

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182869 and Complaint IN00183716.</p> <p>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00182869 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Complaint IN00183716 -- Unsubstantiated due to lack of evidence.</p> <p>Survey date: October 1 and 2, 2015 Partially Extended Survey date: October 6, 7 and 8, 2015</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Census bed type: SNF/NF: 134 Total: 134</p> <p>Census payor type: Medicare: 16 Medicaid: 78</p>	F 0000	Preparation and submission of this Plan of Correction does not constitute the admission or agreement by the Provider to the truth of the "findings" alleged or conclusions set forth in the Statement of Deficiencies (CMS-2567). The Plan of Correction is prepared, executed and submitted solely because it is required by the provisions of federal and state law. The Provider is requesting independent informal dispute resolution with respect to the findings and allegations under F-223, F-225, and F-226. The Provider formally requests a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0223 SS=J Bldg. 00	<p>Other: 40 Total: 134</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on October 13, 2015</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure sexual abuse by a staff member did not occur towards 3 of 6 residents reviewed for sexual abuse resulting in mental anguish. (Resident #B, #C and #D)</p> <p>The Immediate Jeopardy began on the evening of 9-18-15 when Resident #B indicated she had been touched</p>	F 0223	<p>I. The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed and certified skilled nursing facility. On Saturday 9/19/15, at approximately 7:15 p.m., a Facility representative (CNA #1) was initially informed by Resident #B of an alleged incident that had occurred on or about 9/19/15.</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>inappropriately in the chest area and CNA #2 exposed his penis to her. The Executive Director, the Director of Nursing and District Director of Clinical Operations were notified of the Immediate Jeopardy on 10-6-15 at 1:45 p.m. The Immediate Jeopardy was removed on 9-21-15 at 4:00 p.m., when CNA #2 was terminated from the facility and told never to return to the facility, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>On 9-19-15 at 10:48 p.m., the facility emailed an initial report regarding an allegation of sexual abuse of a female resident by CNA #2 to the Indiana State Department of Health (ISDH), Long Term Care Division. It indicated on the evening of 9-19-15 at approximately 7:15 p.m., Resident #B indicated to CNA #1 that on 9-17-15 or 9-18-15, CNA #2, a male employee, had asked her if she was ready. Resident #B indicated she assumed he was referring to getting ready for bed. She continued, that CNA #2 then inappropriately touched her breasts while getting her undressed and then proceeded to expose his penis to her. She</p>		<p>CNA #1 promptly reported the allegation to LPN #3, who promptly reported the alleged incident to the Executive Director (as well as other senior clinical representatives and the Resident's family) for the Facility. The allegation related to actions by CNA #2, who was not working on that day and who had recently submitted a two-week notice of termination of employment to be effective in two weeks. Resident #B was interviewed by Facility staff regarding the alleged incident. When questioned as to why she did not report the incident previously, Resident #B, who is alert and oriented, stated, "I don't know." The Facility also notified the daughter of Resident #B, who also questioned Resident #B about the incident. The daughter of Resident #B received the same response regarding Resident #B's delay in reporting the incident. Promptly following the report by Resident #B, the treating physician and family members were notified. Initial orders were received for labs, urinalysis, and review of any new medications. On the morning of 9/20/15 the Facility began interviews of all alert and oriented female residents, while performing head-to-toe skin assessments of all non-alert and oriented female residents on all units of the Facility where CNA #2 had been scheduled since CNA #2 began employment at the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>indicated CNA #2 then asked her to touch his penis. She indicated she yelled, "No," at least twice. The report indicated CNA #2 then briefly laid on top of her, but no sexual intercourse took place.</p> <p>In a written timeline provided by the Executive Director (ED) on 10-2-15 at 9:20 a.m., and an updated timeline provided by the Corporate Nurse on 10-6-15 at 4:59 p.m., the timeline indicated the following information: -9-17-15 at 1:00 p.m. CNA #2 submitted a two week notification of resignation as a full time employee as he had secured a position elsewhere. He requested to become a "PRN" (as needed) staff member. CNA #2 worked on the long term care portion of the facility at that time. It indicated he was scheduled to work on 9- 17-15 and 9-18-15, then return to work until 9-21-15. -9-19-15 at 7:15 p.m. CNA #1 informed LPN #3 that Resident #B had made an abuse allegation. LPN #3 interviewed Resident #B in regards to the sexual abuse involving CNA #2. -9-19-15 at 7:35 p.m. LPN #3 notified the ED, Director of Nursing Services (DNS), the attending physician and the resident's family of the abuse allegation. -9-19-15 at 8:00 p.m. ED interviewed LPN #3 and CNA #1. -9-19-15 at 10:48 p.m. ED submitted</p>		<p>Facility (start date of 7/28/15). Those interviews resulted in a determination that one additional female resident (Resident #C) may have been involved in an incident with CNA #2. The treating physician and family members for Residents #C and #D were notified. Local law enforcement was notified of the incidents. Additional interviews were then conducted with male residents. When interviewed by Social Service representatives, Resident #D stated that he had been involved in certain interactions with CNA #2. Interviews were conducted with all alert and oriented male residents, and head-to-toe skin assessments were conducted on all male residents that were not alert and oriented. No other concerns or allegations were discovered. Counseling services were provided for each of the 3 affected residents. Social Services continued to meet on a daily basis with each resident at the Facility to address any psychosocial concerns that might arise. None of the three residents, nor any other residents at the Facility, expressed any new or related psychosocial issues. None of the three affected residents raised any fear or concern with respect to reporting allegations, nor did they express concerns of any sort relating to any other staff member at the Facility. All three residents stated</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>abuse allegation report to ISDH.</p> <p>-9-20-15 (all day) Investigation conducted which included interviews with all alert and oriented female residents on the long term care unit regarding abuse. For non-alert and oriented females on the long term care unit, head to toe skin assessments were conducted. All residents on the transitional care unit were interviewed regarding abuse, as all were alert and oriented. Findings indicated another female resident, Resident #C, expressed a similar experience in which a male staff member had exposed his penis to her. Resident #B was able to identify the staff member by name. Resident #C was able to describe the male staff member. The investigation indicated each resident had been interviewed multiple times with their interviews being consistent in details. Notifications were attempted to the family of Resident #C. The facility's administrative team met to review their investigational results and substantiated the sexual abuse allegation. CNA #2 was notified of suspension, pending results of the facility's investigation. Arrangements were made for CNA #2 to come into the facility the following day for an interview. Local police department was notified of the abuse investigation.</p> <p>-9-21-15 (all day) Staff interviews were conducted by management staff regarding</p>		<p>that they felt comfortable and knowledgeable about reporting any activities or concerns with respect to verbal, sexual, physical, or mental abuse. The initial report regarding the incident was submitted to ISDH at 10:48 p.m. on 9/19/15. The Facility SDC attempted to contact CNA #2 on several occasions during the evening of 9/19/15 in order to notify CNA #2 that he was suspended pending further investigation. Those contact attempts continued through the morning of 9/20/15 until CNA #2 was contacted at 2:30p.m. on 9/20/15. CNA #2 was informed that he was suspended pending the investigation, and that he should come to the Facility for purposes of interviews with the Executive Director and police on 9/21/15. The Executive Director for the Facility contacted the local police department, and he spoke with police officers that came to the Facility on the afternoon of 9/20/15. Following further investigation, including meetings with CNA #2, the Facility terminated CNA #2's employment on 9/21/15. II. All residents have the potential to be affected by the alleged action, and the Facility took immediate steps in order to determine whether any such incidents may have occurred, whether by CNA #2 or otherwise. All alert and oriented residents (both female and male) were interviewed, and all</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the incident and included staff education regarding abuse policies. Resident #D was interviewed and identified as having a similar incident as Resident #B and #C. Interview with Resident #D indicated he and the alleged suspect had touched each other's penis, with nothing beyond that. The Medical Director, and attending physician for each of the three residents, was notified of the incidents. The POA/guardians of Resident #C and #D were notified of the allegations. Interviews were conducted with all alert and oriented male residents on the long term care unit regarding abuse. For non-alert and oriented males on the long term care unit, head to toe skin assessments were conducted. Interview conducted with CNA #2 by ED, DNS and two local police department's detectives. CNA #2 did not confess to any of the sexual abuse allegations. CNA #2 was notified his employment was immediately terminated and was not to enter onto facility property, not to communicate with any staff or residents. The ED filed "Report of Reasonable Suspicion of a Crime Against a Resident." 9-22-15 (all day) Continued staff interviews were conducted by management staff regarding the incident and included staff education regarding abuse policies. Continued</p>		<p>non-alert or oriented residents (both female and male) received head-to-toe skin assessments. It was discovered that two other residents had recently experienced incidents with CNA #2 during his period of employment at the Facility. CNA #2's employment file was reviewed, and all pertinent documentation reflected complete background checks and reference checks without any concerns noted. None of the residents indicated any concerns or inhibitions regarding reporting concerns with respect to any staff member at the Facility, and all expressed comfort in their ability to report any suspected acts of abuse. The Executive Director notified local law enforcement, which assumed responsibility for a thorough investigation of the allegations. The Executive Director also filed a "Consumer Complaint" with the Indiana Attorney General's Office, which immediately suspended CNA #2's certification. Further, all staff at the Facility were interviewed as to any knowledge of any of the events or any activity relating to CNA #2, and no staff expressed any prior knowledge of the alleged incidents or of any behavior raising concerns by CNA #2. All staff were also questioned in regards to the types of abuse and the steps to take if it is ever witnessed or suspected, or if it is ever reported to a staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>communication with families of the involved residents and with the local police department's detective. Counseling services met with each of the residents involved. ED filed a "Consumer Complaint" with the State Attorney General's office regarding incident and licensure of CNA #2. Follow up report emailed to ISDH. The Performance Improvement Committee met to review allegations of abuse. Care plans for the 3 affected residents were updated by 9-24-15 to reflect the potential for psychosocial distress. Education regarding abuse/abuse prohibition and reporting was provided to alert and oriented residents during a Resident's Council Meeting on 10-7-15. Additional written education on the same topic was distributed to all alert and oriented residents, as well as the family members of all residents.</p> <p>A. In an interview with Resident #B on 10-1-15 at 2:15 p.m., she indicated she had received care from CNA #2 previously with no concerns. She indicated the event of "several weeks ago," was the first time any staff member had been inappropriate with her. She indicated the male staff member asked her if she was ready and she assumed he was referring to getting ready for bed for the evening. She indicated he</p>		<p>member by a resident. All interviews confirmed that the staff was knowledgeable in the types of abuse that may be present in a longterm care facility, and the steps to take if an allegation of abuse is witnessed or reported to them by a resident. The Facility scheduled an ad hoc Resident Council meeting and invited as many alert and oriented residents to attend as possible. During the meeting, the Executive Director spoke to the residents about the types of abuse and how to report any occurrence. All of the attendees at the Resident Council meeting indicated that they were aware of the types of abuse that can occur and how to report it and to whom. Additional written education on the same topic was distributed to all alert and oriented residents, as well as the family members of all residents. All newly admitted residents and the family members of such new residents will receive a copy of this written education material, along with any other materials that are already provided upon admission. Additional abuse training was held on 10/5/15 at an all-staff meeting. III. In addition to the interviews, counseling and other activities described, the Facility will interview at least ten alert and oriented residents on a monthly basis utilizing the abuse and resident rights questions as written in the Abaqis Resident Interview. The Facility</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>inappropriately touched "my chest [breasts]." She indicated he also exposed his penis to her.</p> <p>In a phone interview with LPN #3 on 10-2-15 at 2:38 p.m., she indicated on the evening in question, CNA #1 told her she needed to talk with Resident #B. She indicated CNA #2 had "pulled it out and then she clarified [meant] penis." LPN #3 indicated the resident "told me the whole story, including [CNA #2] laying on top of her, but said they didn't have sex." LPN #3 indicated Resident #B "specifically named [name of CNA #2]." She indicated the resident was upset, but not distraught.</p> <p>Review of Resident #B's clinical record on 10-1-15 at 5:35 p.m., indicated her most recent quarterly Minimum Data Set assessment, dated 9-1-15, indicated she was cognitively intact. A Social Services note, dated 9-1-15, indicated she was cognitively intact, had normal vision and was able to understand and to be understood.</p> <p>B. In an interview with Resident #C on 10-1-15 at 2:27 p.m., she indicated an unknown male had exposed his penis to her over one month ago. She indicated she was unsure who the young, white male was or the exact date or time it</p>		<p>will also interview at least ten family members of non-alert and oriented residents utilizing the abuse and resident rights questions as written in the Abaqis Family Interview. The interviews of at least ten alert and orientated residents and ten family members will occur for six months. Auditing will happen each month over the six months to ensure that the interviews of residents and families are occurring, that the interviews are completed, and that the issues raised will be addressed. The Director of Nursing or their designee will be the responsible person. Any concerns raised during any interview will be promptly reported to the Executive Director. The licensed nurses will continue to complete weekly skin checks on the residents, and CNAs will continue to communicate any skin concerns to the licensed nurses on a daily basis. The Facility has always engaged in validation of appropriate license or certification prior to hiring an individual, as well as completing a criminal background check and reference check. Those practices will continue. The Facility staff has always been regularly educated at the time of hiring on types of abuse, abuse prevention, reporting guidelines, and resident rights. The Facility also conducts additional education for all staff on a quarterly basis on these topics.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>occurred. She indicated she yelled, "No," and he left her room and did not return.</p> <p>In review of the ISDH Reportable incident, submitted by the facility on 9-22-15, it indicated Resident #C had identified the male as CNA #2. It indicated CNA #2 "had exposed himself by pulling out his penis and asking the Resident to touch it. The Resident states she told the CNA, 'No,' and that he left her room. Resident states that there was only one incident."</p> <p>Review of Resident #C's clinical record on 10-1-15 at 5:55 p.m., indicated her most recent Minimum Data Set assessment, dated 7-21-15, indicated she was cognitively intact.</p> <p>C. In an interview with Resident #D on 10-1-15 at 2:42 p.m., he indicated he had previously had a mutual relationship with CNA #2. He indicated CNA #2 was "the one who initiated things," referring to the relationship. He indicated they only saw each other during CNA #2's work hours and were involved for a few weeks. He indicated CNA #2 was no longer employed at the facility.</p> <p>In review of the ISDH Reportable incident, submitted by the facility on 9-22-15, it indicated Resident #D had</p>		<p>Those practices will continue. The Facility requested of the Resident Council President that the topic of abuse as a standing agenda item for Resident Council meetings, and this was agreed upon and will be added as a regular agenda item. IV. The practices described above, including those practices that will be continued or enhanced going forward, were shared with and approved by the Performance Improvement Committee on 9/22/15. The Medical Director was in attendance at that meeting. The Executive Director will be responsible for the continuing practices, and will be responsible for monitoring these and other practices under this plan of correction to ensure substantial compliance with the regulatory requirements. V. The Facility contends it was always in substantial compliance with respect to its obligations under F-223. Notwithstanding that contention, and without waiving its rights, for purposes of completing this Plan of Correction and satisfying its regulatory requirements, the date by which the actions described here in will be completed is on or before 10/30/15.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>identified CNA #2 as the person he had a relationship with. He indicated this relationship included incidents in which CNA #2 had pulled his penis out and asked the resident to touch it, which he did, as well as CNA #2 touching Resident #D's penis. The report indicated Resident #D indicated "there were multiple incidents, he could not quantify or be specific with dates. The Resident claims that some of the incidents included the Resident and CNA exposing themselves, both individuals having erections and ejaculations."</p> <p>Review of Resident #D's clinical record on 10-1-15 at 6:10 p.m., indicated his most recent Minimum Data Set assessment, dated 8-17-15, indicated he was moderately cognitively impaired.</p> <p>Review of CNA #2's employee file indicated he had been employed at the facility less than 2 months at the time of the abuse allegation. It indicated his orientation period included education on Resident's Rights and Abuse Prevention. Review of the "Job Description" for "Certified Nursing Assistant," indicated CNA #2 signed this document during his orientation period. The job description indicated, "Conducts job responsibilities in accordance with the standards set out in the Company's Code of Business</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Conduct, its policies and procedures, the Corporate Compliance Agreement, applicable federal and state laws, and applicable professional standards."</p> <p>The ISDH "Nurse Aide Curriculum, revised 3-21-14, indicated, "<u>Any sexual relationship</u> with a resident is considered to be abuse."</p> <p>On 10-1-15 at 3:00 p.m., the ED provided a copy of a policy entitled, "Abuse." This policy had a "Release Date," of 7-28-14, and was identified as the current policy utilized by the facility. This policy indicated, "Verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property is strictly prohibited. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown injuries of source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey agency and certification agency). Individuals are not hired when a history of abuse is known. Retribution against patients, staff or visitors who file</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>reports is strictly prohibited."</p> <p>The Immediate Jeopardy that began on the evening of 9-18-15 was removed on 9-21-15 at 4:00 p.m., when CNA #2 was terminated from the facility and told never to return to the facility, completed their investigation, notified ISDH Long Term Care Division, notified the local police department, State Attorney General's office, completed staff inservice education and resident/family education on abuse/abuse prohibition. Post inservice interviews were conducted with staff and residents to verify understanding of what to do in the event of abuse. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy as the facility continued to provide re-education and reassurance to residents and families regarding their right to be free of abuse, knowledge of all types of abuse, procedures for reporting and protection against retaliation.</p> <p>This Federal tag relates to complaint IN00182869.</p> <p>3.1-27(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of sexual abuse by a staff member towards 3 of 6 residents reviewed for sexual abuse was reported to the Indiana State Department of Health, Long Term Care Division immediately. (Resident #B, #C and #D)</p> <p>Findings include:</p> <p>On 9-19-15 at 10:48 p.m., the facility emailed an initial report regarding an allegation of sexual abuse of a female resident by a male CNA to the Indiana State Department of Health (ISDH), Long Term Care Division. It indicated on the evening of 9-19-15 at approximately 7:15 p.m., Resident #B indicated to CNA #1 that on 9-17-15 or 9-18-15, CNA #2, a male employee, had asked her if she was ready. Resident #B indicated she assumed he was referring to getting ready for bed. She continued, that CNA #2 then inappropriately touched her breasts while getting her undressed and then proceeded to expose his penis to her. She indicated CNA #2 then asked her to touch his penis. She indicated she yelled, "No," at least twice. The report indicated CNA #2 then briefly laid on top of her, but no sexual intercourse took place.</p>	F 0225	<p>I. The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed and certified skilled nursing facility. Resident #B initially reported the alleged incident to CNA #1 at 7:15 p.m. on 9/19/15 (Saturday). CNA #1 promptly reported the alleged incident to LPN #3. At 7:35 p.m., LPN #3 notified the Facility's Executive Director, the Director of Nursing Services, the treating physician and the family of Resident #B. The Executive Director then conducted interviews of CNA #1 and LPN #3. Soon there after, the Executive Director for the Facility began preparing an initial report to ISDH, and the report was submitted to ISDH at 10:48 p.m. on 9/19/15. CNA #2 had not worked at the Facility since 9/18/15. Telephone calls were made the evening of 9/19/15 to CNA #2 to notify him of his suspension pending further investigation. The next morning (Sunday 9/20/15) the Facility proceeded with further investigations, which included the Executive Director, the Director of Nursing Services, the Unit Manager RN, the SDC RN, the Nurse Manager RN, the Unit Manager LPN, and the Social Worker. All alert and oriented female residents were interviewed. All non-alert and</p>	10/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>In a written timeline provided by the Executive Director (ED) on 10-2-15 at 9:20 a.m., and an updated timeline provided by the ED on 10-6-15 at 4:59 p.m., the timeline indicated the following information:</p> <p>-9-19-15 at 7:15 p.m. CNA #1 informed LPN #3 that Resident #B had made an abuse allegation. LPN #3 interviewed Resident #B in regards to the sexual abuse involving CNA #2.</p> <p>-9-19-15 at 7:35 p.m. LPN #3 notified the ED, Director of Nursing Services (DNS), the attending physician and the resident's family of the abuse allegation.</p> <p>-9-19-15 at 8:00 p.m. ED interviewed LPN #3 and CNA #1.</p> <p>-9-19-15 at 10:48 p.m. ED submitted the initial allegation of abuse report to ISDH.</p> <p>The local police department was notified of the abuse allegation on 9-20-15 at 4:15 p.m. The "Report of a Reasonable Suspicion of a Crime Against a Resident" was filed on 9-21-15 at 3:00 p.m.</p> <p>A follow up report was emailed to ISDH on 9-22-15 which indicated the facility's investigation identified two other residents who had been touched inappropriately by CNA #2, as well as CNA #2 exposing his penis to them. It indicated the facility's investigation was on-going.</p>		<p>oriented female residents had head-to-toe skin assessments completed. In the course of that investigation, it was determined that one other resident may have been affected by the actions of CNA#2. The local police were contacted on Sunday 9/20/15, and discussions with police officers took place that afternoon at the Facility. On 9/22/15 (Tuesday), the Executive Director for the Facility filed a "Consumer Complaint" with the Indiana Attorney General's Office, which promptly suspended CNA #2's license. That same afternoon, the Executive Director submitted a follow-up to the initial report to ISDH. II. All residents are potentially affected by acts of abuse by staff at a Facility. The Facility interviewed all alert and oriented female residents and performed head-to-toe skin assessments for all non-alert and oriented female residents. Those interviews occurred during the morning of 9/20/15 (Sunday). Similar interviews and assessments were then performed for all male residents. On 9/21/15, a Social Worker, upon re-interviewing the male residents, discovered that a male resident had an interaction with CNA #2. This was reported to the police that same day. III. The reporting issues were discussed with the Executive Director by the District Director of Clinical Operations for the organization</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>On 10-1-15 at 3:00 p.m., the ED provided a copy of a policy entitled, "Abuse." This policy had a "Release Date," of 7-28-14, and was identified as the current policy utilized by the facility. This policy indicated, "Verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property is strictly prohibited. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown injuries of source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey agency and certification agency). Individuals are not hired when a history of abuse is known. Retribution against patients, staff or visitors who file reports is strictly prohibited."</p> <p>This Federal tag relates to complaint IN00182869.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>		<p>managing the clinical operations at the Facility. A member of the district team will monitor the time frames for the reporting of events by the Executive Director to assure prompt reporting to ISDH and other appropriate authorities. That district team member will monitor the Performance Improvement Committee's monthly meetings at the Facility, and report upon any issues or concerns with respect to reporting time frames. That will occur for the next three (3) months, and then quarterly thereafter. IV. The Facility contends that it was in substantial compliance with the regulatory requirements under F-225. Notwithstanding that contention, and without waiving its rights, for purposes of completing this Plan of Correct and in order to satisfy its regulatory requirements, the Facility states that the actions taken described here in will be in place on or before October 30, 2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure a staff member implemented the facility's policies regarding abuse prohibition in that an allegation of sexual abuse by a resident was made and substantiated to indicate sexual abuse towards 3 of 6 residents. (Resident #B, #C and #D)</p> <p>Findings include:</p> <p>On 9-19-15 at 10:48 p.m., the facility emailed an initial report regarding an allegation of sexual abuse of a female resident by a male CNA to the Indiana State Department of Health (ISDH), Long Term Care Division. It indicated on the evening of 9-19-15 at approximately 7:15 p.m., Resident #B indicated to CNA #1 that on 9-17-15 or 9-18-15, CNA #2, a male employee, had asked her if she was ready. Resident #B indicated she assumed he was referring to getting ready for bed. She continued, that CNA #2</p>			F 0226	<p>I. The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed and certified skilled nursing facility. The responses to the findings under F-223 and F-225 describe the Facility's implementation of its protocols and policies associated with the alleged mistreatment, neglect, and abuse of residents. CNA #1, who received the initial report at 7:15 p.m. on 9/19/15 (Saturday), promptly reported the matter to the supervising LPN #3. That LPN #3 promptly reported the incident to the Executive Director, the Director of Nursing Services, the treating physician and family members. Interviews were promptly conducted by the Executive Director, telephone calls were attempted to the CNA #2 in question, and a report to the ISDH occurred by 10:48 p.m. that evening. Over the subsequent days, interviews of all staff were conducted, state and local</p>		10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>then inappropriately touched her breasts while getting her undressed and then proceeded to expose his penis to her. She indicated CNA #2 then asked her to touch his penis. She indicated she yelled, "No," at least twice. The report indicated CNA #2 then briefly laid on top of her, but no sexual intercourse took place.</p> <p>In a written timeline provided by the Executive Director (ED) on 10-2-15 at 9:20 a.m., and an updated timeline provided by the Corporate Nurse on 10-6-15 at 4:59 p.m., the timeline indicated the following information: -9-17-15 at 1:00 p.m. CNA #2 submitted a two week notification of resignation as a full time employee as he had secured a position elsewhere. He requested to become a "PRN" (as needed) staff member. CNA #2 worked on the long term care portion of the facility at that time. It indicated he was scheduled to work on 9- 17-15 and 9-18-15, then return to work until 9-21-15. -9-19-15 at 7:15 p.m. CNA #1 informed LPN #3 that Resident #B had made an abuse allegation. LPN #3 interviewed Resident #B in regards to the sexual abuse involving CNA #2. -9-19-15 at 7:35 p.m. LPN #3 notified the ED, Director of Nursing Services (DNS), the attending physician and the resident's family of the abuse allegation.</p>		<p>authorities were notified, family members and treating physicians were contacted, residents potentially affected were interviewed and/or assessed, and the Facility cooperated with local police authorities in conducting a thorough investigation. Residents and family members were questioned about their understanding and familiarity with relevant policies and procedures, and all residents and family members indicated an awareness of the policies as well as a willingness to report any signs of mistreatment, neglect, or abuse of residents. All staff were interviewed to assure awareness and understanding of the Facility's policies and procedures, and expressed an awareness and willingness to report any allegation of mistreatment, neglect or abuse of residents. The Facility reviewed the employment file for CNA #2 to assure that all reference, background and licensure checks had been properly conducted, and the Facility's protocols were re-examined. Additional educational materials were prepared for distribution to alert and oriented residents and for distribution to new residents and their family members upon admission. These are in addition to information and materials previously made available to residents and provided to newly</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>-9-19-15 at 8:00 p.m. ED interviewed LPN #3 and CNA #1.</p> <p>-9-19-15 at 10:48 p.m. ED submitted abuse allegation report to ISDH.</p> <p>-9-20-15 (all day) Investigation conducted which included interviews with all alert and oriented female residents on the long term care unit regarding abuse. For non-alert and oriented females on the long term care unit, head to toe skin assessments were conducted. All residents on the transitional care unit were interviewed regarding abuse, as all were alert and oriented. Findings indicated another female resident, Resident #C, expressed a similar experience in which a male staff member had exposed his penis to her. Resident #B was able to identify the staff member by name. Resident #C was able to describe the male staff member. Indicated each resident had been interviewed multiple times with their interviews being consistent in details. Notifications were attempted to the family of Resident #C. The facility's administrative team met to review their investigational results and substantiated the sexual abuse allegation. CNA #2 was notified of suspension, pending results of the facility's investigation. Arrangements were made for CNA #2 to come into the facility the following day for an interview. Local police department was</p>		<p>admitted residents and their family members. II. All residents have the potential to be affected by such an incident. As described in response to the other alleged deficiencies, the Facility followed its protocols, assuring compliance with its policies and procedures relating to mistreatment, neglect and abuse of residents. This involved interviews and assessments of all residents, and interviews of all staff. This also included calling an ad hoc Resident Council meeting and inviting as many alert and oriented residents as possible to attend. All attendees indicated an awareness of the Facility's policies and the types of abuse that can occur and how to report any occurrence. Written education on the topic was distributed to all alert and oriented residents, as well as family members of all residents. All newly admitted residents and their family members will receive a copy of this written education. Additional staff training relating to policies and protocols regarding mistreatment, neglect and abuse of residents was held on 10/5/15 at an all-staff meeting.</p> <p>III. The Facility will interview at least 10 alert and oriented residents on a monthly basis utilizing the abuse and resident rights questions as written in the Abaqis Resident Interview. The Facility will also interview at least</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>notified of the abuse investigation.</p> <p>-9-21-15 (all day) Staff interviews were conducted by management staff regarding the incident and included staff education regarding abuse policies. Resident #D was interviewed and identified as having a similar incident as Resident #B and #C. Interview with Resident #D indicated he and the alleged suspect had touched each other's penis, with nothing beyond that. The Medical Director, and attending physician for each of the three residents, was notified of the incidents. The POA/guardians of Resident #C and #D were notified of the allegations.</p> <p>Interviews were conducted with all alert and oriented male residents on the long term care unit regarding abuse. For non-alert and oriented males on the long term care unit, head to toe skin assessments were conducted. Interview conducted with CNA #2 by ED, DNS and two local police department's detectives. CNA #2 did not confess to any of the sexual abuse allegations. CNA #2 was notified his employment was immediately terminated and was not to enter onto facility property, not to communicate with any staff or residents. The ED filed "Report of Reasonable Suspicion of a Crime Against a Resident."</p> <p>9-22-15 (all day) Continued staff interviews were conducted by</p>		<p>10 family members of any non-alert and oriented residents using those same questions. The interviews of at least ten alert and orientated residents and ten family members will occur for six months. Auditing will happen each month over the six months to ensure that the interviews of residents and families are occurring, that the interviews are completed, and that the issues raised will be addressed.</p> <p>The Director of Nursing or their designee will be the responsible person. Any concerns that may be voiced during an interview will be reported promptly to the Facility's Executive Director. Licensed nurses will continue to complete a weekly skin check on residents, and CNAs will continue to communicate any skin concerns to licensed nurses on a daily basis. The Facility will continue its practices of validating appropriate licenses and certifications for all pre-hire caregivers, as well as completing a criminal background check and reference check. Upon hire, all staff are trained upon abuse prevention, types of abuse, reporting guidelines and resident rights. Additional education for all staff on these topics is provided on a quarterly basis. This will also be added as a regular topic at Resident Council meetings as requested by the Facility to the Resident Council President. III.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>management staff regarding the incident and included staff education regarding abuse policies. Continued communication with families of the involved residents and with the local police department's detective. Counseling services met with each of the residents involved. ED filed a "Consumer Complaint" with the State Attorney General's office regarding incident and licensure of CNA #2. Follow up report emailed to ISDH.</p> <p>In an interview with Resident #E on 10-6-15 at 2:20 p.m., she indicated she has resided at the facility approximately three years. She indicated she has had both male and female caregivers who have treated her very well. She indicated she has had no concerns with inappropriate touch or actions.</p> <p>In an interview with Resident #G on 10-6-15 at 2:15 p.m., he indicated he has resided at the facility for approximately 3 months. He indicated he has had both male and female caregivers who have treated him very well. He indicated he has had no concerns with inappropriate touch or actions.</p> <p>In an interview with Resident #H on 10-6-15 at 2:30 p.m., he indicated he has resided at the facility for approximately 4</p>		<p>The policies relating to mistreatment, neglect and abuse of residents were reviewed, along with the practices at the Facility arising out of this incident on 9/22/15 at the Performance Improvement Committee which was attended by the Medical Director. The Executive Director is responsible for oversight of the implementation of actions described in this Plan of Correction. IV. The Facility contends that it was in substantial compliance with the regulatory requirements under F-226. Notwithstanding that contention, and without waiving its rights or that position, the Facility states that the actions described here in will be completed on or before 10/30/15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>months. He indicated he has had both male and female caregivers who have treated him very well. He indicated he has had no concerns with inappropriate touch or actions.</p> <p>In an interview with LPN #4 on 10-1-15 at 3:55 p.m., she indicated she had worked with CNA #2. She indicated she perceived him to be a good worker and willing to ask questions. She indicated she had noted no behavioral changes of her residents on the long term care unit.</p> <p>In an interview with CNA #5 on 10-1-15 at 4:08 p.m. She indicated she had worked with CNA #2. She indicated when she had the opportunity to observe his care, it seemed acceptable. She indicated the only female resident she was aware of that ever mentioned that she did not want CNA #2 to care for her was a resident who routinely did not want male caregivers. She indicated she "never picked up any negative vibes from him."</p> <p>In an interview with Unit Manager of the long term care unit on 10-1-15 at 4:30 p.m., she indicated she had received no concerns regarding CNA #2's job performance. She indicated he had been employed at the facility less than 90 days, and typically the first work performance</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>evaluation is conducted at 90 days with the Unit Manager and the Director of Nursing.</p> <p>In an interview with the Staffing Coordinator on 10-2-15 at 2:22 p.m., she indicated she had several opportunities to work with and observe the care provided by CNA #2. She indicated she never had seen any thing in the care provided by CNA #2 that made her think there were any reasons to have cause for concern regarding the treatment of the facility's residents.</p> <p>A. In an interview with Resident #B on 10-1-15 at 2:15 p.m., she indicated she had received care from CNA #2 previously with no concerns. She indicated the event of "several weeks ago," was the first time any staff member had been inappropriate with her. She indicated the male staff member asked her if she was ready and she assumed he was referring to getting ready for bed for the evening. She indicated he inappropriately touched "my chest [breasts]." She indicated he also exposed his penis to her.</p> <p>In a phone interview with LPN #3 on 10-2-15 at 2:38 p.m., she indicated on the evening in question, CNA #1 told her she needed to talk with Resident #B. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>indicated CNA #2 had "pulled it out and then she clarified [meant] penis." LPN #3 indicated the resident "told me the whole story, including [CNA #2] laying on top of her, but said they didn't have sex." LPN #3 indicated Resident #B "specifically named [name of CNA #2]." She indicated the resident was upset, but not distraught.</p> <p>Review of Resident #B's clinical record on 10-1-15 at 5:35 p.m., indicated her most recent quarterly Minimum Data Set assessment, dated 9-1-15, indicated she was cognitively intact. A Social Services note, dated 9-1-15, indicated she was cognitively intact, had normal vision and was able to understand and to be understood.</p> <p>B. In an interview with Resident #C on 10-1-15 at 2:27 p.m., she indicated an unknown male had exposed his penis to her over one month ago. She indicated she was unsure who the young, white male was or the exact date or time it occurred. She indicated she yelled, "No," and he left her room and did not return.</p> <p>In review of the ISDH Reportable incident, submitted by the facility on 9-22-15, it indicated Resident #C had identified the male as CNA #2. It indicated CNA #2 "had exposed himself</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>by pulling out his penis and asking the Resident to touch it. The Resident states she told the CNA, 'No,' and that he left her room. Resident states that there was only one incident."</p> <p>Review of Resident #C's clinical record on 10-1-15 at 5:55 p.m., indicated her most recent Minimum Data Set assessment, dated 7-21-15, indicated she was cognitively intact.</p> <p>C. In an interview with Resident #D on 10-1-15 at 2:42 p.m., he indicated he had previously had a mutual relationship with CNA #2. He indicated CNA #2 was "the one who initiated things," referring to the relationship. He indicated they only saw each other during CNA #2's work hours and were involved for a few weeks. He indicated CNA #2 was no longer employed at the facility.</p> <p>In review of the ISDH Reportable incident, submitted by the facility on 9-22-15, it indicated Resident #D had identified CNA #2 as the person he had a relationship with. He indicated this relationship included incidents in which CNA #2 had pulled his penis out and asked the resident to touch it, which he did, as well as CNA #2 touching Resident #D's penis. The report indicated Resident #D indicated "there were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>multiple incidents, he could not quantify or be specific with dates. The Resident claims that some of the incidents included the Resident and CNA exposing themselves, both individuals having erections and ejaculations."</p> <p>Review of Resident #D's clinical record on 10-1-15 at 6:10 p.m., indicated his most recent Minimum Data Set assessment, dated 8-17-15, indicated he was moderately cognitively impaired.</p> <p>Review of CNA #2's employee file indicated he had been employed at the facility less than 2 months at the time of the abuse allegation. It indicated his orientation period included education on Resident's Rights and Abuse Prevention. Review of the "Job Description" for "Certified Nursing Assistant," indicated CNA #2 signed this document during his orientation period. The job description indicated, "Conducts job responsibilities in accordance with the standards set out in the Company's Code of Business Conduct, its policies and procedures, the Corporate Compliance Agreement, applicable federal and state laws, and applicable professional standards."</p> <p>The ISDH "Nurse Aide Curriculum, revised 3-21-14, indicated, "<u>Any sexual relationship</u> with a resident is considered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>to be abuse."</p> <p>On 10-1-15 at 3:00 p.m., the ED provided a copy of a policy entitled, "Abuse." This policy had a "Release Date," of 7-28-14, and was identified as the current policy utilized by the facility. This policy indicated, "Verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property is strictly prohibited. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown injuries of source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey agency and certification agency). Individuals are not hired when a history of abuse is known. Retribution against patients, staff or visitors who file reports is strictly prohibited."</p> <p>This Federal tag relates to complaint IN00182869.</p> <p>3.1-28(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	