STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/19/2023

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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00400575 completed on Febraury 9, 2023. Complaint IN00400575 - Not corrected. Survey date: April 19, 2023 Facility number: 011075 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 27, 2023.	R 0000		
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;	R 0052	**1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	05/19/2023

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from abuse related to a resident being physically, verbally, and mentally abused by a staff member while providing bedtime personal care for 1 of 1 resident reviewed for abuse. (Resident B) Finding includes: During an interview, on 4/19/23 at 1:25 p.m., the Care Service Manager (CSM) indicated since the facility's plan of correction, dated 3/11/23, there had been one abuse allegation substantiated and Resident Care Partner (RCP) 5 had been terminated due to abuse of a resident. The record for Resident B was reviewed on 4/19/23 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, CVA (a stroke) with dominant sided weakness, hemiplegia and hemiparesis, anxiety disorder, and rhabdomyolysis.		Effective as of 3/22/2023, RCP 5 is no longer employed by the community. Resident B was assessed for physical injury and psychosocial distress on 3/15/2023 by the Care Services Manager (CSM) with no findings. Resident B was monitored for 72 hours and did not exhibit any signs of distress or pain. **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:** Interviews with current staff and interviews with residents without cognitive impairment were completed between 4/20/2023 and 4/21/2023 by the Executive Director (ED) to ensure resident rights are upheld and residents are free from abuse. No additional findings noted. Skin assessments of residents with cognitive impairment were completed on 5/4/2023	

	The resident was on Hospice. She required total assistance with toileting, dressing, grooming, and mobility. She used a Broda chair (a tilting reclining chair for comfort) for transportation around the facility. She was unable to propel her Broda chair, so she had to be escorted around the facility by staff members. She had to be moved and always repositioned with two staff members and the use of a Hoyer lift to transfer her in and out of the bed into her Broda chair. She had dementia and was unable to do the Mini Mental Exam to evaluate her cognitive status. A document, titled "Indiana State Department of Health Survey Report System," indicated on 3/15/23 at 6:30 p.m., RCP 3 indicated RCP 5 was rough, spoke inappropriately and failed to use the Hoyer lift to transfer Resident B when assisting her with bedtime care. Two staff members reported witnessing RCP 5 being rough when providing care for Resident B. The facility substantiated the abuse allegation against RCP 5 and terminated his employment effective 3/22/23. A document, titled "Enlivant Universal Incident Report," indicated the incident occurred on 3/15/23 at 6:30 p.m., and		by the Regional Care Specialist (RCS) and designee to ensure residents are free from abuse. No findings noted. **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 ED was re-educated on 4/20/2023 by the Regional Director of Care Services (RDCS) on the abuse policy and resident rights. Current staff were re-educated on 3/16/2023 and 5/3/2023 by the ED on resident rights and the abuse policy. New employees will be educated on abuse and resident rights during initial orientation. The ED or designee reviewed resident rights and the abuse policy during the resident council meeting on 4/26/23. **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**	

	was witnessed by RCP 3. RCP 3 reported RCP 5 allegedly provided rough care to Resident B. He "manhandled" her and did not stop when the resident was screaming, he spoke rudely to her, and placed her in bed without using the Hoyer lift. On 4/19/23 at 3:00 p.m., Resident B was observed in her room sitting in her Broda chair in front of her television. She was leaning to the right side of the Broda chair with her head lying on the upper pad of the Broda chair with a Hoyer sling under her. When she was spoken to, she spoke in nonsensical conversation while squeezing a green sponge ball she had in her left hand. The resident was unable to be questioned regarding the incident which occurred on 3/15/23. During an interview, on 4/19/23 at 3:24 p.m., the CSM indicated she was unable to print off the termination paperwork for RCP 5. He was terminated for a substantiated abuse allegation. During a phone interview, on 4/19/23 at 3:30 p.m., RCP 3 indicated on 3/15/23, the facility was understaffed for the evening shift due to a call-in, so there was only one CNA working. She agreed to stay over from dayshift and work until someone could come in after 6:00 p.m. She had never		**place:** Effective 5/15/2023, the ED or designee will interview 3 residents and interview 3 staff members to ensure resident rights are upheld and residents are free from neglect. The RCS or designee will complete skin assessments on 5 cognitively impaired residents. The interviews and assessments will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Effective 5/15/2023, the ED or designee will ensure current staff completes an individual training module: Preventing, Recognizing, and Reporting Abuse by 5/19/2023. Current staff will be re-educated on the residents' rights and abuse policy monthly for 3 months. Interviews and assessments will be reviewed at monthly QI meeting. The QI committee will determine if continued interviews and assessments are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed**	

	worked with RCP 5 before this day. Between 6:30 and 7:00 p.m., she was going in Resident B's room to help RCP 5 place her in bed with the Hoyer lift and to provide p.m. care for her. When she got to Resident B's room, RCP 5 was already in her room and she was screaming blood curdling screams like "she was in fear screams." RCP 5 was attempting to remove her shirt. Her right arm could not be lifted because she had a stroke. RCP 5 was trying to get her left arm out first, but she would not let him. She continued to scream and cry and would not let him raise her arm. She was crying, so hard real tears were coming out of her eyes. He continued to try to remove her shirt until Resident B gritted her teeth at him, then she lunged off the back of her Broda chair at him. During this time, RCP 5 was very frustrated, and he was "manhandling" her while trying to remove her shirt by moving her harshly from side to side in her Broda chair trying to remove one or the other arm. When this tactic did not work, he grabbed her by the back of the neck and pulled her neck forward and tried to remove her shirt over her head by lifting it up her back and over her head, but that did not work either. During this time, RCP 5 was very frustrated and was cursing at the resident. He repeated "I'm		Completion date: 5/19/2023	

so f***ing p***ed" "Your p***ing me off" and "It's not this f***ing hard," then he was "rambling" about her not cooperating with him while he was trying to remove her shirt. RCP 3 indicated she told him several times to sit down, take a break, and she would take her shirt off, but he continued to try.

RCP 3 went to the resident's closet to get her Hoyer lift. When she turned around with the lift, RCP 5 was observed with Resident B in his arms, out of the chair, and he was placing her in her bed. The Hoyer lift worked, so she should have been placed to bed with the Hoyer lift. RCP 5 indicated he normally transferred her to bed without the use of the Hoyer lift. RCP 3 indicated to RCP 5 to leave the room and she would finish getting Resident B ready for bed. After reporting the abuse allegation to LPN 4, who was the charge nurse for the shift, she called the ED (Executive Director) who connected the CSM on the phone and she reported the "traumatic abuse" incident to both the ED and CSM. The aides and nurses knew Resident B had a traumatic sexual abuse incident by a male at some point in her life, so RCP 5 should not have been providing care for her anyway.

During a phone interview, on

4/19/23 at 3:52 p.m., RCP 5 indicated he tried to remove Resident B's sweater, but she would not allow him to do it. He allowed RCP 3 to console the resident for approximately 30 minutes because she was screaming and crying while he was trying to remove her sweater. She was making the "usual sounds" she made every evening when he got her ready for bed. After RCP 3 consoled her, he was able to remove her sweater and they both placed her gown on her. He indicated he was probably terminated from the facility for not using the Hoyer lift to transfer the resident. When asked how often he transferred the resident in that manner, he indicated the Hoyer lift did not work half the time, so he would transfer her manually.

During a phone interview, on 4/19/23 at 4:06 p.m., LPN 7 indicated she had heard RCP 5 in the hallway acting frustrated one day. He was walking fast and mumbling to himself under his breath. When she asked him if something was wrong, he indicated he had a lot of work to get finished. She had heard from other staff members Resident B had a traumatic sexual abuse event in the past and did not like males caring for her. RCP 6 told her RCP 5 did not use the Hoyer lift to transfer the resident all the time and she

had reported this to the CSM about one to two weeks prior to the abuse incident.

During a phone interview, on 4/19/23 at 4:22 p.m., the ED when asked if she knew Resident B did not want male caregivers providing care for her due to a traumatic abuse incident in her life, she indicated she did not know that.

During an interview, on 4/19/23 at 4:38 p.m., the CSM indicated she did not know Resident B did not want male caregivers providing care to her, until this incident occurred. When she called and spoke to the resident's daughter regarding the 3/15/23 incident, the daughter told her the resident had a traumatic abuse event involving a male and she did not want male caregivers.

During a phone interview, on 4/20/23 at 10:57 a.m., RCP 6 indicated she witnessed RCP 5 be rough with Resident B when he was removing her shirt from her on separate occasions. He pulled her forward very hard by grabbing one of her shoulders in a forward "jerking motion." On two occasions, she remembered RCP 5 pulled the resident's shirt off her by pulling it from her back and over her head, then pulling her arms out, which was not the proper way to remove her shirt. When she would start

crying, he would tell her he should be the one crying not her. She did not like males providing care for her. LPN 4 and 7 knew she did not like males providing care for her.

During a phone interview, on 4/20/23 at 11:16 a.m., LPN 4 indicated RCP 3 was on her way to her car and stopped to talk to him when he was in the parking lot in his car on his lunch break. She asked him how well he knew RCP 5. He told her, he did not know him well. She told him she did not care for something RCP 5 said to Resident B. She told him Resident B was crying during care and RCP 5 asked RCP 3 why the resident was crying and that he should be the one crying not her because he was going to be the one working by himself for the next four hours. She indicated she was calling the ED to report the statement as abuse.

A current policy, titled "Abuse, Neglect and Exploitation Policy-Indiana Communities," dated 03/01/2022 and provided by the CSM on 4/19/23 at 2:30 p.m., indicated "...Definitions: "Abuse" means any physical or mental injury or sexual assault inflicted on a resident in the community, other than by accidental means...."

This State deficiency was cited

on February 9, 2023. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, interview and record review, the facility failed to ensure a resident was free from abuse related to a resident being physically, verbally, and mentally abused by a staff member while providing bedtime personal care for 1 of 1 resident reviewed for abuse. (Resident B)

Finding includes:

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The resident was on Hospice. She required total assistance with toileting, dressing, grooming, and mobility. She used a Broda chair (a tilting reclining chair for comfort) for

transportation around the facility. She was unable to propel her Broda chair, so she had to be escorted around the facility by staff members. She had to be moved and always repositioned with two staff members and the use of a Hoyer lift to transfer her in and out of the bed into her Broda chair. She had dementia and was unable to do the Mini Mental Exam to evaluate her cognitive status.

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When she got to Resident B's room, RCP 5 was already in her room and she was screaming blood curdling screams like "she was in fear screams." RCP 5 was attempting to remove her shirt. Her right arm could not be lifted because she had a stroke. RCP 5 was trying to get her left arm out first, but she would not let him. She continued to scream and cry and would not let him raise her arm. She was crying, so hard real tears were coming out of her eyes.

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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