STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON HOME	206 E MARION ST SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Investigation of Complaint IN00109700. Complaint IN00109700 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223 and F226. Survey date: June 25, 26, 27, 2012 Facility number: 001141 Provider number: 155738 AIM number: 200905640 Survey Team: Sandra Haws, RN- TC Shannon Pietraszewski, RN June 27, 2012 Janet Adams, RN June 27, 2012 Census Bed Type: SNF: 10 SNF/NF: 17 Residential: 22 Total: 49 Census by Payor Type: Medicare: 5 Medicaid: 13 Other: 31 Total: 49	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on July 6, 2012 by Bev Faulkner, RN			

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F0223 SS=D	483.13(b), 483.13(b)(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. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
	Based on record review and interviews, the facility failed to ensure a resident was kept free from sexual abuse related to the resident's roommate's visiting spouse touching the resident inappropriately and pulling the resident's privacy curtain during care exposing her unclothed body for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident # B) Findings include: Resident # B's record was reviewed on 6/25/12 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; Anxiety, dementia, weakness, and paranoia. The resident's record indicated she was admitted to the facility on 6/26/11. Resident # B's Significant change MDS (Minimum Data Set) assessment, dated 3/21/12, indicated her cognition was moderately impaired. She required minimal assistance with transfers and	F0223	1. No other residents other those mentioned in this tag were affected by this deficient practice. The roommate visiting spouse was immediately removed and prohibited from returning to the building after allegation was brought to the Administrator's attention on 6/6/2012. Resident # B was transferred to another room on 6/8/2012. on 6/7/2012 the Director of Social Services, Administrator and owner met with the family of roommate visiting spouse to inform them that visiting spouse was no longer allowed in the building. Both residents were evaluated by the psychiatrist and will be continued to be followed up by the psychiatrist. The residents will be monitored as needed for any psycho-social changes. 2. The facility has reviewed and enhanced the orientation process to include a greater emphasis on the importance of identifying and reporting elder abuse. In order to ensure no other residents were affected by this deficient practice the Director of Social Services will	07/27/2012

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	bathing with the help of 1 staff. The MDS indicated she required extensive assistance with 1 to 2 staff assistance with dressing. The MDS indicated the resident was occasionally incontinent of her bladder function. Review of an incident report, dated 6/6/12, reported to the state agency by the facility indicated an allegation of abuse was reported to the Administrator and the Director of Nursing by Hospice staff. The report indicated that Resident # B told her (Hospice staff) that a visitor who came to visit her roommate was touching her arm, hand and stomach and she was afraid he may touch other areas if she didn't report it. The incident indicated an investigation began on 6/6/12, the visitor was asked to leave the facility and not be allowed to return pending the investigation and the findings. The staff and the resident were interviewed. The investigation was completed on 6/7/12 and the claim was unsubstantiated due to the resident recanting the statement made to Hospice staff. The interviews with staff showed there was an intrusion to the resident's privacy when staff was providing care. The result of the incident investigation indicated the visitor would no longer be allowed to visit unless supervised by his		do face to face interviews with all nursing home residents. A Mandatory In-service on Abuse and Neglect , Privacy and Reporting Suspicious Activity will be conducted on 7/19/2012. 3. In-services on Abuse and Neglect will be done quarterly for the next year and then twice a year. These in-services will at times include outside sources like APS. Mandatory In-service on Abuse and Neglect, Privacy and Reporting Suspicious Activity will be conducted for all current staff on 7/19/2012. Orientation process related to abuse and neglect was revised and enhanced for all new employees. 4. The Social Services Director or Designee will randomly sample residents on a bi-monthly basis To determine any concerns regarding any allegation of Abuse & Neglect. These surveys will be done for 3 months and then bi-annually. Assistant of Director of Nursing or Designee will randomly sample staff on bi-monthly basis to determine if there are any concerns regarding allegation of Abuse and Neglect. These surveys will be done for 3 months and then bi-annually. Surveys will be monitored by the Administrator and the Director of Nursing and results will be tracked and reported to the quarterly to the Quality Assurance Committee. 5. Date of Completion 7/27/2012 The	

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	son. A follow-up reported incident, dated 6/7/12, indicated " ...This is additional information obtained relative to the incident that was submitted to ISDH (Indiana State Department of Health) on 6/7/12. On the evening of 6/7/12, the family (belonging to Resident # B) came to the facility with the police and was very upset because of allegations of inappropriate touching by the roommate's husband. Family (belonging to Resident #B) called by the owner on 6/8/12 to come in for a meeting to discuss concerns. A meeting was held in the morning with Adult Protective Services, the Ombudsman and the facility administration and the family. The Ombudsman and the APS (Adult Protective Services) interviewed the resident who indicated that the roommate's husband had touched her on two separate occasions; once on the arm and once he held her hand. The granddaughter went with APS to interview the resident one more time and this time the resident indicated that the roommate's husband had touched her under her gown on her breast and her stomach and the APS then asked 'did he touch you between your legs?' and the resident said, 'yes.' We met again with APS, the Ombudsman and the		facility is asking for paper compliance Addendum to F 223. The Social Services Director or Designee will sample 10 residents on a bi-monthly basis to determine if there are any concerns regarding allegation of Abuse and Neglect. Assistant of Director of Nursing or Designee will sample 10 employees on bi-monthly basis to determine if there are any concerns regarding allegation of Abuse and Neglect.	

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	granddaughter and we decided that we will not allow the roommate's husband back in the facility at all during the investigation...." During an interview with the Administrator on 6/25/12 at 9:50 a.m., regarding the above incident, she indicated the son of the roommate's husband questioned his father about touching Resident # B between her legs and he admitted to his son that yes, he did touch her between her legs. A written statement provided by CNA # 3, dated 6/6/12, indicated "To start with this is not the first time we've had this problem with (Visitor # 4) and other roommates since (Resident #B) been in that rm (room). (Visitor # 4) has giving (sic) CNA a hard time about leaving rm when we want to in (sic) and do pt (patient) care on both residents he also has something smart to say. A few times he would not leave the room so I would pull the privacy curtain (sic) and he would pull the curtain (sic) back right in the middle of resident care...He also always (sic) closing the door after we asked his (sic) not to...." Another written statement, dated 6/6/12, provided by CNA # 3 regarding Visitor # 4 indicated "I was in rm (room number)			

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	about 6:30 6:45 p (sic) taking of (sic) both resident, (sic) at the time the door bust on (sic) I looked and it was (Visitor # 4) in (sic) stated (Visitor # 4) 'I cleaning (sic) these ladies up you need to not come in the rm' (sic) about 30 seconds later CNA # 5 came in the room, I said 'who is it,' CNA # 5 said, 'me.' I though (sic) it was (Visitor # 4) again. Once I seen (sic) it was CNA # 5 I ask (sic) to stay by the door for me and not to leave..." The statement indicated the staff stayed with the resident and called the police to escort Visitor # 4 out of the building. A statement written by CNA # 6, dated 6/6/12, indicated "On Friday (Visitor # 4) refuse (sic) to excuse his self (sic) from the room when we had to do resident care, he pulled back the curtain to see us do resident care to bed 1. He also remove (sic) the breathing machine from her face and cut off the machine to her bed while she was in it moving her blankets back off her body while she in the bed (sic). Taking the bedroom door to block the other door so we couldn't come in, moving the bedside table away from her." During an interview with the Director of Nursing on 6/26/12 at 1:15 p.m., regarding Visitor # 4, she indicated staff came to her with concerns about Visitor # 4 preventing care and cursing at staff.			

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	She indicated she had asked staff to document information so she would have the needed information to discuss with the family of Resident # D (wife of Visitor # 4). She further indicated a note, dated 6/4/12, was slipped under her door. She indicated on 6/5/12 she spoke with Resident # D regarding setting up a meeting with her family. A written statement, dated 6/4/12, and signed by CNA's # 4, # 5, and # 6 indicated on 6/1/12 "(Visitor # 4) had stated we were watchin (sic) T.V. and he wasn't going to keep leaving the room (sic) for (sic) bed was off and on floor taken breathing treatment off of (Resident # B) and turning machine off. Can't do care on (Resident # B) cause (sic) he would not leave the room and he pulls the curtain back. I leave the room come back her (sic) bedside table been (sic) moved. In May he was try (sic) to put cover on (Resident # B) after I had finish her (sic) up and she didn't want the blanket on." This statement was obtained by the Director of Nursing on 6/5/12. The DoN indicated the staff slid it under her door on 6/4/12 and she received it the next morning. During an interview with the Hospice Aide # 7 on 6/25/12 at 3:30 p.m.,			

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	regarding the incident, she indicated when she went to see (Resident # B) on 6/4/12 she had to ask (Visitor # 4) to leave. She indicated he was huffy about it but he left as she wanted to provide care to (Resident #B.) She indicated when she left she put her bedside table beside her so she could reach her things. She indicated she left the room and went to the nurses' station to chart, she indicated she forgot something and went back into (Resident # B's) room and found her bedside table at the foot of her bed. She asked Resident # B if she was ok because she looked aggravated, she indicated the resident replied "yes." Hospice Aide # 7 indicated on her next visit on 6/6/12 she asked the resident if there was a problem because she seemed aggravated on her last visit. She indicated she asked her if there was a problem with her roommate's husband and she replied to her "yes, because he bothers me, he touches me." She asked her where he touched her and she pointed to her right arm, her hand and her stomach. The Hospice Aide indicated she denied he touched her "down there," but stated to her "It was only a matter of time before he does and that's what I'm afraid of." Hospice Aide # 7 indicated she immediately reported the comment from Resident # B to her Hospice Supervisor on 6/6/12 who then reported it			

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	immediately to the facility Administrator on 6/6/12. During an interview with CNA # 3 on 6/25/12 at 3:10 p.m., regarding Visitor # 4's actions, she indicated Visitor # 4 has been doing this for a long time (pulling the privacy curtain open during care). CNA # 3 indicated when Visitor # 4 would pull open the curtain, (Resident #B's) naked body would be exposed. She indicated he would refuse to leave the room when care was being provided. CNA # 3 indicated she reported Visitor # 4's behaviors to the nurse. During an interview with the Administrator regarding the above interview on 6/25/12 at 3:45 p.m., she indicated the nurse who CNA # 3 reported the incident was no longer working at the facility and not able to be interviewed due to health issues. She further indicated none of the above information regarding Visitor # 4's actions of pulling open the privacy curtain was brought to light until the allegation was made and interviews and statements were obtained on 6/6/12. Review of nurses' notes on 6/25/12 lacked information documented from the nurse regarding Visitor # 4's actions or any interventions to protect Resident # B's privacy.			

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	Resident # D's record was reviewed on 6/25/12 at 1:50 p.m. The resident's diagnoses included, but were not limited to; Bipolar, and depression. Resident #D's Significant change MDS, dated 4/29/12, indicated her cognition was intact. Resident # D was the wife of Visitor # 4 and the resident who shared a room with Resident #B. Resident # D's record indicated a Social Service note, dated 12/22/11, and indicated "Spoke with res (resident) on today's date regarding spouse using wheelchair while visiting. Spouse has been witnessed propelling wheelchair backwards through the hall and also bumping into roommate's bed. Writer also informed resident of roommate's need for privacy during resident's vitiation with husband. Informed resident that if the staff or resident closes the privacy curtain it is to remain closed to ensure the privacy of the other resident. Informed the resident that if more space is needed during visit they can use first floor living room. Writer also informed resident that if spouse has any questions regarding this issue to speak with either administrator or writer." During an interview with Social Service			

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	staff on 6/26/12 at 1:30 p.m., regarding concerns with Visitor # 4 that was shared with her on 6/4/12 by the DoN, the Social Service staff indicated the Director of Nursing shared her concerns with Social Service regarding Visitor # 4 pulling Resident # B's privacy curtain open during care. She indicated the Director of Nursing informed her she was getting statements from the staff regarding Visitor # 4's behaviors. Social Service indicated she called the family the next day on 6/5/12 to set up a family care conference and indicated Visitor # 4 was in the facility on the 6/5/12 and informed him as well. Review of a Psychiatric Progress Note, dated 6/13/12, indicated "...Staff had discussed 2 patients on my list with me before I saw this patient. It was reported that (Resident # B) was sharing a room with another patient whose husband came to visit his wife every day and (Resident #B) had told her granddaughter that he was inappropriately touching her. It got out of hand and staff had to interview her and Adult Protective Services had to come and the police came to get a report. The staff had to let that process go on because they had to report it to the police and they then changed her room. She has another roommate who was out for something at this time. Patient did not			

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	talk about that and I did not bring that issue up either. She seems to be doing fine. I was told that the staff does not know how long the inappropriate sexual behavior had been going on. She has told staff that she was afraid to tell anybody...." A meeting was held on 6/26/12 at 12:00 p.m., with the Administrator, Director of Nursing, Corporate RN, ISDH Supervisor and Surveyor regarding the above issues with Resident # B. The facility staff present indicated they were fairly new to the facility and was not aware of Visitor # 4's behaviors until the allegation was reported by Hospice. The Hospice Aide reported the resident's concerns to her supervisor on 6/6/12 who then reported it to her supervisor who then contacted the facility the same day, 6/6/12. During an interview with the owner of the facility who was also a licensed Administrator on 6/27/12 at 1:00 p.m., regarding any other resident's having shared a room with Resident # D while her husband visited, she indicated there was only one other resident who shared a room with Resident # D and "she is gone, she was discharged some time ago." During an interview with CNA # 6 on 6/27/12 at 2:45 p.m., she indicated she			

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	didn't know who wrote the 6/4/12 note, but she did acknowledged signing it. She indicated on 6/1/12, Visitor # 4 would open the bathroom door and had it pushed against the resident's door that enters the room. She indicated this happens all of the time. She also indicated Visitor # 4 would not allow her to shut the curtain and indicated she had been yelled at by Visitor # 4. CNA #6 indicated he (Visitor # 4) would pull the curtain open while she was providing care to Resident # B and indicated she would leave the room for a minute and when she returned, Resident # B's air machine unit to her bed would be on the floor. CNA # 6 indicated she did report this to the nurse on 6/1/12. CNA # 6 indicated that all the aides help each other out whether was their assignment or not as most of the residents require 2 people to assist them with care. This was also expected of the CNA's even if they are on the assisted living side of the building. CNA #6 indicated she did not see Visitor # 4 remove the covers off of Resident # B, but indicated the resident was not able to remove them herself. The resident's record lacked any documentation from the nurse regarding what the CNA reported During an interview with the DoN on 6/27/12 at 10:30 a.m., she indicated that CNA # 5 came to her on 6/4/12 and told			

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	her "something has to be done about Visitor # 4." The DoN indicated she had instructed CNA # 5 to write down in detail what Visitor # 4 was doing and to slide it under her door and she would look at it when she returned on 6/5/12. The DoN indicated she did receive the note under her door on 6/5/12, but was unsure who wrote the note since there were three CNAs who signed it. The DoN indicated when she read the note, she immediately went to the Social Worker and the Administrator. She indicated she did not interview all three CNAs. The DoN indicated the Hospice Nurse informed her of the allegation on 6/6/12. The DoN further indicated the resident was moved into a different room the next day. An inservice was presented by an Adult Protective Services (APS) staff member on 6/19/12. The inservice sheet indicated 28 signed the attendance sheet. The content of the inservice included information on "Common Indicators of Endangerment," "Who is an Endangered Adult?," and "What Can Adult Protective Services Do?" The identified areas covered under "Common Indicators of Endangerment" included "malnutrition or weight loss without medical cause, unsuitable clothing or grooming, unsafe or			

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	inhabitable housing, lack of medical care, implausible stories, dependent person left unattended for long periods of time, frequent or unexplained injuries, sudden change in finances, unnecessary Power of Attorney or guardianship." The identified areas covered under "Who is an Endangered Adult" included information defining endangered adults as those individuals age of 18 years or older who are "incapable of managing self-care or property because of a physical or mental incapacity" and "harmed or threatened with harm as a result of neglect, self-neglect, battery, or exploitation." An inservice was presented by the facility Social Service staff on 6/26/12. The inservice was titled "Privacy and Reporting Suspicious Activity." The inservice sign in sheet indicated 20 of the staff members had attended the inservice. When interviewed on 6/27/12 at 1:50 p.m., Social Service staff indicated she had conducted an inservice titled "Privacy and Reporting Suspicious Activity" on 6/26/12 for the employees who worked on 6/26/12. The Social Service staff indicated at this time no other staff had been inserviced.			

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	The facility policy titled "Abuse Prevention and Reporting Policy" undated, was reviewed on 6/25/12 at 3:00 p.m. and indicated "...Abuse. Sexual includes, but is not limited to, sexual harassment, sexual coercion, sexual assault, resident to resident non-consensual sexual acts or staff-to resident sexual abuse. Some consensual situations may meet definition depending on the cognitive status." This Federal tag relates to Complaint IN00109700. 3.1-27(a)(1)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	Based on record review and interviews, the facility failed to follow their abuse policy to ensure all allegations of abuse and or neglect was immediately investigated and addressed to ensure the resident was protected from further abuse related to the facility failing to immediately address inappropriate behaviors by a visitor to (Resident # B) for 1 of 3 residents reviewed for abuse in a sample of 3. Findings include: Resident # B's record was reviewed on 6/25/12 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; Anxiety, dementia, weakness, and paranoia. The resident's record indicated she was admitted to the facility on 6/26/11. Resident # B's Significant change MDS (Minimum Data Set) assessment, dated 3/21/12, indicated her cognition was moderately impaired. She required minimal assistance with transfers and	F0226	F-226 1.No other residents were affected by this deficient practice. Effective immediately the abuse policy will be revised to include immediate intervention and investigation of all allegation and unusual occurrences. All management staff will be re-educated on 7-18-12 on the importance of investigating and providing intervention immediately for any allegation of abuse . 2. Orientation process will be revised including training of identifying signs of elder abuse and the importance of prompt reporting. The orientation process is currently being revised and will be monitored by the Administrator. In order to ensure on other residents were affected by this deficient practice the Director of Social Services will do a face to face interviews with nursing home residents. 3. All staff mandatory in-service will be held on 7/19/2012 regarding the prompt reporting of any suspicious activity and all allegations of Abuse and Neglect. Failure to report signs of elder abuse will result in disciplinary action and possible	07/27/2012

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	bathing with the help of 1 staff. The MDS indicated she required extensive assistance with 1 to 2 staff assistance with dressing. The MDS indicated the resident was occasionally incontinent of her bladder function. A written statement, dated 6/4/12, signed by CNA's # 4, # 5, and # 6 indicated on 6/1/12 " (Visitor # 4) had stated we were watchin (sic) T.V. and he wasn't going to keep leaving the room (sic) for (sic) bed was off and on floor taken breathing treatment off of (Resident # B) and turning machine off. Can't do care on (Resident # B) cause (sic) he would not leave the room and he pulls the curtain back. I leave the room come back her (sic) bedside table been (sic) moved. In May he was try (sic) to put cover on (Resident # B) after I had finish her (sic) up and she didn't want the blanket on." This statement was obtained by the Director of Nursing (DoN) on 6/5/12. The DoN indicated the staff slid it under her door on 6/4/12 and she received it the next morning. Resident # B's record indicated she was seen by Hospice on 6/4/12. Hospice Aide # 7 provides care to Resident # B. During an interview with the Hospice Aide # 7 on 6/25/12 at 3:30 p.m., she		termination. RN Consultant will provide re-education for management staff on 7/18/2012. 4.In order to monitor and ensure that abuse policies are followed the Director of Social Services or Designee will randomly sample residents on a bi-monthly basis to determine any concerns regarding any allegation of Abuse & Neglect. These surveys will be done for 3 months and then bi-annually. The Assistant Director or Nursing Designee will randomly sample staff on bi-monthly basis to determine if there are any concerns regarding allegation of Abuse & Neglect. These surveys will be done 3 months and then bi-annually. Surveys will be monitored by the Administrator and the Director of Nursing and results will be tracked and reported quarterly to the Quality Assurance Committee. 5.Date of completion 7/27/12 The facility is asking for paper compliance Addendum to tag 226 The Director of Social Services or Designee will sample 10 residents on a bi-monthly basis to determine if there are any concerns regarding allegation of Abuse & Neglect. The Assistant Director of Nursing or Designee will sample 10 employees on a bi-monthly basis to determine if there are any concerns regarding allegation of Abuse & Neglect.	

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	indicated when she went to see (Resident # B) on 6/4/12 she had to ask (Visitor # 4) to leave. She indicated he was huffy about it but he left as she wanted to provide care to (Resident #B.) She indicated when she left she put her bedside table beside her so she could reach her things. She indicated she left the room and went to the nurses' station to chart. She indicated she forgot something and went back into (Resident # B's) room and found her bedside table at the foot of her bed. She asked Resident # B if she was ok because she looked aggravated, she indicated the resident replied "yes." Hospice Aide # 7 indicated on her next visit on 6/6/12, she asked the resident if there was a problem because she seemed aggravated on her last visit. She indicated she asked her if there was a problem with her roommate's husband and she replied to her "yes, because he bothers me, he touches me." She asked her where he touched her and she pointed to her right arm, her hand and her stomach. The Hospice Aide indicated she denied he touched her "down there" but stated to her "It was only a matter of time before he does and that's what I'm afraid of." Review of an incident, dated 6/6/12, reported by the facility indicated an allegation was reported to the Administrator and the Director of Nursing			

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	by Hospice staff that Resident # B told her that a visitor who came to visit her roommate was touching her arm, hand and stomach and was afraid he may touch other areas if she didn't report it. The incident indicated an investigation began on 6/6/12, the visitor was asked to leave the facility and not be allowed to return pending the investigation and the findings. The staff and the resident were interviewed. The investigation was completed on 6/7/12 and the claim was unsubstantiated due to the resident recanting the statement made to Hospice staff. The interviews with staff showed there was an intrusion to the resident's privacy when staff was providing care. The result of the incident investigation indicated the visitor would no longer be allowed to visit unless supervised by his son. A follow-up reported incident, dated 6/7/12, indicated " ...This is additional information obtained relative to the incident that was submitted to ISDH (Indiana State Department of Health) on 6/7/12. On the evening of 6/7/12 the family (belonging to Resident # B) came to the facility with the police and was very upset because of allegations of inappropriate touching by the roommate's husband. Family (belonging to Resident			

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	#B) called by the owner on 6/8/12 to come in for a meeting to discuss concerns. A meeting was held in the morning with Adult Protective Services, the Ombudsman and the facility administration and the family. The Ombudsman and the APS (Adult Protective Services) interviewed the resident who indicated that the roommate's husband had touched her on two separate occasions; once on the arm and once he held her hand. The granddaughter went with APS to interview the resident one more time and this time the resident indicated that the roommate's husband had touched her under her gown on her breast and her stomach and the APS then asked 'did he touch you between you legs?' and the resident said, 'yes.' We met again with APS, the Ombudsman and the granddaughter and we decided that we will not allow the roommate's husband back in the facility at all during the investigation...." During an interview with the Administrator on 6/25/12 at 9:50 a.m., regarding the above incident, she indicated the son of the roommate's husband questioned his father about touching Resident # B between her legs and he admitted to his son that yes, he did touch her between her legs.			

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	During an interview with Social Service staff on 6/26/12 at 1:30 p.m., regarding if concerns with Visitor # 4 were shared with her on 6/4/12 by the DoN. Social Service staff indicated the Director of Nursing shared her concerns with Social Service regarding Visitor # 4 pulling Resident # B's privacy curtain open during care. She indicated the Director of Nursing informed her she was getting statements from the staff regarding Visitor # 4's behaviors. Social Service indicated she called the family (Resident D's) the next day on 6/5/12 to set up a family care conference and indicated Visitor # 4 was in the facility on the 6/5/12 and informed him as well. During an interview with the DoN on 6/27/12 at 10:30 a.m., she indicated that CNA # 5 came to her on 6/4/12 and told her "something has to be done about Visitor # 4." The DoN indicated she had instructed CNA # 5 to write down in detail what Visitor # 4 was doing and to slide it under her door and she would look at it when she returned on 6/5/12. The DoN indicated she did receive the note under her door on 6/5/12 but was unsure who wrote the note since there were three CNAs who signed it. The DoN indicated when she read the note, she immediately went to the Social Worker and the			

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	Administrator. She indicated she did not interview all three CNAs. The DoN indicated the Hospice Nurse informed her of the allegation on 6/6/12. The DON further indicated the resident was moved into a different room the next day. During an interview with the owner of the facility who was also a licensed Administrator on 6/27/12 at 1:00 p.m., regarding any other resident's having shared a room with Resident # D while her husband visited, she indicated there was only one other resident who shared a room with Resident # D and "She is gone; she was discharged some time ago." Resident # B's record failed to indicate interventions or plans were put in place on 6/4/12 when the information was provided to the Director of Nursing to prevent Visitor # 4 from touching or bothering Resident # B any further. During an interview with the Administrator on 6/27/12 at 3:40 p.m., regarding no plans being put in place on 6/4/12 when the information was provided to the DoN, she indicated Visitor # 4 was not in the building on 6/4/12 and the family was called on 6/5/12 to inform the family of a needed meeting concerning Visitor # 4's behaviors.			

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	Social service note, dated 6/8/12, indicated Resident # B was moved on 6/8/12. A note documented by the DoN, dated 6/8/12, indicated " ...(Late Entry for 6/7/12) ...resident moved to new room ..." During an interview with CNA # 6 on 6/27/12 at 2:45 p.m., she indicated she didn't know who wrote the 6/4/12 note, but she did acknowledged signing it. She indicated on 6/1/12, Visitor # 4 would open the bathroom door and had it pushed against the resident's door that enters the room. She indicated this happens all of the time. She also indicated Visitor # 4 would not allow her to shut the curtain and indicated she had been yelled at by Visitor # 4. CNA # 6 indicated he would pull the curtain open while she was providing care to Resident # B and indicated she would leave the room for a minute and when she returned, Resident # B's air machine unit to her bed would be on the floor. CNA # 6 indicated she did report this to the nurse on 6/1/12. The resident's record lacked any documentation from the nurse regarding what the CNA reported. CNA # 6 indicated that all the aides help each other out whether was their assignment or not as most of the residents require 2 people to assist them with care. This was also			

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	expected of the CNA's even if they are on the assisted living side of the building. CNA #6 indicated she did not see Visitor # 4 remove the covers off of Resident # B, but indicated the resident was not able to remove them herself. The undated facility policy titled "Abuse Prevention and Reporting Policy" was reviewed on 6/25/12 at 3:00 p.m., indicated "Purpose: To establish guidelines and procedures for preventing, investigating, resolving and reporting resident abuse, neglect involuntary seclusion, and misappropriation of property and to ensure staff are properly trained in effective methods of prevention and surveillance. Responsibility: Administrator, Director of Nursing, Social Service Director and all staff...It is the policy of The Milton Home to protect residents and staff from abusive acts and to adequately train facility personnel in methods of detection and prevention of abuse...." This Federal tag relates to Complaint IN00109700. 3.1-28(a)			

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