| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SILVER BIRCH OF KOKOMO | 408 S WASHINGTON STREET<br>KOKOMO, IN 46901 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00399826.<br><br>Complaint IN00399826 - No deficiencies related to the allegations are cited.<br><br>Unrelated deficiency is cited.<br><br>Survey date: March 14 and 15, 2023<br><br>Facility number: 014137<br><br>Residential census: 104<br><br>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on March 23, 2023. | R 0000 | We respectfully request a desk review of the following plan of correction to the survey conducted at Silver Birch of Kokomo.<br><br>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of correction is submitted to meet the requirements established by the state and federal law.<br><br>Silver Birch of Kokomo desires that this Plan of Correction be considered the facility's Allegation of Compliance effective April 6, 2022. | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br>Based on interview and record review, the facility failed to ensure a resident was free from physical abuse related to a staff member aggressively touching the resident's forehead during a physical altercation for 1 of 2 residents reviewed for | R 0052 | How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice.<br>R 052 Residents' Rights – Offense | 04/13/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Piper Bakrevski | Senior Clinical Advisor | 04/12/2023 |

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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| | physical abuse. (Resident B)<br><br>Finding includes:<br><br>During an interview, on 3/14/23 at 1:34 p.m., the Executive Director (ED) and the Director of Health and Wellness (DHW) were in attendance. The ED indicated the Resident B called Server 3 a B**** after she would not give him more bacon. Resident B's abuse allegation against Server 3 was substantiated and she was terminated for abuse. There were witnesses who observed her placing her two fingers (the ED demonstrated with his index and middle finger) in the middle of the resident's forehead pushing his forehead backwards, while telling him not to call her that name again.<br><br>A document, titled "Indiana State Department of Health Survey Report System," indicated on 12/27/23 at 8:50 a.m., Resident B indicated he called Server 3 a "B****" because she told him there was no more bacon, but he observed other residents getting bacon. He indicated later, Server 3 came up to him and pushed him in his forehead with two fingers and told him not to call her that again.<br><br>A written statement from Server 3, dated 12/29/23 at 10:21 a.m., indicated she took another resident's order and told him they were out of bagels, then she took Resident B's order and he asked for bacon. She told him they were out of bacon. He called her a liar and told her she had just told the other resident they had bacon. She and Resident B was in each other's faces pointing their fingers at each other, but she did not touch the resident.<br><br>A written statement from a witness, dated 12/27/23, indicated this person heard arguing | | · Culinary Server who was employed by facility during the time period of this alleged deficient practice no longer works at the facility.<br>· Report submitted to State Agency as it pertains to incident involving resident identified Resident B.<br>· Resident B was interviewed and indicated that “he is over the incident”; ” resident confirms feeling safe at facility.<br>· Care Plans of resident identified B and reviewed and updated as deemed necessary.<br>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:<br>All residents have potential to be affected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice. All residents were interviewed on 1-13-2023.<br>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:<br>· Executive Director in-serviced all staff on Investigate/Prevent/Correct Alleged Violation. Specifically, this education focused on the facility’s responsibility to ensure that in response to allegations of abuse, neglect, exploitation or | |

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| | while in the dining room and when he or she came out of the dining room Server 3 and Resident B was observed "going at it." Server 3 indicated to Resident B he was not going to keep calling her "B******" and "Ho's" then she came from around the office area and walked up to Resident B and took her two fingers and pushed his head backwards and indicated "I got your B****" then she walked away and indicated "Your momma's a B****."<br><br>During an interview, on 3/15/23 at 1:09 p.m., Resident B indicated the server lied to him about there not being any bacon left to eat, so he called her a "B****". Server 3 told him there was no bacon left, but he saw her serving it to other residents, so he knew she lied. She did not like him, and she would not give him what he asked for all the time. He told her she lied to him. She indicated she did not have to "deal with him" this was when he called her a "B****." When he was at the elevator, she came and got in front of his face and used her index and middle finger and poked him in the middle of his forehead with her fingers pushing his head back indicating to him at the same time, "F*** you, call me a B****." The ED witnessed her doing this to him along with some residents and other employees. She no longer worked at the facility.<br><br>A current policy, titled "Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated with a revision date 2/1/20 and provided by the ED on 3/14/23 at 3:45 p.m., indicated "Purpose: Each resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone including but not limited to facility staff...Policy: Residents have the right to be free from physical...abuse...Definitions: Abuse is the willful infliction of injury, | | mistreatment, that the alleged violations are thoroughly investigated and reviewed to prevent further potential incidents on 1-11-2023.<br>4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:<br>· Executive Director or designee will update and maintain Grievance/Reportable Events Log to ensure that facility appropriately respond Executive Directors and investigates allegations of potential misconduct. This log will be utilized for Abuse Prevention Committee Meetings which will be held weekly x4, biweekly x2 and monthly x1 to ensure ongoing and sustained compliance with this alleged deficient practice. Any adverse findings will be immediately addressed and reported to the State Agency as deemed necessary.<br>· Findings and trends will be reported to QAPI Committee and Corporate Compliance for further review and consideration.<br>5 By what date the systemic changes will be completed:<br>Completion date: 4/13/2023 | |

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| | unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being...Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment...." | | | |