STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO PLACE	3025 W SYCAMORE ST KOKOMO, IN 46901

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00400575. Complaint IN00400575 - Substantiated. State deficiencies related to the allegations were cited at R0052. Survey date: February 9, 2023 Facility number: 011075 Residential Census: 31 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 16, 2023.	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 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 observation, interview and record review, the facility failed to ensure residents were free from neglect, related to residents were denied personal care services on their first request and the personal care services were not given in a timely manner for 6 of 6 residents being reviewed for neglect (Residents B, E, D, G, C and F).	R 0052	*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*	03/11/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Stout, RN	CSM (DON)	02/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Findings include: A document, titled "Indiana State Department of Health Survey Report System," undated and provided by the Director of Nursing (DON) on 2/9/23 at 12:50 p.m., indicated on 1/25/23 at 5:30 p.m., five residents (Residents B, C, D, E and F) were refused services by QMA 6 while in the dining room. QMA 6 indicated no one was leaving the dining room until it was cleaned. QMA 6 made the comment regarding "hating" or "disliking" "old people." The abuse investigation was substantiated and QMA 6 was terminated from her position. During an interview, on 2/9/23 at 11:45 a.m., the ED (Executive Director) and DON were in attendance. The DON indicated QMA 6 refused to provide services while in the dining room, on 1/25/23, for five residents while bussing tables. She and the ED's expectations of her at that time, would have been to stop bussing tables and tend to the residents' needs. The nurse was passing medications and the other two CNAs were feeding residents. They did not expect the two CNAs to stop feeding residents to provide care or the nurse to stop passing medications. QMA 6 was only bussing tables. When Resident D asked to go to the bathroom, she told her "No." Then Resident E told QMA 6 Resident D had to go to the bathroom and she was told Resident D would have to wait until she was done cleaning the dining room. Resident C and B asked to go back to their rooms. They were told by QMA 6 no one was leaving the dining room until it was cleaned. This was when she indicated she did not like "old people." Resident F wanted to take her waffles back to her room and she was told she could not take food back to her room. CNA 5 saw Resident		*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 052 Residents' Rights – Offense** ="" span Residents B, E, D, G, C, and F's needs were met by another staff member on 1/25/2023. The residents were assessed for psycho-social distress on 1/26/2023 by the Care Services Manager (CSM) with none noted. Effective 2/1/2023, QMA 6 is no longer employed by the community. **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 on 2/24/2023 by the Executive Director (ED) and CSM	

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	D walking without her walker following Resident C and took her to the bathroom. LPN 3 took Resident C and Resident B to their rooms, then he took Resident F some waffles down to her room. All the residents' got the services provided to them, but not by QMA 6 when they requested. After the DON started her investigation, she found out QMA 6 had made the statement about not liking old people prior to the dining room incident and she had been rude to other residents, so she and the ED decided they were terminating her for her offensive behavior. A document, titled "Terminate [Name of QMA 6]," undated and provided by the ED on 2/9/23 at 1:18 p.m., indicated QMA 6 was terminated for offensive behavior. Her last day worked was 1/25/23. During an interview, on 2/9/23 at 12:37 p.m., Resident B indicated, on 1/25/23, she was told by QMA 6 she had to wait until the dining room was cleaned before she could be taken to her room. She had always been taken to her room in the past before the dining room was cleaned. She heard her make a statement she did not like "old people." During an interview, on 2/9/23 at 12:51 p.m., Resident E indicated she was in the dining room and QMA 6 was there bussing tables and told Resident D (her tablemate) she could not go to the bathroom. She told QMA 6, Resident D had to go to the bathroom and the girl told her "No" Resident D could not go to the bathroom until she was done cleaning the tables. One of the girls who was feeding another resident got up and took Resident D to the bathroom. As she started out of the dining room, she stopped LPN 3 to talk about the girl not taking Resident D to the bathroom because it really upset her and she wanted to		to ensure resident rights are upheld and residents are free from neglect. No additional 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 and CSM were re-educated on 2/9/2023 by the Regional Director of Care Services (RDCS) on the abuse policy and resident rights. Current Staff were re-educated on 2/24/2023 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 will review resident rights and the abuse policy during the resident council meeting on 3/8/23. **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 place:** Effective 3/1/2023, the ED or designee will interview 5 residents and interview 3 staff members to ensure resident rights are upheld and residents are free from neglect. The interviews will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews will be reviewed	

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	make sure Resident D was taken care of. LPN 3 walked her back to her room. During a phone interview, on 2/9/23 at 1:52 p.m., QMA 6 indicated, on 1/25/23, during dinner service she did not refuse to provide care to any resident. Resident D asked to go to the bathroom, then Resident E told her Resident D had to go to the bathroom and she told both of them they would have to give her a minute because she was busy. When she told Resident E she was busy, she got up and started taking Resident D to the bathroom without her walker. LPN 3 came and gave Resident D her walker and took her to the bathroom. When asked what she was busy doing, she indicated bussing the dinner tables. When asked if she would have done something differently, she indicated she should have stopped bussing tables and taken Resident D to the bathroom. She did not remember telling any of the residents she would not take them to their rooms until the dining room was cleaned. She probably told them to give her a minute to finish what she was doing because she had dishes in her hands. She had made the statement she did not like "old people" before in the laundry room out of frustration, but never where a resident could hear her. When she was told at least three residents heard her say the statement in the dining room, on 1/25/23, she indicated if she said it, she said it because she was frustrated and was sorry if residents heard her. She did not mean it, she was only venting. During an interview, on 2/9/23 at 3:04 p.m., LPN 3 indicated he was at the med cart, by the dining room, on 1/25/23, passing medications as the residents exited. He did not know residents were being denied services until Resident E came out of the dining room and was upset. He took her to her		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: 3/11/2023	

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	room to find out what upset her. Resident E indicated QMA 6 told Resident D when she asked to go to the bathroom "NO,' then the second time when Resident E told QMA 6 Resident D had to go to the bathroom QMA 6 indicated "in a little bit." Resident E asked LPN 3 if QMA 6 didn't like "old people" than why was she working at the facility. LPN 3 reassured Resident E, Resident D was being taken care of. After he took Resident E to her room, he sat down and fed Resident G. CNA 4 was feeding a resident, CNA 5 was toileting Resident D, and QMA 6 was bussing the dinner dishes off the tables. While feeding Resident G, he heard Resident C and Resident B getting upset. They were angry because they had asked to go to their rooms and they were told "No" by QMA 6. She told them no one was leaving the dining room until she was done bussing the tables, and "God I hate old people." LPN 3 took both of them back to their rooms. CNA 5 had came back from toileting Resident D, and was feeding Resident G. When he got back from taking the two residents to their rooms, Resident F was upset because QMA 6 would not let her take her waffles to her room. The waffles were sitting in the kitchen window getting cold while QMA 6 bused the tables. He told Resident F to go to her room and he would bring her waffles to her. He had the kitchen make the resident fresh waffles and took them to her room. After dinner, all the staff except QMA 6 helped get the residents back to their rooms. She finished bussing the tables in the dining room. LPN 3 indicated when QMA 6 came into the facility that day she was agitated about something. He talked to her about her tone of voice and pitch after the dining room incident that evening on 1/25/23. During an interview, on 2/9/23 at 3:40 p.m., Resident F indicated she had "gotten into it" with			

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	QMA 6 who was bussing the tables in the dining room a couple of weeks ago. She did not like what was being served for dinner, so she asked for some waffles. They waited so long to serve the waffles, she wanted to take them back to her room and QMA 6 told her she could not have a to-go box to bring her waffles back to her room. She told her residents were not allowed to bring food back to their rooms. Not to long after she got back to her room, LPN 3 brought her some waffles to her room and apologized for her not getting the waffles when she asked for the to-go box. During an interview, on 2/9/23 at 3:54 p.m., Resident C indicated she and her friend Resident B both wanted to go to their rooms, but QMA 6 told them they could not go to their rooms until the dining room was cleaned. When LPN 3 got back from walking Resident E to her room, Residents B and C told him what happened in the dining room and he took both of them to their rooms. Resident C indicated if someone did not like working with "old people," then why work in a place where "old people" reside? During a phone interview, on 2/9/23 at 4:27 p.m., with CNA 4 indicated QMA 6 was being rude to the residents and staff on 1/25/23. She was feeding a resident, but Resident D was sitting directly behind her, so she heard Resident D ask QMA 6 to take her to bathroom. QMA 6 told Resident D "No" she was not stopping what she was doing to take her. She did not know anything else was going on with any other residents because her back was to the other residents. QMA 6 would get upset when she had to work on the floor as a CNA and she would have an attitude with the residents and the staff. QMA 6 indicated when she came in that particular shift, on 1/25/23, it was her third or fourth day in a row			

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	working as a CNA and she was not happy about it. When she was a QMA, she sat in the office and did her homework until it was time to pass medications at 5 p.m., and 7 p.m. The evening of 1/25/23, she sat up front and did the laundry and her homework, so she did not do any resident care after the dining room incident. During a phone interview, on 2/10/23 at 12:12 p.m., CNA 5 indicated she was feeding Resident G with her back towards QMA 6 and the rest of the residents, on 1/25/23. She did know QMA 6 was bussing and wiping the tables down as she went along. It was the evening shifts responsibility to bus and wash the tables down and night shifts responsibility to reset the tables for the breakfast meal. She heard a resident ask to go to the bathroom, but she did not know who the resident was. She did not hear what QMA 6 told her, but she continued to bus and clean the tables. Then another resident told her the resident had to go to the bathroom. QMA 6 indicated "Nobody is going anywhere until this dining room is clean." then she stated "I don't even like old people." She made the statement in front of residents' listening range and loud enough some of them had to have heard her. Next thing she seen was Resident E getting up to take Resident D to the bathroom. QMA 6 was arguing with Resident C about going back to her room and told her she was not going back to her room until the dining room was cleaned up. Resident C indicated she would walk to her room by herself. When she got back from taking Resident D to the bathroom, she noticed Resident C's walker was gone. She found her walker up by the front door area where visitors sign in, which was around the corner from the dining room, so she asked who moved the walker and QMA 6 indicated Resident C could not walk back to her apartment by herself. Resident F asked			

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	her for a to-go box for her waffles. QMA 6 told her they did not have any to-go boxes and she was not allowed to take food back to her room. The resident left the dining room mad and went back to her room. QMA 6 indicated earlier in the shift she felt like every time she was on the schedule she worked as a CNA instead of a QMA. She did not like working as a CNA. After dinner, she never helped put residents to bed. There was usually three CNAs and she would sit up front and do her homework instead of helping the other two CNAs put the residents to bed or answer lights. Instead of helping her and CNA 4 the evening of 1/25/23, she stayed up front and watched a video on her phone. A current policy, titled "Resident Rights Policy," dated 3/1/22 and provided by the DON on 2/9/23 at 12:50 p.m., indicated "...and its employees strive to protect and promote the rights of each resident as afforded to them by citizenry and regulation. Procedure: 1) Employees will honor each resident as an individual, treating them with respect and dignity at all times. Each resident has the right to, at minimum...to receive care, treatment and services which are adequate and appropriate...." A current policy, titled "Abuse, Neglect and Exploitation Policy-Indiana Communities," dated 3/1/22 and provided by the DON on 2/9/23 at 12:50 p.m., indicated "...Definitions..."Neglect" means: (i) an act or omission that places a resident in a situation that may endanger the resident's life or health; (ii) abandoning or cruelly confining the resident; (iii) depriving the resident of necessary support, including food, clothing, shelter or medical care; or (iv) depriving the resident of education as required by statue...." This State finding relates to Complaint			

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