STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MISHAWAKA	3630 HICKORY ROAD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 1/15 and 1/16/2025 Facility number: 014260 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 1/24/2025	R 0000		
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on interview and record review, the facility failed to ensure a yearly inspection was performed on the heating and ventilation system. This had the potential to affect 90 of 90 residents that reside in the facility. Finding includes: During an interview on 1/16/2025 at 10:00 A.M., the Maintenance Director indicated the facility had the heating and ventilation last inspected in December of 2023. An invoice for the heating and ventilation system inspection, dated December 2023 was provided. He indicated that it should have been done yearly. During an interview on 1/16/2025 at 11:20 A.M., the Maintenance Director indicated heating and ventilation system was not done for the year 2024 but he had contacted the company and scheduled	R 0148	*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 of correction for this survey. Please find the sufficient 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*	02/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natasha Welch	Executive Director	02/04/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the inspection for February 2025. On 1/16/2025 at 12:07 P.M., the Administrator indicated the facility did not have a policy regarding heating and ventilitation system inspections, but they followed the state regulation.		*additional information be necessary to confirm said compliance, please feel free to contact Natasha Welch, Executive Director, Silver Birch of Mishawaka.* R148 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No adverse effects noted to any resident. Inspection of heating and ventilation completed on 1/30/2025. 2 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 have the potential to be affected by the alleged deficiency. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Yearly inspection added to TELS preventative maintenance tracking system. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place: ESM or designee will audit monthly preventative maintenance to ensure compliance and document findings. ESM will review results in QAPI meeting until 100% compliance noted for three consecutive months. 5 By what date the systemic changes will be completed: 2/4/2025	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to store food under sanitary conditions related to undated food in the food preparation area for 1 of 1 kitchen areas observed and failed to serve food in a sanitary manner for 1 of 1 dining rooms observed. These issues had the potential to affect 90 of 90 residents who consumed food from the kitchen and/or ate in the dining room. Findings include: 1. On 1/15/2025 at 9:30 A.M., during an initial tour of the kitchen with the Kitchen Manager, the following items were observed: 12 undated loaves of bread in the kitchen preparation area on a shelving unit. The bread did not have a manufacturer's expiration date. During an interview, on 1/15/2025 at 9:30 A.M., the Kitchen Manager indicated she had many new staff and some staff might be unaware of policies on dating food. The Kitchen Manager indicated the bread should have been dated.	R 0273	*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 of correction for this survey. Please find the sufficient 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*	02/05/2025

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	2. During a continuous observation, on 1/15/2025 beginning at 11:30 A.M. and ending at 11:50 A.M., Employee 3 served food with her thumb over the rim of the plates, resting on the eating surface of the plates, to 3 of 21 residents in the dining room. Employee 4 served food with her thumb over the rim of the plates, resting on the eating surface of the plates, to 6 of 21 residents in the dining room. During an interview, on 1/16/2025 at 11:50 A.M., the Kitchen Manager indicated the kitchen staff should not be placing their thumbs on the eating surface of any resident's meal plates while serving and indicated she had instructed them in the correct way to serve residents their food. On 1/16/2025 at 11:12 A.M., the Kitchen Manager provided a policy titled, "Receiving Food and Supplies," dated 8/1/2018 and indicated the policy was the one currently used by the facility. The policy indicated "...all food should be labeled and dated..." On 1/16/2025 at 12:07 P.M., the Administrator indicated the facility had no dining and/or serving meal policy.		*contact Natasha Welch, Executive Director, Silver Birch of Mishawaka.* R273 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No adverse effects noted to any resident. 2 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 have the potential to be affected by alleged deficiency. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Culinary manager to re-train and document training for all servers to properly serve a dish without touching the eating surface. Culinary Manager to re-train and train all culinary staff on FIFO and tracking through ensuring all food items are dated in accordance with state and local sanitation and safe food handling standards including 410 IAC 7-24. 4 How the corrective action(s) will be monitored to ensure the	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Culinary Manager or designee will monitor meal service at least twice weekly to ensure proper service and document findings. Will report audit results during QAPI meeting until 100% compliance noted for three consecutive months. Culinary Manager or designee will check all kitchen stock at least twice weekly for dates and and document findings. Culinary manager will report audit results during QAPI meeting until three consecutive months of 100% compliance noted.	