STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF FORT WAYNE	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
R 0000	INITIAL COMMENTS This visit was for a State Licensure Survey. This visit included Investigation of Intakes 468846 and 468469. Intake 468846 - No deficiencies related to the allegations are cited. Intake 468469 - No deficiencies related to the allegations are cited. Survey dates: April 6, 7 and 8, 2026 Facility number: 014316 Residential Census: 69 These State Residential Findings are cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-5. Quality review completed April 9, 2026	R 0000		

R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.	R 0117	Corrective Action Taken for the Individual(s) Affected The facility immediately reviewed staffing schedules and certification records. Upon identification of the alleged deficiency, the facility ensured that a staff member with current CPR and First Aid certification was present on-site. Any shifts lacking appropriately certified staff were corrected by adjusting staffing assignments or utilizing certified management staff to cover gaps until compliance was restored. To prevent recurrence, the facility has implemented the following measures: All direct care staff and designated supervisory staff are required to always maintain current CPR and First Aid certification. A minimum of one CPR and First Aid–certified staff member will be scheduled during all hours of operation. The facility has established a certification tracking binder that includes expiration dates for each staff member’s CPR and First Aid credentials.	04/20/2026

	Based on interview and record review, the facility failed to ensure a First Aid certified individual was in the facility at all times. This had the potential to affect 69 of 69 residents who resided in the facility. Findings include: On 4/6/2026, the Executive Director (ED) provided a list of the Cardiopulmonary Resuscitation (CPR) and First Aid certified staff members, dated March 29, 2026 through April 4, 2026. The completed form showed on March 30, 2026, a First Aid certified individual was not on duty between the hours of 5:30 PM and 10:00 PM. On 4/8/2026, the ED provided a list of the CPR and First Aid certified staff members, dated April 5, 2026 through April 7, 2026. The completed form showed on April 6, 2026, a First Aid certified individual was not on duty between the hours of 5:30 PM and 10:00 PM. In an interview, on 4/7/2026 at 11:05 AM, the ED indicated the facility did not have first aid coverage for March 30, 2026. The ED indicated the Director of Nursing (DON) thought a nurse being on shift met the qualifications. The ED indicated she had provided education a staff member had to be first aid		The DONW or designee will verify CPR and First Aid certification status prior to finalizing weekly schedules. The facility will monitor compliance through: Monthly audits of staff certification records conducted by the Administrator or designee. Weekly review of staffing schedules to confirm certified staff coverage. Documentation of audits and corrective actions maintained in a compliance log. Immediate corrective action if a lapse is identified, including staff removal from duty until certification is renewed. The Administrator or designee is responsible for implementation, monitoring, and ongoing compliance with this corrective plan. Full compliance was achieved as of 4/23/2026, and the facility will maintain continuous 100% compliance moving forward.	

	certified. In an interview, on 4/7/2026 at 1:25 PM, the ED indicated the facility did not have a policy for first aid or CPR. The ED indicated the facility followed the regulation. In an interview, on 4/8/2026 at 9:38 AM, the ED indicated the schedule was accurate and the facility did not have first aid coverage for April 6, 2026, from 5:30 PM to 10:00 PM. At the time of exit, the ED and DON indicated they did not have any additional information to provide.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and record review the facility failed to maintain sanitary conditions for 4 of 4 laundry rooms located in the facility. Findings include: During an observation, on 4/6/26 at 9:01am, of the 1st	R 0144	Corrective Action Taken for the Individual(s) Affected Upon identification of the alleged deficiency, the facility immediately cleaned and sanitized all laundry rooms to ensure a safe and sanitary environment. All visibly soiled areas, equipment surfaces, floors, and waste receptacles were addressed. Staff were re-educated on proper sanitation expectations. The facility has implemented the following measures to prevent recurrence of this deficiency:	04/20/2026

	floor resident laundry room the trash can had no lid, with visible trash. There was debris behind the dryer. There was some lint and trash visible. During an observation, on 4/6/26 at 9:06am, of the 2nd floor laundry room there was some debris visible behind the washer and dryer. During an observation on, 4/6/26 at 9:09am, of the 3rd floor resident laundry room there was debris visible behind washer and dryer. The floor visibly needed swept and mopped as evidenced by small pieces of debris and lint as well as the floor was sticky. During an observation, on 4/6/26 at 9:14am, of the 4th floor resident laundry room the sink had visible black and grey grime. One dryer had about ½ inch of lint in trap with no clothes inside dryer. During an observation, on 4/7/26 at 10:36am, of the 1st floor resident laundry room the trash can did not have a lid with trash visible. During an observation, on 4/7/26 at 10:43am, the 3rd floor laundry room had a black trash bag outside of the trash can sitting by the trash can. In the 3rd floor laundry room one of the lint traps were full of lint of		A written laundry room cleaning schedule has been developed or revised to clearly outline cleaning frequency, and responsible staff. A cleaning log has been implemented for each laundry room, requiring staff to document date, time, tasks completed, and staff signature. Staff responsible for housekeeping and laundry services have received retraining on sanitation standards and documentation requirements. Supervisory staff have been instructed to ensure laundry rooms remain free of clutter, debris, and unsanitary conditions. The facility will monitor compliance with sanitation and documentation requirements through: Weekly inspections of laundry rooms conducted by the Director of Environmental Services or designee. Weekly review of laundry room cleaning logs to verify completion and accuracy. Monthly audits with documented findings and corrective actions if deficiencies are identified.	

	varying colors approximately a ½" thick. During an observation, on 4/7/26 at 10:46am, the 4th floor laundry room had 2 streaks of blue liquid down the front of the washer. The liquid was dried and sticky with 5 drops of blue liquid leading towards the south wall on the floor leading back behind the washer itself. During an observation, on 4/7/26 at 12:28pm, the 2nd floor laundry room had a black trash bag on the floor near the trash can on the outside of the can. A review of facility cleaning logs indicated there were no cleaning documentation sheets for cleaning the 2nd, 3rd, or 4th floor resident used laundry rooms . The cleaning logs were dated 3/20/26 through 4/7/26. A policy and procedure titled, Common Areas, dated 5/1/18, was provided by the Executive Director on 4/8/26 at 8:40am. The policy indicated ...To provide specific guidelines for the frequency and type of tasks that assured the highest standards of sanitation for resident apartments ...The common areas were to receive the same attention to detail as resident apartments. There was no detailed list of cleaning the laundry rooms		Immediate follow-up and retraining if cleaning or documentation lapses are discovered. The Director of Environmental Services or designee is responsible for implementation, monitoring, and ongoing compliance with this plan of correction. Full compliance was achieved as of 4/23/2026 and the facility will maintain 100% adherence to sanitation and safety standards.	

	provided or listed in the policy.			
R 0353	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(f) (f) The facility shall have a policy that ensures the staff has sufficient information to meet the residents ' needs. Based on interview and record review, the facility failed to maintain current information for the emergency file book related to code status, for 3 of 3 residents reviewed (Resident 15, Resident 16, Resident 17) Findings include: During a review of the emergency file book on 4/6/26 at 11:10 AM., 3 residents did not have code status on their emergency file. 1. Resident 15's emergency file, dated 2/19/26, indicated there was not a code status documented. Resident 15's physician order indicated to administer cardiopulmonary resuscitation (CPR) as appropriate. 2. Resident 16's emergency file, dated 10/17/25, indicated there was not a code status documented.	R 0353	Corrective Action Taken for the Individual(s) Affected Immediately upon identification of the alleged deficiency, the facility reviewed the emergency binder and all resident face sheets. The emergency binder was updated to ensure accurate and complete information was available for all residents. To prevent recurrence of this deficiency, the facility has implemented the following actions: All resident face sheets included in the emergency binder will be reviewed to ensure required clinical information, including resident code status, is clearly documented. A standardized emergency binder checklist has been developed requiring verification of code status prior to placement or update of face sheets. Nursing and administrative staff responsible for maintaining clinical records and emergency binders have been re-educated on documentation requirements and the importance of accurate, complete emergency information.	04/20/2026

	Resident 16's physician order indicated to administer CPR as appropriate. 3. Resident 17's emergency file, dated 2/25/26, indicated there was not a code status documented. Resident 17's physician order indicated the resident desired to be do not resuscitate (DNR). In an interview, on 4/6/26 at 2:18 PM, the Administrator indicated the facility did not have a facility policy for the emergency file book. The front desk printed the face sheets out before the staff had entered all the information in.		The facility will monitor compliance through the following: Monthly audits of the emergency binder conducted by the Director of Nursing or designee. Documentation of audit findings maintained in a compliance log for six consecutive months or until 100% compliance noted during QAPI review. Immediate corrective action and staff re-education if incomplete or missing code status documentation is identified. The Director of Nursing or designee is responsible for ensuring implementation, monitoring, and sustained compliance with this Plan of Correction. Compliance was achieved as of 4/23/2026, and the facility will maintain 100% compliance on an ongoing basis.	

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 SIGNATURENatasha Welch	TITLEExecutive Director	(X6) DATE04/30/2026