| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 08/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SILVER BIRCH OF EVANSVILLE | 475 S GOVERNOR STREET, EVANSVILLE, , 47713 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00359307.<br><br>Complaint IN00359307 - Substantiated. State deficiencies related to the allegations are cited at R0053.<br><br>Survey date: August 5, 2021<br><br>Facility number: 014238<br><br>Residential Census: 96<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on August 10, 2021. | R 0000 | | |
| R 0053 | Residents' Rights - Deficiency<br><br>410 IAC 16.2-5-1.2(w)<br><br>(w) Residents have the right to be free from verbal abuse. | R 0053 | The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory | 09/20/2021 |

Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. A staff member verbally abused a resident and it was not immediately reported to the Administrator. (Resident F)

Findings include:

On 8/5/21 at 10:55 A.M., the clinical record of Resident F was reviewed. Diagnoses included, but were not limited to, COPD with acute exacerbation.

A Level of Service assessment, dated 5/14/21, indicated Resident F had no memory impairment.

On 8/5/21 at 11:45 A.M., Resident F was interviewed. Resident F was sitting in a chair with oxygen on. Resident F indicated a staff member "got hateful" with her the previous night. QMA 3 was trying to transfer her to a portable oxygen tank, and the resident was trying to help her. QMA 3 told the resident to shut up, and said "If you can talk, you can breathe." Resident F indicated QMA 3 told her she was busy, but the resident did not feel that the staff member should have spoken to her that way. Resident F indicated she informed CNA 5 last evening,

requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC.

**R 053 Resident's Rights - Offense**

**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**

Resident F has remained free of harm. Resident F is comfortable reporting concerns to Social Worker or DONW or ED. The staff member identifiedwas immediately placed on Administrative Leave upon acknowledge of incident.

**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 Social Worker, DONW and Executive Director will conduct interviews with Alert and Oriented Residents of the Community to determine**

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| | and then told CNA 2 about the incident this morning.<br><br>During a confidential interview, a staff member indicated she had heard from another staff member that QMA 3 told Resident F to "shut up" during the previous evening. The staff member indicated the incident had been reported.<br><br>On 8/5/21 at 11:20 A.M., RN 1 was interviewed. RN 1 indicated she started work at approximately 8:00 A.M. on 8/5/21. CNA 2 reported to her and LPN 2 that Resident F had reported to her an incident this morning. QMA 3 was exchanging the oxygen tanks, and told the resident, "If you just shut up for a minute and let me think." RN 1 indicated she thought she was notified at approximately 8:15 A.M., and left the office to speak to the resident. LPN 2 at that time was calling the Director of Nursing (DON). RN 1 indicated the resident told her she didn't feel unsafe, but thought QMA 3 was being mean.<br><br>On 8/5/21 at 11:35 A.M., LPN 2 was interviewed. LPN 2 indicated she came in at 8:00 A.M. on 8/5/21. At around 8:20 A.M., CNA 2 came into the office and told us Resident F complained about QMA 3 telling her to shut up the previous evening. At about that same | | **Residents feel safe and know who to inform if an incident occurs.**<br><br>**<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u>**<br><br>**Resident Rights and Abuse inservice completed by the DONW and designated Nurses with Staff of Community. Resident education for reporting fear, abuse or concerns was provided by Social Worker, DONW and Executive Director at time of Community interviews.**<br><br>**<u>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality</u>** | |

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| | time, the DON walked in and was told that "QMA 3 was ugly last night while changing the oxygen over."<br><br>During an interview on 8/5/21 11:12 a.m. with the Administrator and Director of Nursing (DON), they indicated Resident F reported to RN 1, a day shift nurse, this morning that QMA 3 told her to, " shut up and give her a minute," last night. The Administrator indicated it was a high stress situation where they were sending out a resident, waiting on an ambulance and orders, and the resident was trying to talk to the CNA. QMA 3 told the resident it was not her, it was just a stressful situation. A CNA from night shift told the day shift that Resident F and QMA 3," got into it last night." The DON indicated she was informed this morning around 8:30 a.m. of the incident. The Administrator was not informed until 11 a.m. this morning. An investigation was being started. The Administrator and DON were going to speak with Resident F now, but per the nurse on the unit currently, Resident F did not have any psychosocial harm.<br><br>During an interview on 8/5/21 at 11:39 a.m., the Administrator and DON indicated they had just spoken with Resident F. She indicated she requested assistance to the bathroom from | | **<u>assurance program will be put into place;</u>**<br><br>**Executive Director or designee will meet with 3 residents weekly x 4 weeks and ask them questions regarding their feelings of safety and well being. Concerns will be addressed immediately upon being voiced by the Executive Director or Designee.**<br><br>**<u>What date the systemic changes will be completed</u>**<br>**9/20/21** | |

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During an interview on 8/5/21 at 11:48 a.m., CNA 2 indicated she was contacted by Resident F on her work cell phone at 9:11 a.m. this morning. Resident F requested she come to her room. Upon entering, Resident F stated she was glad she was there. She had a look on her face that made her think something was wrong, so she asked what was wrong. Resident F would not say at first. She then told CNA 2 that she had a rough night due to an incident with a staff member. She told CNA 2 the staff member was QMA 3. They " got into it." Resident F asked QMA 3 to change out her oxygen tank, and told her she needed her portable oxygen, but QMA 3 told her to wait. Resident F told her she needed it, and QMA 3 told her to " shut up, if she could talk, she could breathe." CNA 2 reported to RN 1 and LPN 2, the day shift nurses. The DON was not yet in the facility. The Administrator and DON were not notified since they were not in the facility. Resident F indicated to CNA 2 that she didn't report it last night because she didn't feel safe.

During an interview on 8/5/21 at 12:01 p.m., the Administrator indicated staff did not alert administration at the time of the incident, as per policy.

During a phone interview on

8/5/21 at 1:35 p.m., CNA 5 indicated Resident F reported to her last night around 7-8 p.m. that QMA 3 told her to, " shut her mouth, " and she was rude when she asked for assistance. CNA 5 did not report the incident to a nurse or other supervisor, as no nurse was in the facility at the time. She indicated QMA 3 spoke with her after the incident and said she went into Resident F's room to assist her, but Resident F told her she did not know what she was doing. She did not mention the verbal altercation with the resident.

During a review of the current policy, " Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated 12/10/18, provided by the Administrator on 8/5/21 at 9:43 a.m., indicated, " Residents have the right to be free from physical, verbal, sexual, mental abuse, misappropriation of property, corporal punishment, and involuntary seclusion...Verbal abuse includes the use of oral, written or gestured language that willfully includes disparaging, and derogatory terms to resident or their families...saying things that frighten a resident...The community identifies the staff member responsible for the initial reporting, investigation of alleged violations and reporting

of results to proper authorities...The Health and Wellness Director will talk to the resident and ensure the resident feels safe from harm..."

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During an interview on 8/5/21 at 11:39 a.m., the Administrator and DON indicated they had just spoken with Resident F. She indicated she requested assistance to the bathroom from QMA 3 because she was feeling lightheaded. Resident F noticed she did not have her oxygen on and asked QMA 3 to get her portable oxygen tank and turn it on. QMA 3 then told her if she could talk, she was breathing, to reassure her. Resident F said she kept telling QMA 3 she couldn't breathe and needed her oxygen, and QMA 3 told her she, " just needed to shut up." She then went to find CNA 5 for help, but she was unavailable. She had an oxygen concentrator in room, but the cup for water on the concentrator was cracked. Resident F called the repairman herself, and he came in until 10 a.m. to repair her concentrator. Resident F said QMA 3 was hateful to her. The RN 1 and LPN 2 were made aware of the incident at 8:15 a.m. this morning. Resident F said she was comfortable and felt secure in the facility and would allow QMA 3 to care for her again.

The DON was made aware of the incident upon arrival to the facility around 8:40 a.m. during morning report. The Administrator indicated staff should have immediately contacted her to report the incident when it occurred, and the DON should have reported immediately this morning to the Administrator when she was made aware, so an investigation could have been initiated.

During an interview on 8/5/21 at 11:48 a.m., CNA 2 indicated she was contacted by Resident F on her work cell phone at 9:11 a.m. this morning. Resident F requested she come to her room. Upon entering, Resident F stated she was glad she was there. She had a look on her face that made her think something was wrong, so she asked what was wrong. Resident F would not say at first. She then told CNA 2 that she had a rough night due to an incident with a staff member. She told CNA 2 the staff member was QMA 3. They " got into it." Resident F asked QMA 3 to change out her oxygen tank, and told her she needed her portable oxygen, but QMA 3 told her to wait. Resident F told her she needed it, and QMA 3 told her to " shut up, if she could talk, she could breathe." CNA 2 reported to RN 1 and LPN 2, the day shift nurses. The DON was not yet in the facility. The

Administrator and DON were not notified since they were not in the facility. Resident F indicated to CNA 2 that she didn't report it last night because she didn't feel safe.

During an interview on 8/5/21 at 12:01 p.m., the Administrator indicated staff did not alert administration at the time of the incident, as per policy.

During a phone interview on 8/5/21 at 1:35 p.m., CNA 5 indicated Resident F reported to her last night around 7-8 p.m. that QMA 3 told her to, " shut her mouth, " and she was rude when she asked for assistance. CNA 5 did not report the incident to a nurse or other supervisor, as no nurse was in the facility at the time. She indicated QMA 3 spoke with her after the incident and said she went into Resident F's room to assist her, but Resident F told her she did not know what she was doing. She did not mention the verbal altercation with the resident.

During a review of the current policy, " Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure," dated 12/10/18, provided by the Administrator on 8/5/21 at 9:43 a.m., indicated, " Residents have the right to be free from physical, verbal, sexual, mental abuse,

misappropriation of property, corporal punishment, and involuntary seclusion...Verbal abuse includes the use of oral, written or gestured language that willfully includes disparaging, and derogatory terms to resident or their families...saying things that frighten a resident...The community identifies the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to proper authorities...The Health and Wellness Director will talk to the resident and ensure the resident feels safe from harm..."

During a review of the current policy, " Incident Reporting Policy," dated 2/1/20, provided by the Administrator on 8/5/21 at 12:01 p.m., indicated, " ...report incidents and unusual occurrences as prescribed by federal , state and local regulations. Any member of the staff with knowledge or an incident/event should immediately report the incident/event to their immediate supervisor; who is then responsible for immediately reporting to the Executive Director. The Executive Director and Director of Nursing have the responsibility to make prompt reports of all reportable incidents to one, two or three of the appropriate agencies, as described in this policy...will

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| | suspend from duty any staff suspected, alleged or involved in participating in incidents of abuse, neglect, or exploitation of a resident, pending investigation of the incident."<br><br>This Residential tag relates to Complaint IN00359307. | | | |

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 |
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