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	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF MICHIGAN CITY	4400 EAST MICHIGAN BLVD MICHIGAN CITY, IN 46360

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387913 and IN00391960. Complaint IN00387913 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00391960 - Substantiated. State deficiency related to the allegations is cited at R0090. Survey date: October 20, 2022 Facility number: 014052 Residential Census: 121 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/21/22.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:			

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

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	(A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not reporting abuse allegations to the Indiana Department of Health (IDOH) for 1 of 1 resident reviewed for abuse. (Resident B)	R 0090	**R090 Administration & Management – Deficiency** **What corrective action will be accomplished for those residents found to have been**	11/17/2022

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	Finding includes: Resident B's record was reviewed on 10/20/22 at 12:09 p.m. The diagnoses included, but were not limited to spinal stenosis. A facility grievance, dated 9/19/22, indicated Resident B had a concern related to how a staff member had spoken to her (Employee 1). The facility initiated an investigation into the concern. An undated hand-written and signed statement from Employee 2 indicated the resident was had been standing in the doorway to the kitchen and was conversing with Employee 3. Employee 1 then walked in between the resident and Employee 3 without saying anything to them. The resident's dog entered the doorway of the kitchen and Employee 3 began to talk about the dog being in the doorway. The resident heard Employee 1 and an argument began between the resident and Employee 1. A signed statement from Employee 3, dated 9/19/22, indicated she and the resident had been talking and she was obtaining a few cans of ginger ale for the resident.. Employee 1 then walked between them without saying anything. The resident's dog then entered the kitchen doorway and the resident had called the dog to stop it from entering the kitchen further. Employee 1 then screamed the dog was in the kitchen and was told to stop screaming. A signed statement from Employee 4, dated 9/19/22, indicated when she had spoke to Employee 3, it was reported the resident and Employee 1 were yelling at each other and the resident was asked to stop arguing. Employee 1		**affected by the deficient practice;** Resident B continues to reside at the community. Any concerns expressed by Resident B will be addressed and / or investigated by the Executive Director or designee and reported to IDOH as appropriate. **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 residents residing at Silver Birch of Michigan City have the potential to be affected by the alleged deficient practice. Employee 1 was re-educated on appropriate conduct when addressing a resident. Executive Director was educated on the need to report any allegation to IDOH prior to starting the investigation, then completing the investigation and finalizing the report to IDOH with any findings and or resolution. Education included Abuse and Neglect and Incident policies, the Grievance policy and log, and was provided by the Senior Advisor of Clinical Services for Silver Birch Living. All Staff were in-serviced on Abuse and Neglect and Incident Policies, including reporting allegations to the Executive Director or designee immediately.	

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	was asked to stop yelling and arguing with the resident. A signed statement from Employee 1, dated 9/21/22, indicated she had informed the resident the dog was not allowed in the dining room and needed to be on a leash. She had walked in the kitchen, turned around and saw the dog right inside the kitchen door and informed the resident the dog was not allowed in the kitchen. The resident had started yelling at Employee 1. During an interview on 10/20/22 at 11:45 a.m., the Administrator indicated the incident had not been reported to the IDOH, as through the investigation, the facility was unable to substantiate abuse. The grievance attachment indicated a letter to the facility had been received from the resident on 10/3/22, which indicated the resident had made an allegation of verbal, mental, and emotional abuse. During an interview on 10/20/22 at 4 p.m., the Administrator indicated the allegation on 10/3/22 had not been reported to the IDOH. She indicated the letter from the resident was the first time an allegation of abuse had been voiced by the resident. A facility abuse policy, dated 2/1/20, and received as current from the Administrator, indicated the facility would investigate all alleged violations and report results to the proper authorities, including the IDOH, Division of Aging, and Adult Protective Services. This state residential finding relates to Complaint IN00391960.		Education was provided by Senior Advisor of Clinical Services for Silver Birch Living. **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 or designee will utilize the grievance log to track reports of concerns, grievances, or allegations from residents and the proper reporting and investigations no less than 5 times weekly for 4 months, then weekly for 4 months, then monthly ongoing. 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 Executive Director or designee will review the grievance log for trends and report findings to the Quality Assurance Committee monthly until 100% compliance has been met for 3 consecutive months, then quarterly ongoing or until the QA Committee determines compliance has been met. **What date the systemic changes will be completed:**	

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