STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO PLACE ASSISTED LIVING	3025 W SYCAMORE ST, KOKOMO, , 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00362384. Complaint IN00362384 - Substantiated. State Residential Findings related to the allegations are cited at R0036 and R0052. Survey date: September 24, 2021 Facility number: 011075 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 5, 2021.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0036	Residents' Rights- Deficiency	R 0036	**1. What corrective action(s)**	10/24/2021

	410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to document the notification of resident's families and physicians after an incident occurred for 3 of 3 residents reviewed for notification. (Resident B, C and D). Findings include: 1. A Facility Reported Incident (FRI), dated 9/12/2021, indicated Resident B exited the facility through the emergency door on the 300 hall. The resident was brought back inside without difficulty. The facility progress notes did not include the notification to the resident's physician of the elopement. 2. A FRI, dated 9/12/21, indicated Resident C and		**will be accomplished for those residents found to have been affected by the deficient practice:** Resident B was discharged to a memory care unit on 9/17/21. The families and physicians for residents C and D were notified of the incident on September 12, 2021 by Care Services Manager (CSM). The resident records were updated on 10/112021 by the CSM to include the notifications. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of resident service notes from past 30 days was completed on 10/11/2021 by the CSM to ensure the resident’s legal representative and physician was notified of a change in condition. No issues	

	Resident D were sitting in main living room. Resident C touched Resident D's penis when Resident D was exposed. The facility progress notes did not include the notification to the families or physicians for Residents C and D. During an interview, on 9/24/21 at 1:43 p.m., the Director of Nursing (DON) indicated she did not have documentation for notifications. A current policy, titled "Incidents and Accidents," dated 9/1/2016 and received from the Administrator in Training (AIT) on 9/24/21 at 2:45 p.m., indicated "...The resident's responsible part, the resident's health care provider and appropriate authorities are notified...." A current policy, titled "Incident Reporting Guidelines," updated 8/2019 and received from the AIT on 9/24/21 at 2:45 p.m., indicated "...The resident's family/responsible party and Physician should be promptly informed of all incidents and accidents...." This State Tag relates to Complaint IN00362384. Based on record review and interview, the facility failed to document the notification of resident's families and		were identified. ..\..\..\..\..\..\..\Documents\attachment 1.xlsx **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director (ED) and Care Services Manager were re-educated on 10/7/2021 by the Regional Director of Care Services (RDCS) on the need to immediately notify a resident's physician and legal representative of a change in condition and to document notification in resident's record. Attachment 2.pdf Current Staff were re-educated on 10/11/2021 by the Care Services Manager the need to immediately notify a resident's physician and legal representative of a change in condition and to document notification in resident's record. ..\..\..\..\..\..\..\Documents\attachment 3.pdf **4. How the corrective action(s) will**	

	physicians after an incident occurred for 3 of 3 residents reviewed for notification. (Resident B, C and D). Findings include: 1. A Facility Reported Incident (FRI), dated 9/12/2021, indicated Resident B exited the facility through the emergency door on the 300 hall. The resident was brought back inside without difficulty. The facility progress notes did not include the notification to the resident's physician of the elopement. 2. A FRI, dated 9/12/21, indicated Resident C and Resident D were sitting in main living room. Resident C touched Resident D's penis when Resident D was exposed. The facility progress notes did not include the notification to the families or physicians for Residents C and D. During an interview, on 9/24/21 at 1:43 p.m., the Director of Nursing (DON) indicated she did not have documentation for notifications. A current policy, titled "Incidents and Accidents," dated 9/1/2016 and received from the Administrator in Training (AIT) on 9/24/21 at 2:45 p.m., indicated "...The resident's		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The CSM or designee will review the 24 hour report sheet for changes in resident condition and the resident record will be reviewed to ensure family and physician have been notified. This review will occur 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going **5. By what date the systemic changes will be completed** Completion date: 10/24/2021	

	responsible part, the resident's health care provider and appropriate authorities are notified...." A current policy, titled "Incident Reporting Guidelines," updated 8/2019 and received from the AIT on 9/24/21 at 2:45 p.m., indicated "...The resident's family/responsible party and Physician should be promptly informed of all incidents and accidents...." This State Tag relates to Complaint IN00362384.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from neglect when the facility failed to thoroughly investigate an elopement (Resident B) and failed to ensure interventions	R 0052	**R 052** **Residents' Rights - Offense** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B was discharged to a memory care unit on 09/17/21. The plan of care and caregiver task sheets for residents C and D were updated on 10/11/2021 by the CSM to include frequent	10/24/2021

	were followed through with after an elopement and inappropriate sexual touching occurred for 3 of 3 residents reviewed for neglect. (Residents B, C and D). Findings include: 1. A Facility Reported Incident (FRI), dated 9/12/2021, indicated an emergency door alarm sounded. Staff responded to the alarm and observed Resident B standing outside the 300 hall door. Resident B was brought inside without difficulty. The preventative measure added was the power of attorney (POA) would provide 1:1 supervision. The record for Resident B was reviewed on 9/24/2021 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, atrial fibrillation and macular degeneration. A Facility "Universal Incident Report," dated 9/12/21 at 12:00 p.m., indicated the alarm sounded near the resident's room and when the staff arrived the resident was found in the resident's bathroom. The resident indicated he went outside and came back in.		checks. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of incident reports and corresponding service notes from past 30 days was completed on 10/11/2021 by the ED to ensure incidents were properly investigated and interventions implemented. No issues were identified. ..\..\..\..\..\..\..\Documents\attachment 4.pdf **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director and Care Services Manager were re-educated on 10/7/2021 by the Regional Director of	

A progress note, dated 9/12/21 with no time documented, indicated Resident B's family was unable to sit 1:1 with the resident and resident would be on 30 minute safety checks.

During an interview, on 9/24/21 at 1:29 p.m., the Clinical Support Manager (CSM) indicated she could not find the documentation of the 30 minute checks for Residents B.

During an interview, on 9/24/21 at 2:24 p.m., CNA 2 indicated Resident B had been exit seeking during the previous 2 weeks. CNA 2 answered the door alarm on 300 hall. A bedside table which belonged to Resident B was found outside but not the resident. Resident B was found in the bathroom in the resident's apartment.

During an interview, on 9/24/2021 at 3:30 p.m., the Administrator in Training (AIT) indicated only the FRI was completed. The AIT indicated the only information reported was included in the FRI. He was unable to provide the name of the staff who reported the elopement or the staff who found the resident.

The facility investigation only included the FRI. The facility investigation did not include staff names or statements.

2. A Facility Reported Incident

Care Services (RDCS) on the abuse policy and resident rights, including
investigation of incidents and monitoring of interventions.
Attachment 2.pdf Current Staff were re-educated
on 10/11/2021 by the Executive Director on resident rights and the abuse
policy, including investigation of incidents and monitoring of interventions.

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5.pdf

**4. How the corrective action(s) will
be monitored to ensure the deficient practice will not recur, i.e., what
quality assurance program will be put into place:**

The ED or designee will review the service notes of residents with an incident to ensure the incident has been
investigated and interventions are implemented. This review will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Results will be reviewed
at monthly QI meeting. The QI Committee will determine if continued interviews
are necessary based on 3

	(FRI), dated 9/12/2021, indicated Resident C and D were both sitting in the main living room when staff observed Resident D's penis was exposed. Resident C was touching Resident D's penis. Resident C and D were put on frequent checks and separated. a. The record for Resident C was reviewed on 9/24/2021 at 12:00 p.m. Diagnoses, included but were not limited to, dementia and old age. b. The record for Resident D was reviewed on 9/24/2021 at 12:05 p.m. Diagnoses, included but were not limited to, dementia. A progress note, dated 9/11/21, indicated Resident C was sitting, in a wheelchair, in a common area. The CNA noticed the resident leaning over Resident D in a Broda chair and had her hand on his penis. The CSM was notified. A progress note, dated 9/13/21, indicated Resident C remained separated from the male resident.		consecutive months of compliance. Monitoring will be on-going. **5. By what date the systemic changes will be completed** Completion date: 10/24/2021	

A facility "Universal Incident Report," dated 9/11/21, indicated Resident C was witnessed with Resident D's penis in her hand. Vital signs were recorded with no physical assessment completed for Resident C.

There was no documentation, in the record, to indicate the physician or the responsible party had been notified of the incident between 9/11/21 to current.

During an interview, on 9/24/21 at 1:23 p.m., the CSM indicated 30 minute checks were started on Resident B, Resident C and Resident D. The 30 minute checks were kept under the wellness or miscellaneous tab in their chart. The CSM looked through Resident B, Resident C and Resident D's charts and was not able to find the 30 minute checks for the residents. She indicated she would check her office and see if they were there.

During an interview, at 1:40 p.m., the CSM indicated she could not find any 30 minute checks documented for Resident B, Resident C or Resident D.

During an interview, on 9/24/21 at 1:43 p.m., the CSM indicated both residents were in the front living room. Resident D had his

pants down and was exposed and Resident C had his penis in her hand. The CSM indicated the resident assessments would be in the progress notes and the notification to family and physician should also be in the progress notes.

During an interview, on 9/24/21 at 2:19 p.m., the CNA 2 she indicated Resident C was a very friendly person. She heard Resident D tell Resident C to get away from him. The residents were sitting next to the fireplace in the common area across from the dining room. Resident D had his pants down and his penis exposed. When CNA 2 walked up to Resident D, she noticed Resident C had her hand under Resident D's blanket. When she tried to separate the resident's she noticed Resident C had her hand on Resident D penis. She took Resident C to the dining room and covered Resident D with a blanket and told her charge nurse. Resident C was able to propel herself in her wheelchair.

A current policy, titled "Incidents and Accidents," dated 9/1/2016 and received from the AIT on 9/24/2021 at 2:45 p.m., indicated "...Investigation of incidents, accidents...The investigation includes a review if the incident and necessary follow up interventions...The

resolution of the incident will be documented...The Executive Director will be responsible for ensuring timely and accurate reporting of all critical events...."

A current policy, titled "Abuse, Neglect and Exploitation," dated 9/1/2016 and received from the AIT on 9/24/21 at 2:45 p.m., indicated "...Neglect is a pattern of conduct or inaction of a care provider that fails to provide goods or services that maintain health or that fails to avoid or prevent physical or mental harm or pain, or an act of omission that constitutes a clear and present danger to health, welfare or safety of a resident...."

This State Tag relates to Complaint IN00362384.

Based on record review and interview, the facility failed to ensure residents were free from neglect when the facility failed to thoroughly investigate an elopement (Resident B) and failed to ensure interventions were followed through with after an elopement and inappropriate sexual touching occurred for 3 of 3 residents reviewed for neglect. (Residents B, C and D).

Findings include:

1. A Facility Reported Incident (FRI), dated 9/12/2021, indicated an emergency door alarm sounded. Staff responded

to the alarm and observed Resident B standing outside the 300 hall door. Resident B was brought inside without difficulty. The preventative measure added was the power of attorney (POA) would provide 1:1 supervision.

The record for Resident B was reviewed on 9/24/2021 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, atrial fibrillation and macular degeneration.

A Facility "Universal Incident Report," dated 9/12/21 at 12:00 p.m., indicated the alarm sounded near the resident's room and when the staff arrived the resident was found in the resident's bathroom. The resident indicated he went outside and came back in.

A progress note, dated 9/12/21 with no time documented, indicated Resident B's family was unable to sit 1:1 with the resident and resident would be on 30 minute safety checks.

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weeks. CNA 2 answered the door alarm on 300 hall. A bedside table which belonged to Resident B was found outside but not the resident. Resident B was found in the bathroom in the resident's apartment.

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The facility investigation only included the FRI. The facility investigation did not include staff names or statements.

2. A Facility Reported Incident (FRI), dated 9/12/2021, indicated Resident C and D were both sitting in the main living room when staff observed Resident D's penis was exposed. Resident C was touching Resident D's penis. Resident C and D were put on frequent checks and separated.

a. The record for Resident C was reviewed on 9/24/2021 at 12:00 p.m. Diagnoses, included but were not limited to, dementia and old age.

b. The record for Resident D was reviewed on 9/24/2021 at

12:05 p.m. Diagnoses, included but were not limited to, dementia.

A progress note, dated 9/11/21, indicated Resident C was sitting, in a wheelchair, in a common area. The CNA noticed the resident leaning over Resident D in a Broda chair and had her hand on his penis. The CSM was notified.

A progress note, dated 9/13/21, indicated Resident C remained separated from the male resident.

A facility "Universal Incident Report," dated 9/11/21, indicated Resident C was witnessed with Resident D's penis in her hand. Vital signs were recorded with no physical assessment completed for Resident C.

There was no documentation, in the record, to indicate the physician or the responsible party had been notified of the incident between 9/11/21 to current.

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This State Tag relates to Complaint IN00362384.

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