

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                                                                                                                 |                      |                                                            |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>155738</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                |                      | (X3) DATE SURVEY COMPLETED<br><br>R-C<br><b>08/10/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MILTON HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>206 E MARION ST<br/>SOUTH BEND, IN 46601</b>                        |                      |                                                            |
| (X4) ID PREFIX TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |                                                            |
| {F 000}                                                | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00109700 completed on 6/27/12.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 6/1/12.</p> <p>Complaint IN00109700- Corrected.</p> <p>Survey date: August 10, 2012</p> <p>Facility number: 001141<br/>Provider number: 155738<br/>AIM number: 100905640</p> <p>Survey team:<br/>Janet Adams, RN, TC<br/>Shannon Pietraszewski, RN</p> <p>Census bed type:<br/>SNF: 12<br/>SNF/NF: 17<br/>Residential: 21<br/>Total: 50</p> <p>Census payor type:<br/>Medicare: 7<br/>Medicaid: 21<br/>Other: 22<br/>Total: 50</p> <p>Sample: 6</p> <p>Milton Home was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Post Survey Revisit to the</p> | {F 000}                                                                 |                                                                                                                 |                      |                                                            |

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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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MILTON HOME</b> |                                                                                                                                                                                                                             |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>206 E MARION ST<br/>SOUTH BEND, IN 46601</b>                        |                      |                                                            |
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| {F 000}                                                | Continued From page 1<br>Investigation of Complaint IN00109700.<br><br>This deficiency reflects state finding cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on August 14, 2012 by Bev Faulkner, RN | {F 000}                                                                 |                                                                                                                 |                      |                                                            |