

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
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NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/05/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a) which resulted in Immediate Jeopardy.</p> <p>Survey Date: 01/05/16 and 01/07/16</p> <p>Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640</p> <p>At this Life Safety Code survey, Milton Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility with a basement is fully sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975.</p>	K 0000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies.	
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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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	<p>The facility has a fire alarm system with smoke detection in the corridors, in resident sleeping rooms on the second floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility has a capacity of 34 and had a census of 25 at the time of this survey.</p> <p>Immediate Jeopardy was determined to exist on 01/05/15 at 3:43 p.m. The facility failed to maintain and quickly respond to building safety issues which included a resident room door latch not operating properly, leaving a resident locked in their room with no way to exit. During this post revisit survey, resident room door 121 was checked to see if the facility corrected the initial survey findings of the door not latching into the frame. When the Housekeeping Director went inside the room to close the door, she was unable to open the door. Minutes later, the Maintenance Director came by and opened the door with a stiff plastic card. I was notified by the Maintenance Director that he was aware of this issue and was on his way to get the parts needed to fix this issue. Instead of fixing the door handle, the Maintenance Director walked with me throughout the</p>			

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K 0029 SS=E Bldg. 01	<p>post revisit survey, until the Immediate Jeopardy was discovered.</p> <p>The Immediate Jeopardy was removed on 01/05/16 at 6:27 p.m. The facility had replaced the door handle assembly. The door operated properly at this time.</p> <p>Quality Review completed on 01/11/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 2 corridor doors to the kitchen, a hazardous area, would latch into the frame. This deficient practice could affect staff and at least 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K 0029	<p>•K0029 The facility will ensure all hazardous area doors, including the kitchen doors, will latch into the frame. Ongoing, the Adimistrator or designee will monitor hazardous area doors to ensure they are latching into the frame. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting for continued compliance, monitoring will be ongoing. Panic bars have been</p>	02/03/2016

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K 0038 SS=E Bldg. 01	<p>Maintenance Director and Housekeeping on 01/05/16 between 2:37 p.m. and 6:29 p.m., one of the two kitchen doors failed to latch when tested. Based on interview at the time of observation, the Housekeeping Director acknowledged the aforementioned condition.</p> <p>This deficiency was cited on 11/05/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 4 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and</p>	K 0038	<p>installed for doors to latch in the frame Kitchen doors have also been adjusted for latching, daily monitoring is being preformed</p> <p>•K0038 The facility will ensure the exitdischarge from all exits lead to a public way with a surface that can bemaintained free of obstructions such as snow. Ongoing, the Administrator or designee will monitor the exit dischargefor all exits to ensure they are readily accessible. Results of the monitoring will be reviewedduring the facility's Quality Assurance meeting for continued compliance, monitoring will be ongoing. Walk way has been installed with concrete</p>	02/03/2016

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	<p>size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect staff, visitors, and at least 8 residents on the first floor and 6 on the second floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Director on 01/05/16 at 4:54 p.m., the exterior exit door by resident room 106 discharged onto 26 inches of cement and then ended. The exit discharge then continued as woodchips and then grass before reaching an area of refuge or a public way. The next closest cement pad was eleven feet away. The facility installed wooden border box for cement, yet no cement was laid. Based on interview at the time observation, the Maintenance Director and the Housekeeping Director acknowledged the aforementioned condition.</p>		pavers for means of egress				

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K 0062 SS=D Bldg. 01	<p>This deficiency was cited on 11/05/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 bathroom sprinkler heads in resident room 210 was maintained. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observations the Maintenance Director and the Housekeeping Director on 01/05/16 at 5:10 p.m., resident room 210 was missing one escutcheon in the resident room bathroom. Based on interview at the time of observation, the Maintenance Director and Housekeeping</p>	K 0062	<p>1) The facility will ensure that automatic sprinkler systems are continuously maintained reliable operating condition and are inspected</p> <p>2) Resident room 210 an escutcheon was installed by provider attachment enclosed with work preformed</p> <p>3) Maintenance director will use QA tool monthly for compliance</p> <p>4) Maintenance director will report to QA&A monthly for review of QA tool</p>	02/03/2016

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K 0064 SS=E Bldg. 01	<p>acknowledged the missing escutcheon at the time of observation.</p> <p>This deficiency was cited on 11/05/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Basement Classroom fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 3 residents.</p> <p>Findings include:</p>	K 0064	<p>1) Facility will ensure portable fire extinguishers are in accordance with Life Safety rules</p> <p>2) Fire extinguishers was replaced by provider for compliance.</p> <p>3) Maintenance Director will use QA tool monthly for compliance.</p> <p>4) Maintenance Director will report findings to the QA&A committee monthly</p>	02/03/2016

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K 0072 SS=D Bldg. 01	<p>Based on observation with the Housekeeping Director on 01/05/16 at 5:32 p.m., the gauge on the portable fire extinguisher located in the Basement Classroom indicated the extinguisher was undercharged. Based on interview at the time of observation, the Housekeeping Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 16 resident room exits was readily accessible at all times in accordance with LSC Section 7.1. This deficient practice could affects 2 residents.</p> <p>Findings include: Based on observation and interview on 01/05/16 at 3:43 p.m., the Housekeeping Director went inside resident room 121 with an elderly resident inside and tested the door to close and latch. When</p>	K 0072	<p>1) Facility will ensure means of egress are continuously maintained free of obstructions or impediments in case of emergency</p> <p>2) Maintenance director installed a new door assembly.</p> <p>3) Maintenance director will use QA tool for compliance.</p> <p>4) Maintenance Director will report to QA&A committee for review monthly</p>	02/03/2016

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K 0076 SS=D Bldg. 01	<p>attempted, the Housekeeping Director was locked inside resident room. The Maintenance Director had to open the door with a stiff plastic card to let the Housekeeping Director out from the corridor side. The Director of Nursing who was in charge of the facility at the time was made aware of the Immediate Jeopardy situation. The Immediate Jeopardy form was provided to the Director of Nursing with the Life Safety Code supervisor contact information. Before leaving the facility, the door on resident room 121 had a new handle assembly operated properly.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 12 cylinders</p>	K 0076	<p>•K0076 The facility will ensure cylinders are properly chained or supported.</p>	02/03/2016

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K 0160 SS=D Bldg. 01	<p>of nonflammable gases was properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Housekeeping Director on 1/07/16 at 5:22 p.m., one oxygen cylinder was discovered unsupported in the oxygen room. Based on interview at the time of observation, the Housekeeping Director acknowledged the aforementioned condition.</p> <p>This deficiency was cited on 11/05/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel</p>		Ongoing, the Administrator or designee will monitor cylinders to ensure they are properly chained or supported. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting for continued compliance, monitoring will be ongoing. A new cylinder rack was purchased for extra storage for cylinders				

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	<p>distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on record review and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Director on 01/05/16 3:40 p.m., the elevator equipment room contained 1 sprinkler head. Based on interview at the time of record review, the Housekeeping Director had three price quotes for installation of an elevator shunt trip, and no other documentation.</p>	K 0160	<p>·K0160 The facility will ensure an elevators shunt trip is provided in the elevator equipment room or provide a signed contract for the installation of the shunt trip. Signed contract is attached for compliance</p>	02/03/2016

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