STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH AT COOK ROAD	3731 WEST COOK ROAD, FORT WAYNE, , 46818

(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: October 14, 15, and 16, 2025. Census Bed Type: Residential: 115 Total: 115 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 20, 2025	R 0000		
R 0147	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(d) (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities.	R 0147	**`R 147- Sanitation and Safety Standards** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**	11/01/2025

	Based on interview and record review, the facility failed to ensure fire drills were completed quarterly on each shift. 115 of 115 residents resided in the facility. Findings include: A review required fire drills began on 10/15/25 at 10:30 AM. Dated February 2025: A fire drill was conducted on 2/28/25, at 3:00 PM during the second shift. Dated March 2025: No fire drill was conducted. Dated April 2025: No fire drill was conducted. Dated May 2025: A fire drill was conducted on May 8, 2025, during first shift. The time was not noted on the form. Dated June 2025: No fire drill was completed. Dated July 2025: No fire drill was completed. Dated August 2025: Three fire drills were conducted. The first fire drill was dated on 8/20/25 at 1:05 PM. Another fire drill was dated on 8/ 24/25 at 3:24 PM, and the last fire drill was dated on 8/27/25, at 6:00 AM. There were no fire drills documented as completed		No residents were affected by this deficient practice. . The Environmental Service Manager (ESM)has been re-educated on the Fire Drill schedule that is conducted monthly and rotates 1st, 2nd, and 3rd shift. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents of the Facility have the potential to be affected by this deficient practice. Facility staff have been in-serviced on Fire Drill instructions. Fire Safety will continue to be a part of the new hire orientation. Facility staff will participate in the monthly Fire Drills. Facility staff will continue to be in-serviced on Fire Safety annually.	

	dated September 2025. No other documentation fire drills were completed was provided on exit. In an interview, on 10/14/25 at 1:36 PM, the Maintenance Director indicated he did not know why the drills were not completed. In an interview, on 10/16/25 at 9:17 AM, teh Administrator indicated the facility did not have a policy regarding when fire drills were due, the company used a program to tell them when the drills were due. Based on interview and record review, the facility failed to ensure fire drills were completed quarterly on each shift. 115 of 115 residents resided in the facility. Findings include: A review required fire drills began on 10/15/25 at 10:30 AM. Dated February 2025: A fire drill was conducted on 2/28/25, at 3:00 PM during the second shift. Dated March 2025: No fire drill was conducted. Dated April 2025: No fire drill was conducted. Dated May 2025: A fire drill was conducted on May 8, 2025,		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Executive Director will participate in the Monthly Fire Drill with ESM and sign off that the Drill has been conducted on the correct schedule. All Fire Drills will be uploaded in The Equipment Lifecycle System that Silver Birch utilizes to record Life Safety tasks. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Executive Director will sign off with ESM for each Fire Drill. Completed Fire Drills will be sent to the Director of Maintenance and Operations Compliance each month for 6 months. Director of Maintenance will audit The	

	during first shift. The time was not noted on the form. Dated June 2025: No fire drill was completed. Dated July 2025: No fire drill was completed. Dated August 2025: Three fire drills were conducted. The first fire drill was dated on 8/20/25 at 1:05 PM. Another fire drill was dated on 8/ 24/25 at 3:24 PM, and the last fire drill was dated on 8/27/25, at 6:00 AM. There were no fire drills documented as completed dated September 2025. No other documentation fire drills were completed was provided on exit. In an interview, on 10/14/25 at 1:36 PM, the Maintenance Director indicated he did not know why the drills were not completed. In an interview, on 10/16/25 at 9:17 AM, teh Administrator indicated the facility did not have a policy regarding when fire drills were due, the company used a program to tell them when the drills were due.		Equipment LifeCycle System monthly thereafter for compliance. Results of Audits will be addressed immediately as needed and reviewed in monthly Quality Assurance meetings. **<u>What date will the systemic changes be completed:</u>** 11/01/2025 .	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d)	R 0216	**<u>R 216-</u> Clinical Records**	11/01/2025

	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview the facility failed to ensure an admission weight was obtained for 1 of 6 residents reviewed. (Resident 5) Findings include: Resident 5's record review began on 10/14/25 at 1:16 PM. Resident 5's first recorded weight was dated 8/15/25. Resident 5's admittission date was listed as 6/27/25. The time frame between 6/27/25 and 8/15/25 was 7 weeks. In an interview, on 10/16/25 at 9:42 AM, the Director of Nursing indicated the 8/15/25 weight		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident 5 was weighed, and accurate weight is now clinical Record. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Audit conducted on resident weights. There are some residents who refuse to be weighed. All other resident weights are in the resident’s clinical record. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

	was the first weight taken for Resident 5. She was unsure why the weight was not obtained on admission. No policy and procedure was provided at time of exit. Based on record review and interview the facility failed to ensure an admission weight was obtained for 1 of 6 residents reviewed. (Resident 5) Findings include: Resident 5's record review began on 10/14/25 at 1:16 PM. Resident 5's first recorded weight was dated 8/15/25. Resident 5's admittission date was listed as 6/27/25. The time frame between 6/27/25 and 8/15/25 was 7 weeks. In an interview, on 10/16/25 at 9:42 AM, the Director of Nursing indicated the 8/15/25 weight was the first weight taken for Resident 5. She was unsure why the weight was not obtained on admission. No policy and procedure was provided at time of exit.		Nursing has been educated on obtaining and documenting weights upon admission. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** 48 hour Audits will be reviewed by DON/Designee for each Admission for 6 months, each admission for 3 months, and 1 month thereafter. Issues will be addressed immediately and reviewed during monthly QA. **What date will the systemic changes be completed:¿** **111/01/2025**	
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 '	R 0353	**R353- Clinical Records** **What corrective action will be accomplished for**	11/01/2025

needs.

Based on interview and record review, the facility failed to ensure current information was maintined in the emergency file book related to hospital preference, for 6 of 10 residents reviewed (Resident 2, Resident 4, Resident 5, Resident 8, Resident 11, and Resident 12).

Findings include:

During a review of the emergency file book on 10/15/25 at 10:55 AM, indicated the following:

1. Resident 2's emergency file, dated 10/6/25, had no hospital preference listed. There was also no picture in the file.

2. Resident 4's emergency file, dated 3/22/25, had no hospital preference listed.

3. Resident 5's emergency file, dated 6/16/25, had no hospital preference listed.

4. Resident 8's emergency file, dated 10/15/25 , had no hospital preference listed

5. Resident 11's emergency file, dated 3/26/25, had no hospital preference listed

6. Resident 12's emergency file, dated 10/15/25, had no hospital preference listed

those residents found to have been affected by the deficient practice;

The hospital preference for Resident 2, 4 5, 8, 11, and 12 has been updated in Emergency File.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

Nursing completed an audit for each resident's hospital preference for the Emergency File. Those resident files who did not have a preference listed have now been updated. Each resident file now has a hospital preference.

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

Chart Audit will be conducted within 48 business hours after admission to ensure

In an interview, on 10/15/25 at 11:10 AM, the Director of Nursing (DON) indicated there were just a few files without the hospital preference but the rest did have it. The DON indicated not all residents had a hospital preference.

On 10/15/25 at 11:15 AM, a policy regarding emergenmcy file documentation was requested.

No policy related to emergency file hospital preference was provided at time of exit.

Based on interview and record review, the facility failed to ensure current information was maintined in the emergency file book related to hospital preference, for 6 of 10 residents reviewed (Resident 2, Resident 4, Resident 5, Resident 8, Resident 11, and Resident 12).

Findings include:

During a review of the emergency file book on 10/15/25 at 10:55 AM, indicated the following:

1. Resident 2's emergency file, dated 10/6/25, had no hospital preference listed. There was also no picture in the file.

2. Resident 4's emergency file, dated 3/22/25, had no hospital preference listed.

weights and all
clinical needs are documented appropriately. Identified issues will be
addressed for compliance immediately.

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

48 business hour Audits will be reviewed by DON/Designee for each Admission for 6 months, each admission for 3 months, and 1 month thereafter. Issues will be addressed
immediately and reviewed during monthly QA.

What date will the systemic changes be completed:

11/01/2025

	3. Resident 5's emergency file, dated 6/16/25, had no hospital preference listed. 4. Resident 8's emergency file, dated 10/15/25 , had no hospital preference listed 5. Resident 11's emergency file, dated 3/26/25, had no hospital preference listed 6. Resident 12's emergency file, dated 10/15/25, had no hospital preference listed In an interview, on 10/15/25 at 11:10 AM, the Director of Nursing (DON) indicated there were just a few files without the hospital preference but the rest did have it. The DON indicated not all residents had a hospital preference. On 10/15/25 at 11:15 AM, a policy regarding emergenmcy file documentation was requested. No policy related to emergency file hospital preference was provided at 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 SIGNATUREMark Thompson	TITLEAdministrator	(X6) DATE10/29/2025