STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGBY PLACE	167 CR W 240 S, LAFAYETTE, , 47905

(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 the Investigation of Complaint IN00357263. Complaint IN00357263 - Substantiated. State deficiency related to the allegations is cited at R0052. Survey date: July 16, 2021 Facility number: 004392 Residential Census: 33 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 19, 2021.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	**R 052** **Residents' Rights - Offense**	08/15/2021

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on record review and interview, the facility failed to ensure residents were free from abuse, related to allegations from the residents in regards to treatment from a staff member during care, for 3 of 3 residents reviewed for abuse. (Residents B, C, and D)

Finding includes:

During an interview, on 7/16/21 at 9:00 a.m., Resident B indicated Employee 1 "tried to show her authority" and had yelled at him.

A review of a Reported Incident to the Indiana Department of Health (IDOH), dated 5/19/21, indicated an abuse allegation occurred on 5/28/21 at 7:30 p.m., which involved Resident C and Employee 1. Resident C reported Employee 1 had been "mean" to him on the prior shift while he was being assisted into a chair. He indicated he was afraid of Employee 1.

A written statement from

1.
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Effective 7/22/2021, Employee 1's employment was terminated. Residents B, C, and D were interviewed by the Care Services Manager on 7/27/2021 Manager to ensure resident rights were upheld and residents were free from sexual abuse; physical abuse; mental abuse; corporal punishment; neglect; and involuntary seclusion. No concerns identified.

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:

Interviews with current interview-able (without cognitive deficit) residents were

	Employee 4 and interview of Resident C, dated 5/19/21 at 4:30 a.m., indicated, the resident voiced to her Employee 1 had been "extremely mean" to him when she assisted him to bed "...he said he was afraid of her...." A statement was obtained by the Director of Nursing (DON) from Resident C on 5/19/21, no time documented, and indicated Employee 1 had yelled at him while care was provided and she had "balled up" her fist like she was going to hit him. She had not hit him. Resident C indicated he was afraid of Employee 1. A statement was obtained by the Executive Director from Resident C on 5/19/21 at 12:15 p.m., and indicated when Employee 1 had assisted him to bed, she raised her fists to him like she was going to hit him. A statement, dated 5/18/21 at 12:30 p.m., reflected Employee 1 indicated she and Employee 2 were in Resident C's room together. Resident C was upset and while they assisted him into the chair, he was giving them, "a hard time". Employee 1 indicated she had not been in the room alone while he was being assisted. A statement, dated 5/19/21 at 7:30 p.m., reflected Employee 2		conducted on 7/26/2021 and 07/27/2021 by the Care Services Manager to ensure resident rights were upheld and residents were free from sexual abuse; physical abuse; mental abuse; corporal punishment; neglect; and involuntary seclusion. No concerns identified through interviews. **3 What measure 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 and Care Services Manager were re-educated on 07/16/2021 by the Regional Director of Care Services (“RDCS”) on the abuse policy and resident rights.Current Staff were re-educated on 07/21/2021 by the Executive Director on resident rights and the abuse policy. The Executive Director or designee reviewed resident rights and the abuse policy during the resident council meeting on 07/21/21. **4 How the corrective action(s)**	

	indicated Resident C and Employee 1 "do not get along". Resident C would be in a good mood, then if Employee 1 comes in, he would get mad. Employee 2 indicated she had left the room briefly to obtain trash bags. She had not witnessed Employee 1 raising her fists, though she had been out of the room momentarily. A statement, dated 5/19/21, no time documented and obtained from Resident B by the DON, indicated Employee 1 yelled at him and would slam his food down on the table at times when she served him. A statement, dated 5/19/21 at 12:30 p.m., obtained from Resident C by the DON, indicated Employee 1 had "always" been mean to him. She would yell at him, and treated him roughly while she assisted him off the toilet. A written statement from Employee 3, dated 5/19/21 at 3:15 p.m., indicated Employee 1 had been mean and hateful to residents. Resident D had yelled as Employee 1 left his room. When asked, the resident indicated he had been incontinent. Employee 1 had informed Employee 3 she had not provided care for the resident when she had been in the room. Resident B had indicated to her Employee 1		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED or designee will interview 3 residents and 2 staff members to ensure resident rights are upheld and residents are free from sexual abuse; physical abuse; mental abuse; corporal punishment; neglect; and involuntary seclusion weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going **5 By what date the systemic changes will be completed** Completion date: 08/15/2021	

was hateful to him and they had been in "a screaming match", in the Dining Room.

1. Resident B's record was reviewed on 7/16/21 at 11:31 a.m. The diagnoses included, but were not limited to, diabetes mellitus.

A Service Plan, dated 12/28/20, indicated there was no cognitive impairment.

2. Resident C's record was reviewed on 7/16/21 at 9:59 a.m. The diagnoses included, but were not limited to, dementia.

A Service Plan, dated 1/26/21, indicated he had trouble recalling the day, date, and time.

3. Resident D's record was reviewed on 7/16/21 at 10:38 a.m. The diagnoses included, but were not limited to, diabetes mellitus.

A Service Plan, dated 1/5/21, indicated there was no cognitive impairment.

During an interview, on 7/16/21 at 10:38 a.m., the Executive Director indicated The Corporate Office had been consulted about the incident and Employee 1 had then been given a "Final Written Warning" discipline on 5/20/21.

During an interview, on 7/16/21 at 12:58 p.m., the Executive Director indicated a five day follow up to the IDOH had not been completed.

A facility policy, titled "Abuse, Neglect and Exploitation," dated 9/1/16 and received from the Executive Director as current, indicated residents would be protected from physical, mental, financial, sexual, and verbal abuse or neglect. Abuse was defined as a willful action or inaction that included intimidation which resulted in mental anguish. Mental abuse was defined as willful action or inaction which included verbal assault that included ridiculing, intimidation, yelling, or swearing.

This Residential tag relates to Complaint IN00357263.

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A statement, dated 5/19/21 at 7:30 p.m., reflected Employee 2 indicated Resident C and Employee 1 "do not get along". Resident C would be in a good mood, then if Employee 1 comes in, he would get mad. Employee 2 indicated she had left the room briefly to obtain trash bags. She had not witnessed Employee 1 raising her fists, though she had been out of the room momentarily.

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	assault that included ridiculing, intimidation, yelling, or swearing. This Residential tag relates to Complaint IN00357263.			

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 SIGNATURE	TITLE	(X6) DATE