

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	---	---

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

(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 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00182147.</p> <p>Complaint IN00182147 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Survey dates: September 28, 29, 30 and October 1, 2, 5 and 6, 2015.</p> <p>Facility number: 001141 Provider number: 155738 AIM number: 200905640</p> <p>Census bed type: SNF/NF: 29 Residential: 19 Total: 48</p> <p>Census payor type: Medicare: 5 Medicaid: 15 Other: 9 Total: 29</p> <p>Sample: 3</p>	F 0000	<p>R119 How the facility will correct the deficiency as it relates to the resident. Employee's #7&9 general orientation and job specific were completed.</p> <p>How the facility will act to protect residents in similar situations. All employee files have been audited to ensure that each employee has a general orientation and a job specific orientation.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Administrator conducted a training with the HR/Payroll employee and BOM on the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB screening.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained. Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the Interdisciplinary team weekly</p>	

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.

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 10/06/2015
--	---	--	---

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

(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
	<p>These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14454 on October 14, 2015.</p>		<p>for 4 weeks, then monthly for 2 months, and atleast quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p> <p>R121</p> <p>How the facility will correct the deficiency as it relates to the resident. Employee #8 no longer works at the facility 10/12/15 Quit with no notice.</p> <p>How the facility will act to protect residents in similar situations. All employee files have been audited to ensure that each employee has first and second step Mantoux testing for TB.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Administrator conducted a training with the HR/Payroll employee and BOM on the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB</p>	

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 10/06/2015
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601		
(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 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to provide showers to 2 of 3 residents per their preferences. (Resident #31 and #34)	F 0242	screening. How the facility plans to monitor its performance to make sure that solutions are sustained. Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance. Date when the corrective action will be completed by: November 5, 2015 F242 How the facility will correct the deficiency as it relates to the resident. Resident # 31 and #34 have been interviewed per social services for	11/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>Findings include:</p> <p>1. During an interview on 9-29-2015 at 1:32 P.M., Resident #31 indicated she would like a shower every day because, " I have a colostomy bag and twice a week is not enough for me."</p> <p>A record review for Resident #31 was conducted on 10-1-2015 at 11:15 A.M. Resident #31 admission date was 4-22-2014. The most recent MDS (Minimum Data Set) assessment for Resident #31, dated 8-7-2015, indicated a BIMS (Brief Interview for Mental Status) assessment score of 14 out of 15. This indicated the resident was cognitively intact.</p> <p>A Care Plan, dated 9-1-2015, indicated, "...Resident requires extensive assist with all ADLs [Activities of Daily Living] and Hygiene R/T [related to] immobility impaired by hemiparesis...Bathe 2 times weekly...." There was no care plan related to preferences available for review.</p> <p>The shower schedule for Resident #31 indicated Monday and Thursday as her scheduled shower days.</p> <p>A "Resident Interview and Resident</p>		<p>preferences in bathing. Resident #31 has chosen to have her shower (2) times per week onMonday, Thursday. Resident #34 has chosen to have his showers (2) times per week on Tuesday and Friday. The shower schedule has been updated toreflect these changes as of October 23, 2015. The care plan has been updated to reflect the resident preferences. How the facility willact to protect residents in similar situations. Re-education of all staff will occur on October 30, 2015 forcorrect implementation of the plan of care and understanding that the residenthas the right to choose activities, schedules and health care consistent withhis or her interests, assessments, and plans of care. Measures the facilitywill take or the systems it will alter to ensure that the problem does notrecur. Documentation of resident preferences will occur at time ofadmission. The medical records nursewill audit new admission charts to ensure completion of resident preferencequestionnaire. How the facilityplans to monitor its performance to make sure that solutions are sustained. The Director of Nursing (DON)/Designee will conduct auditsusing quality assurance review form titled "Preferences and right to makechoices". This audit will be conductedweekly x 4</p>				

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 10/06/2015
--	---	--	---

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

(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
	<p>Observation," dated 8-19-2015, for Resident #31 indicated, "...Do you choose how many times a week you take a bath or shower?...Yes...."</p> <p>During an interview on 10-1-2015 at 1:00 P.M., the DON (Director of Nursing) indicated that a recent assessment was conducted by staff to update resident preferences just a few weeks ago. The DON was unable to locate the assessments for review.</p> <p>During an interview on 10-1-2015 at 2:10 P.M., Resident#31 indicated she had not been asked about her shower preferences during her stay at the facility. Resident #31 indicated that the staff informed her, when she was admitted, that her shower days would be Monday and Thursday.</p> <p>A policy related to resident preferences was not available to review.</p> <p>2. During an interview on 9-29-2015 at 3:14 P.M., Resident #34 indicated he would like to have a shower twice a week. Resident #34 indicated he has had only one a week during his stay at the facility.</p> <p>On 10-1-2015 at 8:45 A.M., a record review for Resident #34 was conducted. Resident #34's admission date was</p>		<p>weeks, monthly x 3 months, and quarterly there after. A summary of findings will be submitted to the Quality Assurance Committee x 3 months and quarterly x 2 months for further recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015
--	---	--	---

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

(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 0279 SS=D Bldg. 00	<p>8-31-2015. The MDS (Minimum Data Set) assessment, dated 9-7-2015, indicated BIMS (Brief Interview for Mental Status) assessment score of 15 out of 15. This indicated the resident was cognitively intact.</p> <p>Review of Resident #34's shower sheets indicated he had a shower on 9-11-2015, 9-15-2015, 9-18-2015, 9-22-2015 and 9-25-2015. Shower sheets dated 9-4-2015 and 9-29-2015 indicated Resident #34 had refused his showers.</p> <p>During an interview on 10-1-2015 at 10:30 A.M., Resident #34 indicated he had not been showered as the shower sheets had indicated and that he had not refused a shower during his stay at the facility.</p> <p>No preference assessment or care plan related to shower preferences was available to review.</p> <p>3.1-3(u)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure care plans were developed for the use of an anti-psychotic, anti-depressant, and anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #20) The facility also failed to develop a plan of care for a resident admitted with an unstageable pressure ulceration for 1 of 3 residents reviewed for pressure ulcerations. (Resident #13)</p> <p>Findings include:</p> <p>1. On 10-5-15 at 6:18 A.M., the clinical record for Resident #20 was reviewed. Resident #20 was admitted to the facility on 6-22-15. The diagnoses included but</p>	F 0279	F279 How the facility will correct the deficiency as it relates to the resident. The care plans for resident # 20 was reviewed and updated to reflect the residents need and use of anti-psychotic, anti-depressant, and anti-anxiety medications. The care plan for resident #13 was reviewed and updated to reflect the resident unstageable pressure ulceration, and ongoing treatments and interventions. How the facility will act to protect residents in similar situations. An audit of current resident care plans will be completed by October 30, 2015 by the Director of Nursing, MDS nurse and Social Services to determine that care plans reflect the resident's needs based on the most recent comprehensive	11/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	---	---

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

(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
	<p>were not limited to "...depression, anxiety, dementia with delusions...."</p> <p>A quarterly MDS (Minimum Data Set) assessment, completed on 8-4-15, indicated "...active diagnoses include:...dementia...depression...anxiety. ..."</p> <p>Physician orders for Resident #20 indicated "...Olanzapine [anti-psychotic medication] tab 7.5 mg [milligrams] take 1 tablet by mouth daily at bedtime...Sertraline tab [anti-depressant medication] 100 mg take 1 tablet by mouth at bedtime for depression...Xanax [anti-anxiety medication] 0.5 mg 1 PO [by mouth] QID [four times daily] for anxiety...."</p> <p>Resident #20's chart showed no documentation of a care plan for Olanzapine, Sertraline or Xanax.</p> <p>On 10-6-15 at 12:25 P.M., the DON (Director of Nursing) indicated "...We don't have any care plans for those medications...."</p> <p>On 10-6-15 at 12:30 P.M., review of the current but undated "Care Plans" policy, received on 9/28/15 at 2:00 PM from the DON, indicated "...to promote individualized resident care plan, with</p>		<p>assessment. Any other careplans identified will be updated at that time by the licensed nurse.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur. Comprehensive care plans will be developed for each resident based on the care needs identified in the Comprehensive assessment (including depression, use of antidepressants, mood and behavior symptoms, wound assessment, treatment and interventions, as well as the Interdisciplinary review process to review these care plans ongoing.</p> <p>Care Plans: Nurses were in-serviced on 10/30/2015 on updating care plans when a new order is received. Attached is document Physician/Prescriber, note at the bottom of the telephone order, box indicating care plan. Binders of care plans on at each nurse's station to use for creating new care plans that may be needed with new Dr. orders. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON/designee will complete an audit using quality assurance review form titled "Care plan review" to determine that care needs as identified in the most recent comprehensive assessment are reflected in the resident plan of care and have been reviewed by the Interdisciplinary team weekly</p>	

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 10/06/2015
--	---	--	---

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

(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
	<p>specific plans from nursing and other disciplines...each discipline will identify actual or potential problems/needs, care to be given and goals to be accomplished...after each discipline identifies problems and goals, the interdisciplinary team will develop the care plan...the care plan will be maintained in a binder at the nurses station or with the Medical Record...."</p> <p>2. On 9-28-15 at 2:25 P.M., during an interview, LPN (Licensed Practical Nurse) #6 indicated, "[Resident #13's name] has an unstageable pressure ulcer to his left heel, I think. He [Resident #13] is seen by the wound doctor, so he must have an ulcer."</p> <p>On 9-29-2015 at 2:29 P.M., a record review for Resident #13 indicated an admission date of 10-12-2013, with a readmission date of 3-19-2015. A "Patient Transfer Assessment Form" from (a local hospital), dated 3-19-2015, indicated, "...Skin Condition Report...Pressure ulcers..." with 2 circles indicating the left heel and the coccyx area on the diagram.</p> <p>A care plan, dated 9-22-2014, indicated "...Stage 2 [Partial thickness loss of dermis presenting as a shallow open ulcer. May also present as a blister] pressure ulcer located to L [left] buttocks.</p>		<p>for 4 weeks, monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for three months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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 0282 SS=D Bldg. 00	<p>Surgical wound on L [left] heel...." An undated update was made with a target date of 9-25-2015, indicating, "Unstageable [Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar] on L [left] heel."</p> <p>A record review of the MDS (Minimum Data Set) assessment, dated 3-26-2015, indicated "One unstageable Pressure Ulcer" for Resident #13.</p> <p>On 10-1-2015 at 3:07 P.M., during an interview, the DON (Director of Nursing) indicated, "He [Resident #13] was admitted back to the facility after a stay in the hospital with an unstageable left heel pressure ulcer...it doesn't look like the care plan was updated until later..."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation, and interview, the facility failed to ensure a physician's order was followed related to getting a resident up in a chair daily.</p>	F 0282	F282 How the facility will correct the deficiency as it relates to the resident.	11/05/2015			

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 10/06/2015
--	---	--	---

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

(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
	<p>(Resident #19)</p> <p>Finding includes:</p> <p>On 9/29/2015 at 10:28 A.M., the clinical record for Resident #19 was reviewed. The admission assessment, dated 11/19/2014, indicated the resident's diagnoses included but were not limited to: vegetative state, dementia, congestive heart failure, and contracture's of the arms and legs.</p> <p>The most recent MDS (Minimum Data Set) assessment, dated 8/13/2015, indicated Resident #19 was in a persistent vegetative state with no discernible consciousness. The resident's functional status indicated total dependence for all activities of daily living.</p> <p>The physician's activities order, dated 9/01/2015 through 9/30/2015, and 10/01/2015 through 10/31/2015, included but were not limited to following, "...up in chair at 1:00 P.M. daily, down in bed at 3:00 P.M. daily...."</p> <p>The following observations of Resident #19 were made: On 9/29/2015 at 2:12 P.M., the resident was laying in bed in her room. On 9/30/2015 at 1:23 P.M., the resident was laying in bed in her</p>		<p>Orders were reviewed by the DON and facility MD. The resident/family preferences were removed from the residents Physicians Order Sheets. The resident/family preferences were added to the C.N.A. assignmentsheet and care plans have been updated.</p> <p>How the facility willact to protect residents in similar situations. Re-education of nursing staff will occur on October 30, 2015for correct transcriptions of resident/family preferences into the plan of careand transcription of orders onto the Physician Order Sheets. Any preference will be added to SocialService communication form and followed up by the Social service Director andcommunicated to the IDT team.</p> <p>Measures the facilitywill take or the systems it will alter to ensure that the problem does notrecur. Medical records nurse will review all new orders received ona weekly basis and ensure all orders are noted in correct place. All resident preferences will be added toC.N.A. assignment sheets and care plans by October 30, 2015.</p> <p>How the facilityplans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete an auditing quarterly assurance review form titled "Preferences and the right to makechoice" to determine that care needs as identified in the most</p>	

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 10/06/2015
--	---	--	---

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

(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 0309 SS=D Bldg. 00	<p>room. On 10/1/2015 at 2:40 P.M., the resident was laying in bed in her room.</p> <p>On 10/01/2015 at 2:33 P.M., an interview with Employee #6 indicated she didn't know if the resident was up in a chair daily from 1:00 P.M. to 3:00 P.M. She indicated there was no place that it would have been recorded to her knowledge.</p> <p>On 10/01/2015 at 2:56 P.M., an interview with the DON (Director of Nursing), indicated the order to have the resident up in a chair from 1:00 P.M. to 3:00 P.M., every day was requested by the resident's family. The DON indicated the request was on the physician's orders and signed by the physician, and the orders should have been followed by the facility staff.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>		<p>recent comprehensive assessment are reflected in the resident plan of care and have been reviewed by the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>Based on interview and record review, the facility failed to follow physician's orders related to administration of insulin for 1 of 5 residents reviewed for unnecessary medications. (Resident #15)</p> <p>Finding includes:</p> <p>On 10/1/2015 at 1:00 P.M., a record review of Resident #15's records was conducted. Resident 15's admission date was 5-30-2012. Resident 15's diagnoses included, but were not limited to, Diabetes Mellitus Type 2.</p> <p>The Physician's orders for Resident 15, dated 5/26/2014, indicated "Check blood sugar twice daily, call MD [Medical Doctor] < [less than] 60 or > [greater than] 400...6AM and 4PM...Humulin 70/30...inject 13 units sub Q [subcutaneous] every morning for DM [Diabetes Mellitus]...Time 8 AM...start: 02/06/2014...Hold insulin if blood sugar <100...start 02/06/2014."</p> <p>The following dates and blood sugars were listed in the MAR (Medicine Administration Record):</p> <p>*Date 7/20/2015 at 6:00 AM, blood glucose 95, 13 units of Humulin 70/30 given at 8:00 AM.</p>	F 0309	<p>F309</p> <p>How the facility will correct the deficiency as it relates to the resident.</p> <p>Resident #15's physician order for blood sugar checks and last 2 months of blood sugar results were reviewed by DON and MD. The order was clarified to read accu checks 15 to 30 minutes before meal service. Resident #15's family was also notified of error.</p> <p>How the facility will act to protect residents in similar situations.</p> <p>An audit was completed on all residents with a diagnosis of Diabetes to ensure physician orders are clearly written and being followed as directed. Any concerns noted have been corrected.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>Licensed nursing staff will be in-service by 10/30/2015 by the DON/designee to review the facility policy on Blood Glucose monitoring to ensure that physician orders and the facility policies are being followed as directed.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Director of Nursing/designee will complete an auditing quarterly assurance review form titled "Physician Orders" to determine that care needs as identified in the most recent</p>	11/05/2015			

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 10/06/2015
--	---	--	---

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

(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
	<p>*Date 7/22/2015 at 6:00 AM, blood glucose 91, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>*Date 7/23/2015 at 6:00 AM, blood glucose 50, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>*Date 7/24/2015 at 6:00 AM, blood glucose 78, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>*Date 7-29-2015 at 6:00 AM, blood glucose 82, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>*Date 7-31-2015 at 6:00 AM, blood glucose 60, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>*Date 8-9-2015 at 6:00 AM, blood glucose 68, 13 units of Humulin 70/30 given at 8:00 AM.</p> <p>Facility was unable to find the September MAR's for review.</p> <p>On 10-2-2015 at 8:10 A.M., during an interview, LPN (Licensed Practical Nurse) #4 indicated the night shift does the 6 AM blood sugar check and the day shift gives the insulin at 8 AM. LPN #4 indicated the insulin should be held if the 6 AM blood sugar is <100.</p>		<p>comprehensive assessment are reflected in the resident plan of care and have been reviewed by the interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015
--	---	--	---

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

(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 0441 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>			

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 10/06/2015
--	---	--	---

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

(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
	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure a nurse washed her hands appropriately before and after completing a pressure ulcer dressing change for a resident. (LPN #4)</p> <p>B. Based on record review and interview, the facility failed to ensure Mantoux testing was completed for 2 of 10 employees whose files were reviewed. (CNA #7 and CNA #8)</p> <p>Findings include:</p> <p>A.1. On 10-1-15 at 10:45 A.M., LPN (Licensed Practical Nurse) #4 was observed to enter the room for Resident #41 to complete a pressure ulcer dressing change. LPN #4 washed her hands in the resident's room bathroom for 6 seconds before donning gloves and completing the dressing change. After the dressing change was complete, LPN #4 was observed to wash her hands for 5 seconds in Resident #41's bathroom.</p> <p>On 10-2-15 at 1:35 P.M., the DON (Director of Nursing) indicated staff should wash their hands for 30 seconds</p>	F 0441	<p>F441 How the facility will correct the deficiency as it relates to the resident. Nurse #4 was in-serviced by the DON/designee regarding facility Handwashing policy/procedure followed by a return demonstration. The in-service specifically reviewed the length of time (30 seconds) that should be spent washing hands. How the facility will act to protect residents in similar situations. Staff will be in-serviced on 10/30/2015 by the DON/designee regarding facility Handwashing policy/procedure – staff will perform a return demonstration of proper handwashing. The in-service will specifically review the length of time (30 seconds) that should be spent washing hands. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. New staff will be trained on proper handwashing techniques upon hire and staff will be in-serviced bi-annually on the facility Handwashing policy/procedure specifically reviewing the length of time to spend on washing hands (30 seconds). The Administrator conducted a training with the</p>	11/05/2015

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>before and after a dressing change.</p> <p>On 10-2-15 at 2:00 P.M., review of the current but undated Hand Hygiene policy, received from the DON on 10-2-15 at 1:35 P.M., indicated "...Hands should be washed for at least 30 seconds...."</p> <p>B.1. On 10/06/2015 at 9:40 A.M., the employee records for CNA (Certified Nursing Assistant) #7 and CNA #8, were reviewed. In the file for CNA #7, there was no documentation of the first or second steps of the required Mantoux testing for TB (Tuberculosis). In the file for CNA #8, there was no documentation of the second step Mantoux testing for TB.</p> <p>On 10/06/2015 at 12:08 P.M., an interview with Employee #5, indicated the Mantoux testing should be done upon hire.</p> <p>On 10/06/2015 at 2:45 P.M., the Administrator, indicated CNAs #7 and #8 should have had the Mantoux testing completed upon hire.</p> <p>No policy was provided by the facility regarding Mantoux testing for employees.</p> <p>This Federal tag relates to Complaint IN00182147.</p>		<p>HR/Payrollemployee and BOM on the state required documents for new hired employees, toinclude but not limited to. B. General orientation of the facility, jobspecific orientation, resident rights training, first and second step TBscreening How the facilityplans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete random auditsusing review form titled handwashing skills validation check off to determine that staffare washing their hands using the proper technique and for the proper amount oftime for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected atthat time by a member of the Interdisciplinary team. A summary of findings will be submitted tothe Performance Improvement Committee monthly for 3 months and then quarterly x2 for further review and recommendation to ensure sustained compliance. Date when thecorrective action will be completed by: November 5, 2015</p>				

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 10/06/2015
--	---	--	---

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

(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 0496 SS=D Bldg. 00	<p>3.1-14(t)(1) 3.1-18(l)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency</p>			

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>evaluation program.</p> <p>Based on interview and record review, the facility failed to ensure a CNA (Certified Nursing Assistant) held an unexpired license, from another state, while employed with the facility. (CNA #10)</p> <p>Finding includes:</p> <p>On 9-30-2015 at 4 P.M., a record review of all the licenses held in the facility was conducted. CNA #10's license was found to have an expired status with the date of 9-1-2015. CNA #10's employment with the facility began on 8-5-2015, and CNA's original license had been obtained in the state of New York. The expiration date was 8-31-2015, with the state of New York. A reapplication had not been attempted. CNA #10 was observed to be working on 9-28-2015 and 9-29-2015 during the day shift on the first floor.</p> <p>On 10-1-2015 at 8:45 A.M., the Administrator indicated, "...we didn't realize her license was expired...she has been taken off the schedule...."</p> <p>3.1-14(f)</p>	F 0496	<p>F496</p> <p>How the facility will correct the deficiency as it relates to the resident.</p> <p>Employee with expired certification was suspended until her certification was renewed.</p> <p>How the facility will act to protect residents in similar situations.</p> <p>Payroll/HR will conduct a full audit on all current employee files to ensure all certifications and licenses are current and in goodstanding.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>All new associates will have their certifications/licenses verified through IPLA, and then a tickler file will be maintained to notify the Payroll/HR of certifications/licenses for renewal dates.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance</p>	11/05/2015			

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 10/06/2015
--	---	--	---

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

(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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint #IN00182147.</p> <p>Complaint IN00182147 - Substantiated. State deficiencies related to the allegation are cited at R119 and R121.</p> <p>Residential Census: 19</p> <p>Sample: 7</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 14454 on October 14, 2015.</p>	R 0000	<p>Improvement Committee monthly for 3 months and then quarterly x2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p> <p>R119 How the facility will correct the deficiency as it relates to the resident. Employee's #7&9 general orientation and job specific were completed.</p> <p>How the facility will act to protect residents in similar situations. All employee files have been audited to ensure that each employee has a general orientation and a job specific orientation.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Administrator conducted a training with the HR/Payroll employee and BOM on</p>	

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 10/06/2015
--	---	--	---

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

(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
			<p>the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB screening.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p> <p>R121</p> <p>How the facility will correct the deficiency as it relates to the resident.</p> <p>Employee #8 no longer works at the facility 10/12/15 Quit with no notice.</p> <p>How the facility will act to protect residents in similar situations.</p> <p>All employee files have been audited</p>	

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 10/06/2015
--	---	--	---

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

(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
R 0116 Bldg. 00	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on record review and interview the facility failed to ensure an employee's pre-employment reference checks were submitted and on file, for 1 of 10 facility employees. (CNA #9)</p> <p>Finding includes:</p> <p>On 10/06/2015 at 9:40 A.M., the employee records for CNA (Certified Nursing Assistant) #9 were reviewed. In the file for CNA #9, there was no documentation of any references submitted before CNA #9 was hired.</p> <p>On 10/06/2015 at 2:45 P.M., the Administrator indicated the references were missing from CNA #9's file and was unable to locate them. The Administrator indicated all employees should have the required references in their file before hire.</p> <p>No policy was provided by the facility regarding references for new employees.</p>	R 0116	<p>R116 How the facility will correct the deficiency as it relates to the resident. Employee #9's references were completed.</p> <p>How the facility will act to protect residents in similar situations. All employee files have been audited to ensure that each employee has 2 (two) reference checks. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Administrator conducted a training with the HR/Payroll employee and BOM on the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB screening.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained. Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring</p>	11/05/2015

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 10/06/2015
--	---	--	---

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

(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
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights.		to the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance. Date when the corrective action will be completed by: November 5, 2015	

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 10/06/2015
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601		
(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	
	<p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to ensure job specific orientation was completed for 1 of 10 facility employees who were reviewed for employee records, and general orientation for 1 of 10 facility employees who were reviewed for employees. (CNA #7 and CNA #9)</p> <p>Finding includes:</p> <p>On 10/06/2015 at 9:40 A.M., the employee records for CNA (Certified Nursing Assistant) #7 and CNA #9, were reviewed. In the file for CNA #7, there was no documentation that the CNA received a general orientation of the facility. In the file for CNA #9, there was no documentation that the CNA received a job specific orientation of the facility.</p> <p>During an interview on 10/06/2015 at 12:08 P.M., the Staff Development</p>	R 0119	<p>R119</p> <p>How the facility will correct the deficiency as it relates to the resident.</p> <p>Employee's #7&9 general orientation and job specific were completed.</p> <p>How the facility will act to protect residents in similar situations.</p> <p>All employee files have been audited to ensure that each employee has a general orientation and a job specific orientation.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The Administrator conducted a training with the HR/Payroll employee and BOM on the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB</p>	11/05/2015	

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 10/06/2015
--	---	--	---

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

(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
R 0120 Bldg. 00	<p>Coordinator indicated training and orientation should be implemented upon hire.</p> <p>On 10/06/2015 at 2:45 P.M., the Administrator indicated training and orientation should be implemented upon hire.</p> <p>No policies were provided by the facility regarding job specific and general facility orientations.</p> <p>This State tag relates to Complaint IN00182147.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of</p>		<p>screening.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015
--	---	--	---

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

(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
	<p>the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure an employee received specific resident rights training upon hire, for 1 of 10 facility employees who were looked at for resident rights training. (Employee #9)</p> <p>Finding includes:</p> <p>On 10/06/2015 at 9:40 A.M., the employee records for CNA (Certified Nursing Assistant) #9 were reviewed. In the file for CNA #9, there was no documentation of resident rights training.</p>	R 0120	<p>R120 How the facility will correct the deficiency as it relates to the resident. Reference checks were completed on the employee How the facility will act to protect residents in similar situations. All employee files have been audited to ensure that each employee has been trained on resident's rights and has the documentation in their file.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Administrator conducted a training with the HR/Payroll employee and BOM on</p>	11/05/2015

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 10/06/2015
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601		
(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	
R 0121 Bldg. 00	<p>During an interview on 10/06/2015 at 12:08 P.M., Employee #5 indicated resident rights training should be done upon hire.</p> <p>On 10/06/2015 at 2:45 P.M., the Administrator indicated resident rights training should be done upon hire.</p> <p>No policy was provided by the facility regarding resident rights training for employees.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of</p>		<p>the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB screening. How the facility plans to monitor its performance to make sure that solutions are sustained. Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance. Date when the corrective action will be completed by: November 5, 2015</p>		

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
	<p>induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure Mantoux testing was completed for 2 of 10 facility employees who were looked at for employee records. (CNA #7 and CNA #8)</p>	R 0121	<p>R121</p> <p>How the facility will correct the deficiency as it relates to the resident.</p> <p>Employee #8 no longer works at the facility 10/12/15 Quit with no notice.</p> <p>How the facility will act to protect residents in similar situations.</p>	11/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	---	---

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

(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
	<p>Finding includes:</p> <p>On 10/06/2015 at 9:40 A.M., the employee records for CNA (Certified Nursing Assistant) #7 and CNA #8, were reviewed. In the file for CNA #7, there was no documentation of the first or second steps of the required Mantoux testing for TB (Tuberculosis). In the file for CNA #8, there was no documentation of the second step Mantoux testing for TB.</p> <p>During an interview on 10/06/2015 at 12:08 P.M., the Staff Development Coordinator indicated the Mantoux testing should be done upon hire.</p> <p>On 10/06/2015 at 2:45 P.M., the Administrator indicated the Mantoux testing should be done upon hire.</p> <p>No policy was provided by the facility regarding Mantoux testing for employees.</p> <p>This State tag relates to Complaint IN00182147.</p>		<p>All employee files have been audited to ensure that each employee has first and second step Mantoux testing for TB.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The Administrator conducted a training with the HR/Payroll employee and BOM on the state required documents for new hired employees, to include but not limited to (2) reference checks, general orientation of the facility, job specific orientation, resident rights training, first and second step TB screening.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Employee files will be audited prior to orientation and again within 7 days of employment. Administrator will choose 2 employee files to bring to the Interdisciplinary team weekly for 4 weeks, then monthly for 2 months, and at least quarterly x 2. Any concerns identified will be corrected at that time by a member of the Interdisciplinary team. A summary of findings will be submitted to the Performance Improvement Committee monthly for 3 months and then quarterly x 2 for further review and recommendation to ensure sustained compliance.</p> <p>Date when the corrective action will be completed by: November 5, 2015</p>	

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 10/06/2015	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601			
(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			
R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to develop services plans for 2 of 7 records reviewed. (Resident # 46 and Resident #47) Findings Include:</p>	R 0217	<p>R217 How the facility will correct the deficiency as it relates to the resident. Resident #46 and Resident #47 service plans have been updated. How the facility will act to protect residents in similar situations.</p>	11/05/2015			

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 10/06/2015
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601		
(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	
	<p>On 10/5/15 at 12:40 P.M., a clinical record review was conducted for resident #47. Record review indicated that no service plan had been developed for Resident #47.</p> <p>On 10/6/15 at 9:30 A.M., a clinical record review was conducted for resident #46. Record review indicated that no service plan had been developed for Resident #46.</p> <p>During an interview on 10/6/15 at 11:00 A.M., the Social Services Director indicated "...we don't have a service plan for Resident #46...."</p> <p>During an interview on 10/6/15 at 11:20 A.M., the Director of Nursing indicated "... Resident #47 doesn't have a service plan...."</p> <p>During an interview on 10/6/15 at 1:00 P.M., the Director of Nursing indicated "... we don't have a policy on service plans...."</p>		<p>An audit of all the resident's receiving assisted livingservices will be conducted by the DON or designee to ensure that each residenthas a current service plan.</p> <p>Measures the facilitywill take or the systems it will alter to ensure that the problem does notrecur.</p> <p>Medical records nurse will set up a tickler system to trackassessments and when they are due.</p> <p>How the facilityplans to monitor its performance to make sure that solutions are sustained.</p> <p>Medical records nurse will audit the Assisted Living chartsmonthly to ensure compliance.</p> <p>Date when thecorrective action will be completed by: November 5, 2015</p>		