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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

(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 the Investigation of Complaints IN00453936 and IN00449077. Complaint IN00453936 - State deficiencies related to the allegations are cited at R0045. Complaint IN00449077- No deficiencies related to the allegations are cited. Survey date: 3/13/25 Facility number: 014034 Residential Census: 109 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 21, 2025.	R 0000		
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency Based on record review and interview, the facility failed to provide residents with written notice of involuntary discharge per facility policy and failed to secure the residents right to an appeals process for 2 of 3 residents reviewed for discharge procedures. (Residents E and F) Finding includes: Resident E's clinical record was reviewed on 3/13/25 at 1:41 p.m. Diagnoses included pain in the knee, open wound of left leg, cellulitis, and borderline personality disorder. The discharge date was 2/5/25.	R 0045	*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*	04/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Collins	Administrator	04/08/2025

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.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

(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
	The clinical record lacked a notice of involuntary discharge. During an interview, on 3/13/25 at 1:41 p.m., the Administrator indicated Resident E was discharged through the involuntary discharge process. The resident had threatened to shoot and kill a staff member, and he felt this was the last straw. The resident had multiple previous behaviors such as removing fruit from the community water coolers with bare hands, arriving to the dining room with unwrapped and/or draining leg wounds, and had feces covering surfaces in the apartment. The housekeeping staff was unable to keep up with cleaning the apartment appropriately. He had not provided the resident with involuntary discharge paperwork since she said "okay" to the transfer. During an interview, on 3/13/25 at 1:55 p.m., the local Ombudsman indicated she was unaware Resident E was transferred until the resident called her. She was previously advised by the residential facility that the resident was demonstrating behaviors such as removing fruit from a public water cooler and had feces all over the apartment without making any attempts to resolve the issue. The Ombudsman indicated she did not feel these reasons warranted an involuntary discharge. Neither the Resident nor the Ombudsman was given notification for involuntary discharge. The lack of notification prevented the resident from being able to appeal the discharge. The Ombudsman was also unaware of the involuntary discharge of Resident F. Resident F's clinical record was reviewed on 3/13/25 at 2:43 p.m. Diagnoses included schizoid personality disorder, hypothyroidism, and anxiety		*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 contact Joe Collins, Executive Director, Silver Birch of Muncie.* Prefix Tag # R045 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Executive Director/Administrator has completed a review of residents E and F eviction processes and documentation within files and systems to identify potential deficiencies. The Regional Operations Manager performed an in-service training session with the Executive Director/Administrator on proper protocol on April 3, 2025. The ROM also reviewed the findings of the review of Residents E and F eviction process and provided direction for future involuntary evictions. The Executive	

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

(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
	disorder. The discharge date was 1/20/25. The clinical record lacked a notice of involuntary discharge. During an interview, on 3/13/25 at 1:55 p.m., the local Ombudsman indicated she was unaware Resident F was involuntarily discharged. The lack of notification prevented the resident from being able to appeal the discharge. During an interview, on 3/13/25 at 2:07 p.m., the DON indicated Resident F was demonstrating behaviors such as stealing from other residents, verbal aggression and arguments with other residents, and turning on the call light then leaving the facility or locking themselves in a room. The DON indicated the facility had not completed investigations into the theft concerns since the resident apologized and returned the items. The resident had requested to go to another residential facility. Resident E was transferred due to her behaviors and her wound care needs. Resident E's behaviors including defecating on the apartment floor, yelling profanities, using vulgar language, and speaking in different tones and voices requiring staff to go check on the resident constantly. The resident had came to the dining room with draining wounds or wounds without dressings. The management staff discussed Resident E and determined the resident required a greater level of care than the facility provided. Resident E was packed a week early. She indicated the Administrator spoke with both residents but she was unaware what documentation was made in the clinical record. During a follow-up interview, on 3/13/25 at 3:35 p.m., the Administrator indicated management had		Director/Administrator completed an in-service training on April 4, 2025, with the leadership team to educate and ensure proper documentation, notifications, meetings, and timelines are completed for current and future residents that are involuntarily evicted. 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: The Executive Director/Administrator, or designee, will complete an audit, to include 100% of residents, to identify any residents who are in process of eviction or currently identified as potentially needing evicted at this time. Following this audit, residents in the eviction process will be verified for completion of documentation, notifications, meetings, and adherence to timelines required by State regulations and Silver Birch Living's Lease protocol. Any missing documentation will be completed as applicable. The involuntary eviction of residents in the future will have updated documentation as notable changes of conditions occur. After the Executive Director/Administrator's, or	

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

(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
	spoken with Resident's E and F related to behaviors and how all the resident needed to do was follow the facility rules. He indicated the Ombudsman was aware of the multiple behaviors demonstrated by Resident E and F. He did not provide either resident with a written notice of involuntary discharge or contact the Ombudsman when the residents transfers were completed. He felt the discharges were appropriate and regular transfers due to level of care needs. An undated, current facility Lease Agreement, provided by the Administrator on 3/13/25 at 9:55 a.m., indicated the following: "...The Owner can terminate this Lease in any of the following instances: ... c. The safety of individuals in the Premises is endangered by your continued residency; d. The health of individuals in the Premises would otherwise be endangered by your continued residency...In event of one of the above occurrences, the Owner will provided thirty (30) days priors written notice of termination of lease. However, thirty (30) days prior written notice is not required for terminations described above in (c) and (d), or if you have resided for less than thirty (30) days. Rather, notice will be provided as soon as possible." This citation relates to complaint IN00453936.		designee's, review the eviction documentation throughout the eviction process will send final documentation to the Regional Operations Manager for their approval prior to evection. 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. The Executive Director/Administrator will educate the management on the following including but not limited to completion of proper protocol during evictions, scheduling of required meetings, notifications, documentation behaviors, and paperwork in the electronic medical record and review of the review of applicable regulations within 410 IAC 16.2-5 by April 4, 2025. Additionally, the Executive Director/Administrator, or designee, will complete routine audit of evection documentation prior to transfers of residents to other care providers and ensure compliance as note within #4 on this Plan of Correction. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE MUNCIE, IN 47304

(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
			program will be put into place: The Executive Director/Administrator, or designee, shall complete a review of 100% of residents who are involuntarily transferred to ensure that proper protocol and regulations are followed. This review will continue monthly for six months. If 100% compliance is not met during the monthly review, the audit will begin again at the previously noted review sequence until there are six consecutive months of 100% compliance. Executive Director/Administrator, or designee, will report to the Regional Operational Manager, Community's Quality Assurance & Performance Improvement Committee any evection and the and will provide through our operational leadership meetings of eviction updates and status of required protocols to the Quality Assurance Committee until the Committee they determine the process is proper and issue is resolved. 5 By what date the systemic changes will be completed: Systematic changes will be in effect by April 04, 2025. The facility respectfully requests a paper compliance review.	