

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2015
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00182255.</p> <p>Complaint #IN00182255- Substantiated. Federal/state deficiencies related to the allegations are cited at F223.</p> <p>Survey dates: September 17, 2015</p> <p>Facility number: 002667 Provider number: 155678 AIM number: 200300090</p> <p>Census bed type: SNF- 33 SNF/NF- 52 Residential- 38 Total- 123</p> <p>Census payor type: Medicare- 33 Medicaid- 24 Other- 28 Total- 85</p> <p>Sample: 3</p> <p>Waterford Place Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the investigation of</p>	F 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. Waterford Place Health Campus respectfully requests Desk Review/Paper Compliance.</p>	

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.

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F 0223 SS=A Bldg. 00	<p>complaint IN00182255.</p> <p>Quality review completed by 21662 on September 18, 2015.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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. Based on record review and interview, the facility failed to follow to ensure employee-resident sexually intended contact did not occur for 1 of 1 resident reviewed for sexual abuse. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 9/17/15 at 11:30 a.m. Diagnoses for Resident B included, but were not limited to, need for rehabilitation services due to difficulty in walking and muscle weakness, congestive heart failure, chronic kidney disease, anxiety disorder, and depressive disorder.</p>	F 0223	<p>1. The identified employee, Environmental Services Associate #1, was immediately suspended pending investigation in order to ensure no further interaction with Resident B. 2. An immediate investigation was initiated to determine if any other residents were affected. Investigation and interviews concluded that no other residents were affected or had inappropriate interactions with Environmental Services Assistant #1 or any other staff. No other resident concerns were identified. 3. The employment of Environmental Services Associate #1 was terminated. All personnel files were audited to confirm current employees have</p>	09/28/2015

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	<p>During an interview, on 9/17/15 at 2:30 p.m., the Director of Health Services (DHS) indicated a facility investigation was conducted related to a kiss between Resident B and Environmental Services Associate #1 (ESA#1). The investigation began on 9/10/15, immediately after Resident B shared her experience with Life Enrichment Assistant #2 (LEA#2).</p> <p>The DHS indicated the investigation results were substantiated for inappropriate contact (hugging & kissing) between ESA#1 and Resident B. The DHS indicated separate interviews were conducted with Resident B and ESA#1. Their recollection's of the morning's incident were very similar. Each admitted to intentionally hugging and kissing without ill-intent.</p> <p>Investigational documentation and the DHS indicated the facility's investigation of the incidents resulted in the following:</p> <p>On the morning of 9/17/15, Resident B asked ESA#1 for a photograph via cellular phone, of the two of them together. Resident B was collecting photos for a personal memory book and had several photos of herself with staff. The pair put their arms around one another and Resident B activated the</p>		<p>received mandatory education regarding resident abuse. All new employees will receive mandatory training regarding abuse education during the new employee orientation process. In addition, a quarterly training will be held as routine education on abuse reporting policies and procedures. 4. The results of the personnel file audits will be reviewed monthly at the Campus Quality Assurance (QA) meeting. The results of new employee file audits will also be reviewed monthly at the QA meeting. The results of the quarterly trainings will also be reviewed quarterly at QA. The Campus Executive Director or designee will present the results of these audits at the Campus QA meeting monthly for six months at which time the QA committee will determine continuation or revisions to the review process. 5. 9/28/15</p>				

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	<p>camera on her cellular phone. After the "selfie" (a self photograph captured by yourself) was captured, Resident B showed the photograph to ESA#1. In that moment, the pair smiled, hugged, and kissed each other. Resident B continued with her usual morning walk around the facility. ESA#1 continued with his work duties. Later that morning (About ten minutes later), ESA #1 visited Resident B in her room. They engaged in friendly conversation and exchanged contact information, including names, addresses, and phone numbers. They hugged and kissed one another, again. ESA#1 exited Resident B's room.</p> <p>During an interview with the DHS, on 9/17/15 at 3:20 p.m., she indicated the facility's investigation team was unable to determine who initiated the actual kiss. ESA#1 admitted, during his employment exit interview, he should not have pursued further communication and/or contact with Resident B, after she took a photograph of the two of them. The DHS indicated agreement.</p> <p>Abuse and Neglect Procedural Guidelines, dated 9/16/2011, was presented by the Executive Director (ED) on 9/17/15 at 11:00 a.m. The guidelines indicated physical abuse was defined as,</p>				

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	<p>but not limited to, "Staff to resident abuse with or without injury." Sexual abuse was defined to include, but not limited to, "humiliation, harassment, coercion or assault."</p> <p>An ISDH reportable incident follow-up report, dated 9/14/15, indicated ESA#1's employment was terminated due to failure to follow sexual abuse policies and procedures.</p> <p>This Federal tag relates to Complaint #IN00182255.</p> <p>3.1-27(a)(1)</p>			