:24 AM, indicated her diagnosis included muscle weakness, insomnia, anemia, diabetes, anxiety, and major depression. Resident 9 did not have a current annual physician statement documented to indicate she was free from communicable diseases. Resident 9's physician annual health statement was dated 9/5/23.

In an interview, on 4/1/25 at 11:02 AM, the Administrator indicated everyone should have a current annual health statement done annually and no more than 12 months old.

A current policy titled, "Infection Prevention and Control Program" dated 9/15/23, was provided by the Administrator on 4/1/25 at 11:02AM, this policy did not include annual health statements.

No other policies were provided at the time of exit.

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 SIGNATURE | TITLE | (X6) DATE |
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