

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                       |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>09/10/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER BIRCH AT COOK ROAD |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>3731 WEST COOK ROAD, FORT<br>WAYNE, , 46818 |                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                         | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION... | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                        | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Intakes 471603, 471773, 471802 and 471987.</p> <p>Intake 471603- No deficiencies related to the allegations are cited.</p> <p>Intake 471773- No deficiencies related to the allegations are cited.</p> <p>Intake 471987- State deficiencies related to the allegations are cited at R00410</p> <p>Intake 471802- State deficiencies related to the allegations are cited at R00117</p> <p>Survey dates: 09/21/2026 and 9/22/2026</p> <p>Facility number: 14553</p> <p>Residential Census: 113</p> | R 0000                                                                                      |                                  |                                                                 |                                                 |

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|        | <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed September 28, 2026</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        |  |            |
| R 0117 | <p>Personnel - Deficiency</p> <p>410 IAC 16.2-5-1.4(b)</p> <p>(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.</p> | R 0117 |  | 09/29/2026 |

Based on interview and record review, the facility failed to ensure sufficient qualified staff were available to administer medications for 3 of 3 residents. (Resident B, Resident C and Resident D)

Findings include:

1. Resident B 's record was reviewed on 9/21/2026 at 9:30 AM. Diagnoses included, type 2 diabetes mellitus without complications.

A review of Resident B 's Medication Administration Record (MAR) indicated, on 8/30/2026, Resident B did not receive the following medications: At 07:30 AM Humalog 100 units/mL KwikPen and at 12:00 PM Humalog 100 units/mL KwikPen.

2. Resident C 's record was reviewed on 9/21/2026 at 9:30 AM. Diagnoses included, chronic kidney disease, allergies, muscle spasms, pain, nausea, skin dermatitis, essential (primary) hypertension, hyperlipidemia, depression, polymyalgia rheumatica / RA, diabetes mellitus due to underlying condition with hypoglycemia, GERD / gastro-esophageal reflux disease with esophagitis, COPD related to bronchitis, dry,

itchy skin, anxiety and supplement use.

A review of Resident C 's MAR indicated, on 8/30/2026, Resident C did not receive the following medications: at 07:00 AM Amlodipine 5 mg, Certavite Senior, Escitalopram 20 mg, Leflunomide 20 mg, Metformin 500 mg, Pantoprazole 40 mg, Fluticasone-Salmeterol 500/50 mcg, Hydrocortisone 2.5% cream, Buspirone 10 mg and Hydroxyzine 50 mg. At 08:00 AM, Calcium 600-D3 400 IU, Cetirizine 10 mg, Fluticasone propionate 50 mcg nasal spray, Folic Acid 1 mg, Oxycodone 15 mg, Pimecrolimus 1% cream, Vitamin B-1 100 mg and Losartan 25 mg. At 11:00 AM Cyclobenzaprine 10 mg. At 12:00 PM Ondansetron 4 mg.

3. Resident D ' s record was reviewed on 9/21/2026 at 9:30 AM. Diagnoses included, type 2 diabetes mellitus with diabetic polyneuropathy.

A review of Resident D ' s MAR indicated, on 8/30/2026, Resident D did not receive the following medication: At 11:00 AM Novolog 100 units/mL FlexPen - sliding scale insulin.

A review of the facility time cards, dated 8/30/2026, indicated Qualified Medication Assistant (QMA) 2 and QMA 3 were clocked in from 06:00 AM

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until 02:00 PM.

A review of staff licenses indicated QMA 2 had an active license. QMA 2 ' s license indicated they were not qualified to give insulin.

A review of staff licenses indicated QMA 3 had an active license. QMA 3 ' s license indicated they were qualified to give insulin.

A review of the facility investigation, dated 9/2/2026, indicated the following: On Sunday, August 30, 2026, 35 residents did not receive scheduled insulin and/or medications due to insufficient staffing coverage ... As a result, one QMA who was not insulin certified was left responsible for medication administration for more than 110 residents. This resulted in significant resident care and safety concerns and a failure to ensure residents received their scheduled medications.

In an interview on, 9/22/2026 at 12:58 PM, the Interim Administrator indicated an investigation was completed and the Executive Director was terminated. The Interim Administrator indicated QMA 3 did not work 06:00 AM - 02:00 PM on 8/30/2026. The Interim Administrator indicated there was an error with the timecard

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|        | <p>for QMA 3 that needed to be fixed. The Interim Administrator indicated the only QMA working in the facility from 06:00 AM - 02:00 PM on 8/30/2026 was QMA 2.</p> <p>A current undated policy, provided by the Interim Administrator, indicated: "Our community offers medication management services for all residents needing or requesting this support. A licensed nurse or qualified medication aide will administer medications, as ordered by the resident 's provider, for residents who are receiving medication administration services ..."</p> <p>This citation is related to intake 471802.</p> |        |  |            |
| R 0410 | <p>Infection Control - Noncompliance</p> <p>410 IAC 16.2-5-12(e)(f)(g)</p> <p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing</p>                                       | R 0410 |  | 09/29/2026 |

should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on interview and record review, the facility failed to ensure tuberculosis (TB) testing and annual TB risk assessments were completed for 3 of 3 residents reviewed (Resident F, Resident G, and Resident K).

Findings included:

1. Resident F's record was reviewed on 9/21/2026 at 12:03 PM. Resident F was admitted in 5/2026. A TB test or an annual TB risk assessment was not documented in the medical record.

2. Resident G's record was reviewed on 9/21/2026 at 12:03 PM. Resident G was admitted in 12/2025. A TB test or an annual TB risk assessment was not documented in the medical record.

3, Resident K's record was

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OMB NO. 0938-0391

reviewed on 9/21/2026 at 12:03 PM. Resident K was admitted in 4/2026. A TB test or an annual TB risk assessment was not documented in the medical record.

In an interview, on 09/22/2026 at 11:58 AM, the Interim Administrator indicated the facility did not have an initial TB test for Resident F, Resident G or Resident K. The Interim Administrator indicated the facility did not have an annual TB risk assessment for Residents F, Resident G or Resident K.

In an interview, on 09/22/2026 at 1:00 PM, the Interim Administrator indicated the facility did not have a policy for TB testing and annual risk assessments.

At the time of exit, no additional documentation was provided.

This citation is related to intake 471987.

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