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	12/21/2022

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

(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 Complaint IN00396076 Complaint IN00396076 - Substantiated. State deficiencies related to the allegations were cited at R0052 and R0119. Survey dates: December 21, 2022 Facility number: 014137 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 3, 2023.	R 0000	R 0000 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.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, related to a resident was not kept safe during a transport ride to and from the facility for approximately 80 miles round trip for 1 of 3 residents reviewed for accidents. (Resident B) This resulted in Resident B falling from his wheelchair during transport. Finding includes:	R 0052	R0052 – Resident Rights - offense What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident B: was sent to hospital to be evaluated for any injury – no injury noted. How the facility will identify other residents having the potential to	01/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	A document, titled "Indiana State Department of Health Survey Report System," undated and provided by the ED indicated, on 12/1/22 at 1:40 p.m., while Resident B was en-route to an appointment on the facility bus he sustained a fall from his wheelchair to the floor of the bus. The LEC (Life Enrichment Coordinator) immediately stopped the bus and the resident got himself off the bus floor back into his wheelchair. He complained of mild pain to his buttocks at that time. The resident had a Stage II pressure on his left buttocks and a Stage I pressure ulcer to the coccyx area. The ED (Executive Director) concluded as of 12/5/22, after completing his investigation, all staff responsible for transporting residents in the facility bus would be retrained on van safety and transportation guidelines. The record for Resident B was reviewed on 12/21/22 at 3:00 p.m. Diagnoses included, but were not limited to, pain, generalized anxiety disorder, hypertension, and chronic obstructive pulmonary disease. An untitled and undated typed document indicated the ED spoke with LEC 3 regarding the facility bus incident involving Resident B. Her statement of the incident was she did not place the seatbelt on the resident going to the appointment because he refused to have it on. On the way back from the appointment, she placed the seatbelt on him, but she did not put the wheel locks in place. A document, titled "Termination Notice," dated 12/1/22 and provided by the DON (Director of Nursing) on 12/21/22 at 4:08 p.m., indicated LEC 3 was transporting a resident on the facility bus to an appointment out of town on 11/29/22. The		be affected by the same deficient practice and what corrective action will be taken; All current residents residing at Silver Birch of Kokomo have the potential to be affected by the alleged deficient practice. As a means of quality assurance all residents that ride the bus have been audited to see if this practice occurred with them. No other residents were identified. As a means of quality assurance all personnel who drive the company bus have been re-educated on company policy on residents' safety while being transported. Re-education was provided by the Environmental Services Manager. All training records will be obtained by Executive Director or designee and will be placed in in the employee files. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Transportation Logs will be audited by the Executive Director or designee weekly x 4 weeks, then every other week x 4 weeks then monthly x 3 months. Any findings will be addressed at the time of discovery. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	resident used a wheelchair, and she did not strap him into the facility bus appropriately, resulting in him being jolted and falling out of his wheelchair when she hit a curb. During the trip back to the facility, she did not strap him into the bus appropriately, nor did she ensure his wheelchair was locked with the wheel locks. LEC 3 had the responsibility to ensure all residents were safe when transporting them on the bus. She was to ensure the residents were appropriately restrained for their own safety. She placed this resident at risk for both legs of the trip and it could have resulted in a serious injury. Due to her actions, she placed a resident at risk and her employment at the facility was terminated effective immediately on 12/1/22. During an interview, on 12/21/22 at 12:41 p.m., the ED indicated LEC 3 did not follow the facility bus safety procedures while transporting a resident to an appointment on the facility bus, so she was terminated. During an interview, on 12/21/22 at 12:52 p.m., Resident B indicated he was being transported to an Orthopedic doctor's appointment in Carmel when the accident happened. He was sitting in his electric wheelchair on the facility bus. LEC 3 did not strap him in with the seatbelt or lock his wheels down with the wheel locks when they left Kokomo. She went around a sharp curve at a fast speed and hit the curb which was when he was "flung" out of his electric wheelchair onto the bus floor. He landed on his left side up against the row of seats. She immediately stopped the bus and attempted to assist him off the floor, but she was not strong enough to lift him. He attempted to lift himself up two to three times before he was successful in getting back into his wheelchair. While attempting to lift himself up, he kept falling		put into place; Executive Director or designee will report the Transportation Log audit findings to the QAPI Committee once per month x 3 months or until 100% compliance has been maintained for 3 consecutive months, and then biannually in Jan and July until the QAPI Committee deems compliance.	

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	back down onto the bus floor because he had no use of his left leg. He already had a shattered left femur, and he had no ball and socket in his left hip due to an infection he had in his left hip this past summer. He had constant left leg pain, but after he was "flung" onto the bus floor, he had increased left leg pain for a few days. On the way back to the facility, LEC 3 fasten the bus seatbelt around him, but she did not lock his wheels down with the wheel locks. During an interview, on 12/21/22 at 3:45 p.m., the ED indicated LEC 3 called him on 11/29/22 and told him she would be late getting back to the facility because there was an incident, and she would tell him about it when she got back. When she and Resident B got back, he immediately went to talk to Resident B, then he spoke to LEC 3. He told her if a resident refused to wear the seatbelt than the facility bus was not to leave wherever she was parked until the resident placed the seatbelt on. A current policy, titled "Transporting Residents," dated 6/8/19 and provided by the ED on 12/21/22 at 1:40 p.m., indicated "...policy is to ensure resident safety when transporting residents. The following policies outlines safety measures to implement when transporting residents...PROCEDURE: Ensure that wheelchairs are fastened to the floor with wheelchair brakes locked and residents strapped into their chairs...Require all occupants to wear seatbelts...Be mindful of road conditions. Reduce vehicle speed during bad weather or when traveling on roads that are unfamiliar or hard to navigate. Only qualified drivers should be behind the wheel. Special training and experience are required to operate 15 passenger vans to ensure your drivers have both...."			

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	This State tag relates to Complaint IN00396076.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on observation, interview and record	R 0119	R0119 – Personnel –	01/27/2023

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	review, the facility failed to ensure a staff member was appropriately trained to ensure resident safety prior to driving the facility bus for 1 of 1 staff member reviewed for specific job training. (Life Enrichment Coordinator 3) Finding includes: An untitled and undated typed document indicated the Executive Director (ED) spoke with Life Enrichment Coordinator (LEC) 3 regarding the facility bus incident involving Resident B. Her statement of the incident was she did not place the seatbelt on the resident going to the appointment because he refused to have it on. On the way back from the appointment she placed the seatbelt on him, but she did not put the wheel locks in place. A document, titled "Termination Notice," dated 12/1/22 and provided by the DON (Director of Nursing) on 12/21/22 at 4:08 p.m., indicated LEC 3 was transporting a resident on the facility bus to an appointment out of town on 11/29/22. The resident used a wheelchair, and she did not strap him into the facility bus appropriately, resulting in him being jolted and falling out of his wheelchair when she hit a curb. During the trip back to the facility, she did not strap him into the bus appropriately, nor did she ensure his wheelchair was locked with the wheel locks. LEC 3 had the responsibility to ensure all residents were safe when transporting them on the bus. She was to ensure the residents were appropriately restrained for their own safety. She placed this resident at risk for both legs of the trip and it could have resulted in a serious injury. Due to her actions, she placed a resident at risk and her employment at the facility was terminated effective immediately on 12/1/22.		non-compliance What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Life Enrichment Coordinator: No longer employed by the Community 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 current residents residing at Silver Birch of Kokomo have the potential to be affected by the alleged deficient practice. As a means of quality assurance personnel records of all staff that drive the Community bus have been audited to ensure the training to drive the bus was completed. All personnel who drive the community bus will be re-educated on company policy on residents' safety while riding the bus. The re-education will be provided by the Environmental Services Manager. All training records will be obtained by Executive Director or designee and will be placed in in the employee personnel files. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff that drive the bus personnel records will be audited	

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	A document, titled "Job Description: Resident Enrichment Coordinator," dated 9/18 and provided by the DON on 12/21/22 at 4:08 p.m., indicated "POSITION SUMMARY...Facilitating transportation to appointments and events...Experience and Qualifications...team members who drive...vehicles must review and sign the Driver job description and be able to perform functions for safety...." This document was signed by LEC 3 on 5/9/22. A Driver job description was not located in the employee file. A PowerPoint document reviewed from in LEC 3's employee file, titled "Driver Training Program," undated and provided by the DON on 12/21/22 at 4:08 p.m., indicated "...How to secure a wheelchair: For the wheelchair: 1. Find a solid welded frame member on the wheelchair to attach the hook of the retractor. 2. Take a direct path with the belts, avoiding any crossing or twisting of the belts. 3. Try to achieve a 45-degree angle from the retractor to the attachment point of the chair. For the occupant: 1. Ensure that the lap belt component is actually resting on the wheelchair occupant's pelvis and the shoulder belt is actually resting on his or her shoulder. 2. Ensure that the belts are not held away from the occupant's body by any component of the wheelchair frame. 3. The red release buckle should be right against the occupant's hip on the aisle side. A document, titled "Driving Test," undated and provided by the DON on 12/21/22 at 4:08 p.m., indicated the form had skills checkoffs for "PRIOR TO LEAVING THE PARKING SPOT" and "DRIVING" sections. There was a "Yes" and "No" line for each skill under each section to		for training documents one x per month x 3 months and then biannually in Jan and July by the Business Office Manager or designee. Any findings will be addressed at the time of discovery. 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 Business Office Manager or designee will report audit findings to the QAPI Committee monthly x 3 or until 100% compliance is reached for 3 consecutive months, and then biannually in Jan and July until the QAPI committee deems compliance.	

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	check off whether LEC 3 completed the skill successfully or not. All the skills were checked "Yes" except 2. "Wheelchair secured correctly." "Yes" or "No" was not checked. LEC 3 signed and dated the form on 7/23/21 and the Maintenance Director signed and dated the form on 8/5/21. During an interview, on 12/21/22 at 12:41 p.m., the ED indicated LEC (Life Enrichment Coordinator) 3 did not follow the facility bus safety procedures while transporting a resident to an appointment on the facility bus, so she was terminated. During an interview, on 12/21/22 at 12:52 p.m., Resident B indicated he was being transported to an Orthopedic doctor's appointment in Carmel when the accident happened. He was sitting in his electric wheelchair on the facility bus. LEC 3 did not strap him in with the seatbelt or lock his wheels down with the wheel locks when they left Kokomo. She went around a sharp curve at a fast speed and hit the curb which was when he was "flung" out of his electric wheelchair onto the bus floor. On the way back to the facility, LEC 3 fasten the bus seatbelt around him, but she did not lock his wheels down with the wheel locks. During an interview, on 12/21/22 at 3:45 p.m., the ED indicated LEC 3 called him on 11/29/22 and told him she would be late getting back to the facility because there was an incident, and she would tell him about it when she got back. When she and Resident B got back, he immediately went to talk to Resident B, then he spoke to LEC 3. He told her if a resident refused to wear the seatbelt than the facility bus was not to leave wherever she was parked until the resident placed the seatbelt on. During an interview, on 12/21/22 at 4:15 p.m., the			

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	ED and Human Resources Manager was in attendance. The ED indicated they could not find LEC 3's signed Driver's job description in her employee file. A current policy, titled "Transporting Residents," dated 6/8/19 and provided by the ED on 12/21/22 at 1:40 p.m., indicated "POLICY...to ensure resident safety when transporting residents. The following policies outlines safety measures to implement when transporting residents...PROCEDURE: Ensure that wheelchairs are fastened to the floor with wheelchair brakes locked and residents strapped into their chairs...Require all occupants to wear seatbelts...Be mindful of read conditions. Reduce vehicle speed during bad weather or when traveling on roads that are unfamiliar or hard to navigate. Only qualified drivers should be behind the wheel. Special training and experience are required to operate 15 passenger vans to ensure your drivers have both." This State tag relates to Complaint IN00396076.			