STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155738	B. W	ING	_	08/01	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			MARION ST		
MILTON	HOME, THE			SOUTH	BEND, IN 46601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for a Recertification and State Licensure Survey. This visit included a State		F 00	000			
	Residential Licens	ure Survey.					
	Survey dates: July 26, 27, 28, 29, and August 1, 2022						
	Facility number: 00	01141					
	Provider number: 1						
	AIM number: 2009						
	Census Bed Type:						
	SNF/NF: 24						
	Residential: 14						
	Total: 38						
	Census Payor Type	e:					
	Medicare: 3						
	Medicaid: 17						
	Other: 4						
	Total: 24						
	These deficiencies accordance with 41	reflect State Findings cited in 10 IAC 16.2-3.1.					
	Quality review con	mpleted on 8/4/22.					
F 0622	483.15(c)(1)(i)(ii)((2)(i)-(iii)					
SS=A		charge Requirements					
Bldg. 00		fer and discharge-					
	§483.15(c)(1) Fac	cility requirements-					
		st permit each resident to					
		lity, and not transfer or					
	_	ident from the facility					
	unless-						
		or discharge is necessary for					
	the resident's wel	lfare and the resident's					
	I				l .		ı

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 1 of 63

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155738	B. W	ING		08/01/	/2022
		l .	I	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			MARION ST		
MII TON	LOME THE				BEND, IN 46601		
WILTON	HOME, THE			300111	BEND, IN 40001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	needs cannot be r	met in the facility;					
	(B) The transfer o	r discharge is appropriate					
	because the resid	ent's health has improved					
	sufficiently so the resident no longer needs						
	the services provided by the facility;						
	(C) The safety of individuals in the facility is						
	endangered due to the clinical or behavioral						
	status of the resident;						
	• •	individuals in the facility					
	would otherwise b	<u> </u>					
	, ,	as failed, after reasonable					
		otice, to pay for (or to have					
	•	are or Medicaid) a stay at					
		yment applies if the					
		submit the necessary					
		d party payment or after the					
		ng Medicare or Medicaid,					
		and the resident refuses to					
		stay. For a resident who					
	_	for Medicaid after admission					
		cility may charge a resident					
	-	arges under Medicaid; or					
	(F) The facility cea	•					
	` '	y not transfer or discharge					
		the appeal is pending,					
		.230 of this chapter, when a					
		s his or her right to appeal a					
		rge notice from the facility					
		.220(a)(3) of this chapter,					
		to discharge or transfer					
	-	ne health or safety of the					
		ndividuals in the facility.					
	•	locument the danger that					
	ा allure to transfer ।	or discharge would pose.					
	0400 45()(0) 5						
	§483.15(c)(2) Doc						
		ransfers or discharges a					
		y of the circumstances					
		raphs (c)(1)(i)(A) through (F)					
	of this section, the	e facility must ensure that					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet Page 2 of 63

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	ETED
		155738	B. WIN	NG		08/01/	2022
		ı		STDEET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF I	PROVIDER OR SUPPLIEF	₹			MARION ST		
MII TON	HOME, THE				BEND, IN 46601		
IVIILION	TIOIVIL, THE			30011	DEND, IN 40001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		charge is documented in					
		dical record and appropriate					
		nmunicated to the receiving					
	health care institution or provider.						
	(i) Documentation in the resident's medical						
	record must include:						
	(A) The basis for the transfer per paragraph						
	(c)(1)(i) of this sec						
	' '	paragraph (c)(1)(i)(A) of this					
	-	fic resident need(s) that					
		cility attempts to meet the					
		nd the service available at ity to meet the need(s).					
		ation required by paragraph					
	· ·	ction must be made by-					
		physician when transfer or					
	, ,	ssary under paragraph (c)					
	(1) (A) or (B) of th						
	. , , , , ,	hen transfer or discharge is					
	, ,	paragraph (c)(1)(i)(C) or (D)					
	of this section.						
		ovided to the receiving					
		ude a minimum of the					
	following:						
	_	nation of the practitioner					
	responsible for the	e care of the resident.					
	(B) Resident repre	esentative information					
	including contact i	information					
	(C) Advance Direc	ctive information					
	(D) All special inst	tructions or precautions for					
	ongoing care, as a						
		/e care plan goals;					
	` '	essary information, including					
		dent's discharge summary,					
	_	·83.21(c)(2) as applicable,					
	· ·	cumentation, as applicable,					
	to ensure a safe a	and effective transition of					
	care.						
		view, and interview, the facility	F 062	22	F622- Transfer and Discharg	е	08/26/2022
	failed to ensure eac	h resident had a			Requirements		

CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039						
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED		
		155738	B. WING		08/01/2022		
			CTDI	EET ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	L.		EET ADDRESS, CITT, STATE, ZIP COD B E MARION ST			
MII TON	HOME, THE			UTH BEND, IN 46601			
WILTON	TIOWE, THE		300	OTTI BEND, IN 40001			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		LD BE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	transfer/discharge s	ummary completed and was		1.What corrective action	(s) will		
	given a written noti	ce of the bed bold policy and		be accomplished for tho	se		
	the appeal of rights	information after the facility		residents found to have	been		
	initiated transfer of	the resident to the hospital for		affected by the deficient			
	2 of 2 residents revi	ewed for hospitalization.		practice?			
	(Residents 21 and 2	4)		·Resident # 21 and resi	dent # 24		
				did not have a negative o	utcome		
	Findings include:			related to the alleged defi	cient		
				practice.			
	Record review for	or Resident 21 was completed		2.How will you identify o	ther		
	on 7/27/22 at 2:12 p.m. Diagnoses included, but			residents having the pot	ential		
	were not limited to, dementia, and Parkinson's			to be affected by the san	ne		
disease.			deficient practice and w	hat			
				corrective action will be	taken?		
	The Admission Mir	nimum Data Set (MDS)		All residents in the facility	have		
	assessment, dated 6	/30/22, indicated the resident		the potential to be affecte	d by the		
	was moderately cog	nitively impaired.		same alleged deficient practice.			
				·Audit of residents that l	have		
	A Progress Note, da	ated 7/24/22 at 6:11 a.m.,		been transferred or discha	arged in		
	indicated the reside	nt's condition declined. The		last 60 days completed to	ensure		
	doctor was notified	and an order was received to		that discharge summary/	bed hold		
	send the resident to	the Emergency Room (ER).		policy was provided or co	mpleted.		
	The paper work was	s done.		rect any			
				irregularities noted if appl	icable		
		locumentation that a		3.What measures will be	put		
		ummary for the resident was		into place or what system			
	_	resident or the resident's		changes you will make t			
	1 -	ved a written notice of the bed		ensure that the deficient			
		appeal of rights information		practice does not recur?			
	I	tiated transfer of the resident to		· Licensed nursing st			
	the hospital.			educated on Bed Hold Po	-		
				process and procedures a			
		se Consultant on 7/29/22 at		requirements for discharg			
		d she was unable to locate the		summary to be sent with			
		that was completed for the		at time of transfer/dischar	ge		
	resident when they	were sent to the hospital.					
				· IDT has been educ			
		or Resident 24 was completed		the process for sending a	• • • • • • • • • • • • • • • • • • •		
	on 7/28/22 at 11:25	a.m. Diagnoses included, but		the discharge papers with	n		

were not limited to, hypertension, diabetes

residents who discharged when

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		155738	B. W	/ING		08/01/2	2022
	PROVIDER OR SUPPLIER	.		206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
	mellitus, and psych	otic disorder.			they are alert and orientated a	and	
					to provide a copy to the		
	The Annual MDS a	ssessment, dated 6/23/22,			responsible party for residents	s	
		nt was cognitively intact.			who are not alert or oriented a		
					time of discharge via the mail.		
	A Progress Note, da	ated 1/11/22 at 3:35 p.m.,					
	indicated the resident had been complaining of				· IDT educated on use of	f	
		doctor was notified with an			Clinical meeting process with		
	order received to se	nt the resident to the ER.			emphasis on IDT discharge re	eview	
					process		
	The record lacked d	locumentation that a					
	transfer/discharge s	ummary for the resident was			· IDT team educated on		
	completed, and the	resident or the resident's			discharge process including B	Bed	
	representative recei	ved a written notice of the bed			Hold Policy and discharge		
	hold policy and the	appeal of rights information			summary requirements		
	after the facility init	tiated transfer of the resident to					
	the hospital.				 Social services/designe 	ee	
					will maintain a log for all		
		se Consultant on 7/29/22 at			discharges and log who was		
		ed she was unable to locate the			provided copies of discharge		
		that was completed for the			paperwork.		
	resident when they	were sent to the hospital.					
	3.1-12(a)(6)(A)						
	3.1-12(a)(9)(A) 3.1-12 (a)(9)(A)				4.How the corrective action ((s)	
	(4)(7)(11)				will be monitored to ensure t		
			deficient practice will not				
					recur, i.e., what quality		
					assurance program will be p	out	
					into place?		
					·SSD/ designee will complete	_{te}	
					the Discharge/ Transfer Audit		
					ensure that Bed Hold policy w		
					followed and discharge summ		
					was completed	´	
					·Audit will be completed		
					weekly x 4 weeks, bi-monthly	for 2	
					months, monthly for 6 and the		
					quarterly to encompass all shi		
					until continued compliance is		

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COM	PLETED
		155738	B. WING		08/0	1/2022
			STREE	T ADDRESS, CITY, STATE, ZIP CO	_ D	
NAME OF I	PROVIDER OR SUPPLIE	R		E MARION ST		
MILTON	HOME, THE		SOU	TH BEND, IN 46601		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	maintained for 2 consec	utivo	DATE
				quarters.	ulive	
				quartoro.	quartors.	
				·The results of these a	udits will	
				be reviewed by the CQI		
				overseen by the ED. If the		
				95% is not achieved an		
				plan will be developed to ensure compliance.		
				Joinplianoc.		
F 0655	483.21(a)(1)-(3)					
SS=D	Baseline Care Pla					
Bldg. 00	-	hensive Person-Centered				
	Care Planning	in a Cons Diana				
	§483.21(a) Basel	e facility must develop and				
	. , , , ,	eline care plan for each				
	•	ides the instructions needed				
		e and person-centered care				
	of the resident that	at meet professional				
	· ·	ity care. The baseline care				
	plan must-					
	resident's admiss	within 48 hours of a				
		nimum healthcare				
	` '	ssary to properly care for a				
		g, but not limited to-				
	_	ased on admission orders.				
	(B) Physician ord	ers.				
	(C) Dietary orders					
	(D) Therapy servi					
	(E) Social service					
	(F) PASARR reco	ommendation, if applicable.				
	§483.21(a)(2) The	e facility may develop a				
	1	are plan in place of the				
		n if the comprehensive care				
	plan-					
	1 ' '	within 48 hours of the				
	resident's admiss	ion.				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 6 of 63

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155738	B. WI	NG		08/01	/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			MARION ST		
MII TON	HOME, THE				I BEND, IN 46601		
WILTON	· · · · · · · · · · · · · · · · · · ·			00011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		uirements set forth in					
		his section (excepting					
	paragraph (b)(2)(i) of this section).					
	- ' ' ' '	e facility must provide the					
		representative with a					
	summary of the baseline care plan that						
	includes but is not						
	(i) The initial goal						
	, ,	the resident's medications					
	and dietary instruc						
		and treatments to be					
	-	ne facility and personnel					
	acting on behalf o						
	. ,	nformation based on the					
		prehensive care plan, as					
	necessary.	on, record review, and	E 06	55	F655 Baseline Care Plan		08/26/2022
		ty failed to develop a baseline	F 0655		1) What corrective action(s)		08/20/2022
		B hours of admission related to			will be accomplished for those		
	_	17 residents whose care plans			residents found to have been		
	were reviewed. (Re	_			affected by the deficient		
	were reviewed. (16)	esident 23)			practice?		
	Finding includes:				produce:		
	8				Resident 23's baseline care pl	an	
	On 7/26/22 at 11:39	9 a.m., Resident 23 was			was completed, and her		
		gen on via a nasal cannula with			comprehensive care plan is up	o to	
	a flow rate of 4 liter	rs. The resident indicated she			date and reflects the use of		
	always wore her ox				oxygen.		
	Record review for I	Resident 23 was completed on			2) How other residents		
	7/26/22 at 1:42 p.m. The resident was admitted to the facility on 6/8/22. A Care Plan indicated the resident had chronic obstructive pulmonary disease (COPD) and respiratory failure. The care plan did not reflect				having the potential to be		
					affected by the same deficien	nt	
					practice will be identified and	t	
					what corrective action(s) will		
					be taken.		
					· All residents that have b		
	oxygen use.				admitted to the facility at risk f		
					same alleged deficient practic	e.	
	The record lacked any documentation a base line				· An Audit of the new		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet Page 7 of 63

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING 00 B. WING		COMPLETED 08/01/2022	
	PROVIDER OR SUPPLIER HOME, THE		206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Interview with Nurs 11:11 a.m., indicate	e Consultant on 7/29/22 at d she could not provide any dicate a baseline care plan for		admissions from the last 60 da completed. Residents with missing or incomplete baseling care plans will be reviewed, audited with comprehensive or plan to ensure accuracy and completion. 3) What measures will be plant to place and what systemic changes will be made to ensure that the deficient practice does not recur. DON/Designee will proveducation to nursing and IDT related to baseline care plans. Education to include: A review of the 48 Hour Baseline Care Plan Policy & Procedure. Special emphasis will be placed on the admitting/readmitting charge responsibility to initiate the 48-hour Baseline Care Plan Unin PCC Further emphasis will be placed on detailing any service and treatment to be administed by the facility according to physician orders such as oxyguse Nurse Consultant will provide education to IDT Tear IDT Admission Review Process Education to include: The DNS and/or designee review all new admissions with 48 hours of admission to ensure	e are but c ide team burse DA e red gen mon ss will him

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 8 of 63

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/01/2022			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				that a Baseline Care Plan or Comprehensive Care Plan has been created and meet the requirements of483.21. DNS and/or designee will complete Baseline Care Plan at that tim the event of noncompliance. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place. The Clinical Management Team will be responsible to identify new admissions or readmissions daily, including weekends and holidays alerting the IDT. The Clinical Manager with assure the 48 Hour Baseline Completed within 48 hours of admission. The Clinical Manager with assure the completed Base Care Plan to assure services at treatments necessary to proper care for a resident. Baseline care plan audit be completed including each admission/readmission to valid Implementation and completion accurate baseline care plan The DON/designee will be responsible for the completion the Baseline Care Plan Audit on Audit will be completed.	the e in constity ut nt Care ager eline and erly will date on of		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

weekly times 4 weeks, monthly

If continuation sheet

Page 9 of 63

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155738	B. W	ING		08/01/	2022
NAME OF I	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
MIL TON	HOME, THE				MARION ST I BEND, IN 46601		
	· -				I DEND, IN 4000 I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
mo	REGGENTORTO	RESCRIPTION THIS INTORMATION		mo	times 5 months, and quarterly	,	DATE
					until continued compliance is		
					maintained for 2 consecutive		
					quarters.		
					The regults of those ou	dita	
					 The results of these au will be reviewed by the QAPI 	aits	
					committee overseen by the E	D If	
					threshold of 95% is not achieve		
					an action plan will be develop		
F 0656	483.21(b)(1)						
SS=D	` ' ' '	ent Comprehensive Care Plan					
Bldg. 00		orehensive Care Plans					
	§483.21(b)(1) The	e facility must develop and					
	implement a com	prehensive person-centered					
		n resident, consistent with					
		s set forth at §483.10(c)(2)					
), that includes measurable					
	· ·	neframes to meet a					
		II, nursing, and mental and de that are identified in the					
	comprehensive a						
	-	are plan must describe the					
	following -	•					
	_	nat are to be furnished to					
	attain or maintain	the resident's highest					
	practicable physic						
		-being as required under					
	§483.24, §483.25	9					
		hat would otherwise be					
		183.24, §483.25 or §483.40					
	•	led due to the resident's					
	_	under §483.10, including treatment under §483.10(c)					
	(6).	rieaunent under 3465.10(6)					
		ed services or specialized					
	. ,	rices the nursing facility will					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 10 of 63

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155738	B. WI	NG		08/01/2022	2
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		206 E N	MARION ST		
MILTON	HOME, THE			SOUTH	H BEND, IN 46601	<u>,</u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	MPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	provide as a resul						
		. If a facility disagrees with					
		PASARR, it must indicate					
		resident's medical record.					
	(iv)In consultation with the resident and the resident's representative(s)-						
		• •					
	(A) The resident's goals for admission and desired outcomes.						
		preference and potential for					
		Facilities must document					
	whether the resident's desire to return to the community was assessed and any referrals						
		gencies and/or other					
		es, for this purpose.					
	1 '' '	ns in the comprehensive					
		ropriate, in accordance with					
		set forth in paragraph (c) of					
	this section.	oct forth in paragraph (o) of					
		view and interview, the facility	F 06	56	656- Developing	08/	/26/2022
		individualized care plan was	1 00	50	comprehensive Assessment		20/2022
		o diabetes management for 1 of			What corrective action(s) will		
	_	ns reviewed. (Resident 11)			be accomplished for those		
	·	,			residents found to have been	ո	
	Finding includes:				affected by the deficient		
					practice?		
	Record review for I	Resident 11 was completed on			·IDT team reviewed residen	11	
	7/27/22 at 3:31 p.m	. Diagnoses included, but were			and compressive care plan wa	as	
	not limited to, diabe	etes management and anemia.			reviewed including care plan f	or	
					Diabetes Mellitus		
	The Admission Mir	nimum Data Set (MDS)			How will you identify other		
		/30/22, indicated the resident			residents having the potentia	al	
		act. The resident had received			to be affected by the same		
	insulin (diabetes me	edication).			deficient practice and what		
					corrective action will be take		
		iny documentation a care plan			All residents in the facility ha		
	had been completed	l related to diabetes			the potential to be affected b	у	
	management.				alleged deficient practice		
					·Facility to complete audit of		
		2 at 10:23 a.m. with Regional			resident's care plans conducte	ed to	
	MDS indicated the	resident should have had a			ensure accuracy facility will a	udit	

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		100/38	B. W	ing		08/01/2	:022
	PROVIDER OR SUPPLIE	R		206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST I BEND, IN 46601		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
PREFIX	REGULATORY O				GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) 5 Resident Care plans weekly 100% of Resident care plans reviewed. What measures will be put it place or what systemic changes you will make to ensure that the deficient practice does not recur? IDT in-serviced on the MD assessment process and their including use of CARE PLAN Review sheet to ensure all arrare addressed Audits Tool "Comprehensing Care Plan Audit Tool" will be completed for all new admiss to ensure completion within 2 days of the date of admission days after the ARD to ensure accuracy of assessments, Caplans, and Coding. Audit Tool "Comprehensing Care Plan Audit Tool" will be completed as part of all reside Quarterly and annual assessments or upon change condition to ensure accuracy MDS and Care Plans within 7 days of the ARD. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place?	y until nto S r role eas /e ions 1 or 7 are ent of of / the	COMPLETION
					MDS/ Designee will comple "Comprehensive Care Plan A Tool" will be completed for all admissions to ensure comple within 21 days of the date of	udit new	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 12 of 63

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155738	B. WIN		00	08/01/2022	
	PROVIDER OR SUPPLIE	R	1	206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST I BEND, IN 46601	<u> </u>	
MILTON (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	SOUTH ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) admission or 7 days after the to ensure accuracy of assessments, Care plans, and Coding. Audit Tool "Comprehensive Care Plan Audit Tool" will be completed as part of all reside Quarterly and annual assessments or upon change condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. O Audit will be completed we times 4 weeks, monthly times months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these aud will be reviewed by the QAPI committee overseen by the EI threshold of 95% is not achieved an action plan will be developed.	ARD d ent of of ekly 5	(X5) COMPLETION DATE
F 0677 SS=D Bldg. 00	§483.24(a)(2) A r carry out activitie necessary servic nutrition, groomir hygiene; Based on observat interview, the facil residents received assistance related t	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good ig, and personal and oral on, record review and ity failed to ensure dependent ADL (activities of daily living) o scheduled showers and residents reviewed for ADL and 19)	F 067	77	677- ADL Care for Dependento Residents 1.What corrective action(s) will be accomplished for the residents found to have been affected by the deficient) se	08/26/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 13 of 63

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155738	B. W	ING _		08/01/	2022
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MARION ST		
MII TON	HOME, THE				I BEND, IN 46601		
IVIILION	I IOIVIL, IIIL			550111	, DEND, IN 70001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					practice?		
	Findings include:				Residents 15 and 19 were		
					provided with ADL care related		
		:16 a.m., Resident 15 was			showers and shaving did not h		
		e was wearing tubigrips (elastic			a negative outcome related to	the	
	coverings) on both arms. Both were soiled with				alleged deficient practice		
		icated he was only getting a			1.How will you identify other		
	shower or bath once	e every two weeks.			residents having the potentia	al	
	men	1 7/27/22			to be affected by the same		
		d was reviewed on 7/27/22 at			deficient practice and what	•	
		dent was admitted on 12/10/21.			corrective action will be take		
	"	, but were not limited to,			All residents in the facility ha		
	Diabetes Mellitus,	weakness and low back pain.			the potential to be affected b	У	
	The Owner of the Mind				alleged deficient practice		
		mum Data Set (MDS)			A		
		7/3/22, indicated the resident			· Audit completed of		
		act, and required one person	showers to ensure that each				
	toileting.	fers, bed mobility and			resident has schedule and agi	reea	
	toneting.				upon shower days, shower schedule to be updated as		
	The June and July 3	2022 shower sheets indicated					
	1	owered on the following days:			necessary		
		7/16/22. He was scheduled to			· Audit completed of		
	· · ·	ery Monday and Thursday.			residents in the facility and all	with	
		mentation he had refused any			facial hair offered ADL care.	WILII	
	scheduled showers.	-			idolar fidir officion ADE odfe.		
	2. On 7/27/22 at 9:	41 a.m., Resident 19 was			1.What measures will be pu	ut	
	observed in bed. He				into place or what systemic		
					changes will you make to		
	The resident's recor	rd was reviewed on 7/27/22 at			ensure that the deficient		
	9:33 a.m. The resid	ent was admitted on 2/26/19.			practice does not recur?		
	Diagnoses included	, but were not limited to,			·Nursing Staff in serviced re	lated	
	Alzheimer's disease	and heart disease.			to ADL care for dependent		
					resident, with emphasis on		
	The Quarterly MDS	S, dated 6/24/22, indicated the			showers, documentation, and		
	resident had severe	cognitive deficits, and			shaving		
	required limited ass	sistance with bed mobility,			1.How will the corrective		
	transfers and toileti	ng.			action (s) be monitored to		
					ensure the deficient practice		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/01/2022	
	PROVIDER OR SUPPLIER		206 E	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	The June and July 2 the resident was showered on 6/8/22 was scheduled to re Wednesday and Sat A telephone intervior 7/26/22 at 1:32 p.m always been clean s shaved in a while. Interview with CNA indicated residents sweek and a shower	022 shower sheets indicated owered and shaved on 7/6/22, , and refused on 7/16/22. He ceive showers every		will not recur, i.e., what qua assurance program will be pinto place? DON/ designee will comple ADL care Audits to monitor residents ADL status including showers and nailcare Audit will be completed we times 4 weeks, monthly times months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audither will be reviewed by the QAPI committee overseen by the Ethreshold of 95% is not achie an action plan will be developed.	lity but ete g eekly s 5
F 0684 SS=D Bldg. 00	applies to all treating facility residents. Examples to all treating facility residents. Examples and the residents' Based on observation interview, the facility received the necessary facility reservations.	a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive in accordance with lards of practice, the erson-centered care plan,	F 0684	684- Quality of Care 1.What corrective action(s) be accomplished for those residents found to have bee	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/01/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
	HOME, THE			206 E MARION ST SOUTH BEND, IN 46601			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		ΓAG	DEFICIENCY)		DATE
		r 1 of 4 residents reviewed for			affected by the deficient		
	•	d skin conditions, not ordering			practice?		
	or following up on a Physician's order for a chest				· MD was notified and		
	x-ray for 1 of 3 residents reviewed for respiratory care, and not following up on a urinalysis for 1 of				treatment orders obtained for		
		viewed. (Residents 15, 20 and			Resident #15, skin tears have now resolved	е	
	21)	riewed. (Residents 13, 20 and			MD notified of Resident	. #	
	21)				20s CXR results orders were		
	Findings include:				received and followed.		
	i manigo metade.				· MD was notified that U	Δ	
	1. On 7/26/22 at 10	0:16 a.m., Resident 15 was			results of Resident # 21 were		
		e was wearing tubigrips (elastic			finalized on 7/15, results with		
		arms. Both were soiled with			than 10,000 CGU/ml	1000	
	· · · · · · · · · · · · · · · · · · ·	icated he fell a few days ago			2.How will you identify othe	r	
		on both arms, and staff had			residents having the potent		
		s. The resident attempted to			to be affected by the same		
		wn to observe the skin tear,			deficient practice and what		
		stuck the wound to the			corrective action will be tak	en?	
	tubigrip.				All residents in the facility h	ave	
					the potential to be affected	by	
	The resident's recor	d was reviewed on 7/27/22 at			alleged deficient practice		
	1:39 p.m. The resid	lent was admitted on 12/10/21.			· Full house skin sweep		
	_	, but were not limited to,			completed		
	Diabetes Mellitus, v	weakness and low back pain.			· Audit of lab and radiolo		
					orders and reports reviewed	for	
		mum Data Set (MDS)			last 30 days and any MD		
		/3/22, indicated the resident			notifications or follow- up		
		act, and required one person			completed as necessary	_	
		fers, bed mobility and			3.What measures will be pu		
	toileting.				into place or what systemic		
	Th				changes you will make to		
		mentation in the progress			ensure that the deficient		
	skin tears.	resident falling or obtaining			practice does not recur?	,ff	
	skin tears.				· All Licensed nursing sta		
	There was no Dhys	cian's order for treatment of			in-serviced Quality of Care at treatment with emphasis on	iu	
	the skin tears.	cian's order for treatment of			obtaining treatment orders for	or new	
	the skill teals.				skin impairment, obtaining la		
	Interview with CN4	A 1 on 7/27/22 at 2:07 p.m.,			UAs, and radiology follow up		
		t had fallen in the bathroom			documentation	ariu	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155738	B. W	ING		08/01/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			MARION ST		
MILTON	HOME, THE				H BEND, IN 46601		
	· I		1		,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		CNIA 1 and another CNIA		TAG			DATE
		CNA 1 and another CNA floor, and he had obtained the			· IDT education on daily		
	skin tears at that tim				clinical meeting and 24-hour re	•	
	Skill tears at that thi	ic.		review to ensure IDT is capturing and following up with outstanding			
	Interview with I DN	I 1 on 7/27/22 at 2:11 p.m.,			clinical follow up such as labs	-	
		nt had picked at his skin so			radiology orders	anu	
	the weekend nurse had placed tubigrips on him.				· IDT education on Lab ar	nd	
	He indicated he was not aware of the resident				Radiology Tracking process	Iu	
	falling or having sk				4.How the corrective action ('e)	
	laming of having sk	in tours.			will be monitored to ensure t	٠,	
	2. Resident 20's red	cord was reviewed on 7/28/22 at			deficient practice will not		
		lent was admitted on 6/19/22.			recur, i.e., what quality		
	Diagnoses included, but were not limited to,				assurance program will be p	ut	
	Diabetes Mellitus a				into place?		
		, I			DNS/designee will comp	lete	
	A Progress Note, da	ated 7/12/22, indicated the			Quality of Care related to char		
	resident was compla	aining of shortness of breath.			of condition Audit to ensure al	•	
	The Physician was	notified, and he ordered a			change of conditions have bee	en	
	chest X-ray and lab	s.			identified and followed up		
					appropriately		
	There was not a che	est X-ray completed until			 DNS/designee to complete 	ete	
	7/21/22.				Lab/Radiology audit to ensure	all	
					labs and radiology have been		
		Unit Manager on on 7/29/22 at			obtained and followed up on		
		the night nurse had notified			appropriately		
		eceived the orders. The Unit			Audits will be completed	b	
	_	she had placed the order stat			daily x 5, weekly x 4 weeks,		
	_	2/22. She was unable to locate			bi-monthly for 2 months, mont	-	
		o the one dated 7/21/22. 3.			for 6 months and then quarter	ly to	
		Resident 21 was completed on			encompass all shifts until		
	_	. Diagnoses included, but were			continued compliance is		
	not limited to, demo	entia, and Parkinson's disease.			maintained for 2 consecutive		
	TE1 A 1 3.5.	. D. (G. (A. (D. G.)			quarters.		
		nimum Data Set (MDS)			The results of these audits wil		
		/30/22, indicated the resident			reviewed by the QAPI commit		
	was moderately cog	gmuvery impaired.			overseen by the ED. If thresho		
	A Duo oug NI-4: 1	ated 6/28/2022 at 6:37 a.m.,			95% is not achieved an action		
		nt was noted with blood in the			plan will be developed to ensu	пе	
		The doctor was notified with			compliance.		
i e	i urme mans buel. I	THE GOODIE WAS HULLITED WILL!					i e

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155738		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY PLETED 01/2022	
	PROVIDER OR SUPPLIER		206 E	ADDRESS, CITY, STATE, ZIP C MARION ST H BEND, IN 46601	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Urinalysis	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	A Progress Note, da	ated 6/29/22 at 7:32 a.m., collected by clean catch for				
	_	ated 7/24/22 at 6:11 a.m., nt had been sent to the elated to a decline.				
		ny documentation of results ompleted on 6/29/22, nor had completed.				
	Director of Nursing	2 at 10:57 a.m. with the Interim indicated they should have on the urine collection.				
	Consultant indicate	2 at 11:11 a.m., with Nurse d she could not provide any related to the delay in the the urinalysis.				
F 0686	3.1-37(a) 483.25(b)(1)(i)(ii)					
SS=D Bldg. 00	Treatment/Svcs to Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre Based on the coma resident, the fact (i) A resident receprofessional standpressure ulcers ar pressure ulcers ur condition demons unavoidable; and	ssure ulcers. Aprehensive assessment of ility must ensure that- ives care, consistent with lards of practice, to prevent and does not develop hless the individual's clinical trates that they were				
	, ,	pressure ulcers receives ent and services, consistent				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 18 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING 00 COI B. WING 08/				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
	F PROVIDER OR SUPPLIE N HOME, THE	R		206 E MARION ST SOUTH BEND, IN 46601			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COM	PLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with professional	standards of practice, to					
	promote healing,	prevent infection and prevent					
	new ulcers from o	developing.					
		Based on observation, record review, and interview, the facility failed to ensure pressure		686	686- Pressure Ulcers	08/2	26/2022
					What corrective action(s) wi	ill	
	_	vere in place as ordered for 1 of			be accomplished for those		
		ed for pressure ulcers.			residents found to have bee	n	
	(Resident 22)	(Resident 22)			affected by the deficient practice?		
	Finding includes:				·Resident #22 had boots pla	aced	
					to BLE, resident with no nega		
	On 7/26/22 at 3:39 p.m., Resident 22 was observed				outcome related to alleged		
	lying in bed. No pressure offloading boots were				deficiency. Resident # 22 wil	I	
	observed on her feet.				continue to be evaluated for		
					healing and appropriate treat	ment	
	On 7/27/22 at 2:08	p.m., Resident 22 was observed			modality weekly by the wound	d	
		ressure offloading boots were			care physician.		
	observed on her fe	et.			How other residents having		
					potential to be affected by the		
		5 a.m., Resident 22 was			same deficient practice will		
		bed. No pressure offloading			identified and what corrective	ve	
	boots were observe	ed on her feet.			action(s) will be taken?		
		D. 11. 100			All residents in the facility h		
		Resident 22 was completed on			the potential to be affected I	by	
		m. Diagnoses included, but			alleged deficient practice		
		, Alzheimer's disease,			·Full house skin sweep		
	hypertension, and	uepression.			completed with any new or	tod	
	The Questonly Min	imum Data Set (MDS)			abnormal assessments repor	ied	
		6/30/22, indicated the resident			to the Physician.	tonts	
		itively impaired. The resident			·Audit completed of all residence to ensure all who are at risk for		
		ive 1 person assist for bed			skin breakdown have prevent	- · I	
	_	of 1 person assist with dressing.			interventions in place and that		
		npairment on both upper and			interventions are listed in Car		
		for a limitation in functional			plan and Kardex	<u> </u>	
		The resident had 2 unstageable			·Nursing staff educated on		
		l was on hospice care.			Nursing staff in-serviced on		
	Prosecute directs direct	and the property care.			preventative wound care with		
	A Care Plan, dated	1 6/23/21 and revised on 7/26/22,			emphasis importance of placi		
		ent was at risk for skin			skin preventative intervention	-	
	1				1 '	ı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/01/2022 155738 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 206 E MARION ST MILTON HOME, THE SOUTH BEND, IN 46601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE breakdown due to decreased mobility. An such as floating heels and intervention included to float heels when in bed. pressure relieving boots. ·Nursing staff educated on use A Care Plan, dated 7/26/22, indicated the resident of Kardex / pocket care plan and had a pressure ulcer to the right medial foot. An what interventions are listed and in intervention included to float heels. place for each resident What measures will be put into A Wound Assessment, dated 7/20/22, indicated place or what systemic the resident had an unstageable pressure ulcer to changes you will make to the right medial foot. ensure that the deficient practice does not recur? The July 2022 Physician's Order Summary ·Nursing staff in-serviced on indicated an order for pressure relieving boots to preventative wound care per policy be worn at all times while in bed and up in the with emphasis importance of chair. placing skin preventative interventions such as floating Interview with QMA 1 on 7/28/22 at 10:48 a.m., heels and pressure relieving boots indicated the resident should have the pressure ·Nursing staff educated on use relieving boots on. She was unable to find them of Kardex and what interventions to apply them. are listed and in place for each resident 3.1-40(a)(2)DON /designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place. ·Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. DON/designee will conduct rounds each shift to ensure preventative pressure relieving

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

devices are in place per plan of

Page 20 of 63

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	IPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155738	B. W	ING		08/01/	2022	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP COD			
					MARION ST			
MILTON	HOME, THE			SOUTH	I BEND, IN 46601			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
					care.			
					How the corrective action (s)			
					will be monitored to ensure t			
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place?			
					·DON/designee will conduct			
					rounds each shift to ensure			
					preventative pressure relieving	1		
					devices are in place per plan of	-		
					care.	•		
					·Wound team to make week	lv		
					rounds on residents identified	-		
					skin impairment to ensure	*******		
					treatments continue to be			
					completed per order and device	202		
					are in place for prevention of s			
					breakdown, notify Physicians			
					changes are needed and that			
					plan of care is current/up-date			
					needed.	u u u		
					·The DON/Designee is			
					responsible for the completion	of		
					the Skin/ Wound Audit weekly			
					4 weeks, bi-monthly for 2 mon			
					monthly for 6 and then quarter			
					encompass all shifts until	ıy to		
					continued compliance is			
					maintained for 2 consecutive			
					quarters. · The results of these audits	sazill		
					be reviewed by the CQI comm			
					overseen by the ED. If thresho	old OI		
					95% is not achieved an action			
					plan will be developed to ensu	re		
					compliance.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 21 of 63

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2022		
	PROVIDER OR SUPPLIER		206 E	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG F 0688	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 00	Increase/Prevent I §483.25(c) Mobilit §483.25(c) Mobilit §483.25(c) (1) The resident who enter range of motion do reduction in range resident's clinical of that a reduction in unavoidable; and §483.25(c)(2) A remotion receives approvent further deceives appropriate assistance to mair with the maximum unless a reduction demonstrably unate Based on observation interview, the facility in place as ordered a specific directions for reviewed for limited 17) Finding includes: On 7/26/22 at 3:52 plying in bed. No spresidents arms. An the nightstand next of the same provided in the same prevent for the same prevent fo	facility must ensure that a rest he facility without limited been not experience of motion unless the condition demonstrates range of motion is sident with limited range of oppropriate treatment and se range of motion and/or to crease in range of motion. sident with limited mobility attended in the services, equipment, and intain or improve mobility practicable independence in mobility is woldable. In precord review, and the failed to ensure a splint was and Physician Orders included for use for 1 of 2 residents a range of motion. (Resident the same splint was observed on the farm splint was observed on to the bed.	F 0688	688 Increase/Prevent Decreatin ROM/Mobility 1.What corrective actions with be accomplished for those residents found to be affected by the alleged deficient practice. Orders for splints clarified a entered for resident # 17 2.How will you identify other residents having the potentit to be affected by deficient practice and what corrective action will be taken? All residents with splints ordered have the potential to affected by the alleged deficient practice and what corrective action will be taken?	ed and and be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 22 of 63

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	JILDING	ONSTRUCTION 00	COM	E SURVEY PLETED 1/2022
	PROVIDER OR SUPPLIEI HOME, THE	2	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	7/27/22 at 12:12 p.i were not limited to contractures, cerebrate and contractures, cerebrate and extension of the Admission o	Resident 17 was completed on m. Diagnoses included, but anoxic brain damage, ral palsy and stroke. Inimum Data Set (MDS) I/23/22, indicated the resident tively impaired. The resident tively impaired. The resident ration of the person assist for bed 2+ assist for dressing. The pairment of both upper and for a functional limitation in the person assist for bed and remark the person assist for bed and person assist for dressing. The pairment of both upper and for a functional limitation in the person assist for bed and person assist		practice.	nsure that d clarified I be put in nic se to ed cur educated on application. on process of splints discussed g actions ensure the I not y vill be put omplete o ensure splints have I to ensure applied per audit weekly y for 2 and then as all shifts ance is ecutive udits will be tee overseen d of 95% is	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 23 of 63

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/01/2022
	PROVIDER OR SUPPLIED	<u>I</u>	206 E	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0689 SS=D Bldg. 00	A policy titled, "Sp from the Administr Nursing staff will: as determined" 3.1-42(a)(2) 483.25(d)(1)(2) Free of Accident Hazards/Supervis §483.25(d) Accide The facility must e §483.25(d)(1) The remains as free or possible; and §483.25(d)(2)Eac adequate supervisto prevent accided Based on observation interview, the facility investigated, post-fand interventions was a history of falls for accidents. (Resident Findings include: 1. On 7/26/22 at 10 observed in bed. He coverings) on both dried blood. He indicated and had skin tears of applied the tubigrip. The resident's reconsidered in the covering of the c	lints" and received as current ator on 7/27/22, indicated, "5 f. follow the device schedule f. fersident environment f. f. accident hazards as is f.	F 0689	developed to ensure compliant developed to ensure compliant developed to ensure compliant developed develo	O8/26/2022 ill and vas I team opriate ents

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 24 of 63

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155738	B. WI	NG		08/01/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			MARION ST		
MII TON	HOME, THE				I BEND, IN 46601		
IVIILIOIN	TIONE, THE			000111			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		mum Data Set (MDS)			corrective action will be take		
		/3/22, indicated the resident			All residents in the facility ha		
		act, and required one person			the potential to be affected b	У	
		Fers, bed mobility and			alleged deficient practice		
	toileting.				·An Audit of resident falls	11	
	There was no documentation in the progress				completed for last 60 days and		
		resident falling or obtaining			fall events reviewed to ensure		
		as no post fall assessment			IDT note was written, and care		
	completed.	as no post fair assessificht			plan was updated with interver	IIIOH	
	compicied.				place		
	Interview with CNA	A 1 on 7/27/22 at 2:07 p.m.,			Resident interviews comple	tad	
	indicted the resident had fallen in the bathroom				to identify any potential falls th		
		CNA 1 and another CNA			did not have accurate assessr		
		floor, and he had obtained the			or documentation	110111	
	skin tears at that tin				·Skin Sweep completed to		
					identity any skin impairment th	at	
	Interview with LPN	1 1 on 7/27/22 at 2:11 p.m.,			may be related to fall event.		
		nt had picked at his skin so			What measures will be put in	to	
	the weekend nurse	had placed tubigrips on him.			place or what systemic		
	He indicated he was	s not aware of the resident			changes you will make to		
	falling or having sk	in tears.			ensure that the deficient		
					practice does not recur?		
		nterim Director of Nursing			·Nursing staff educated on fa	all	
		at 2:14 p.m., indicated she had			policy and procedures with		
		e resident fell. If a resident had			emphasis on post fall assessn		
		e notified and an incident			and documentation. Nursing s	taff	
		npleted, and the resident			educated on fall follow up		
	should be monitored	d.			procedures and documentatio		
	0 0 7/07/00 0	1.7/20/20 2.12			·IDT was educated on facility		
		41 a.m. and 7/28/22 at 8:49 a.m.,			Fall policy with emphasis on II		
	-	served in bed. There were no			review and Care Plan Updates	and	
	_	he floor next to his bed, and a			interventions.		
	floor mat was leaning	ng against the wall.			·All falls will be reviewed by		
	The modification	d was reviewed on 7/27/22 at			IDT team the following busines		
					day as part of the daily clinical		
		ent was admitted on 2/26/19.			meeting to determine root cau		
	Alzheimer's disease	, but were not limited to,			and other possible intervention		
	Aizneimer's disease	and neart disease.			prevent future falls. Care plan	S WIII	
					be updated as appropriate.		

08/29/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/01/2022 155738 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 206 E MARION ST MILTON HOME, THE SOUTH BEND, IN 46601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Quarterly Minimum Data Set (MDS) ·DON/Designee will conduct assessment, dated 6/24/22, indicated the resident rounds weekly to ensure fall had severe cognitive deficits, and required limited interventions are implemented per assistance with bed mobility, transfers and plan of care toileting. How the corrective action (s) will be monitored to ensure the A Care Plan, updated 6/30/21, indicated the deficient practice will not resident was at risk for falls and had a history of recur, i.e., what quality falls with serious injury. Interventions included to assurance program will be put have a floor mat on bedside, and non-skid strips into place? ·DON/ designee will complete the Fall Management audit tool to Interview with the Interim DON on 7/28/22 at 8:54 ensure fall procedures are followed a.m., indicated when the resident was in bed, the and interventions are in place. floor mat should be in place. ·Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly Interview with the MDS nurse on 7/28/22 at 9:00 for 2 months, monthly for 6 and a.m., indicated she spoke to staff and they then quarterly to encompass all indicated the mat was slipping and that was why it shifts until continued compliance was not in use. She indicated staff should have is maintained for 2 consecutive notified them of the concern, and new quarters. interventions would need to be put into place. ·The results of these audits will be reviewed by the CQI committee 3.1-45(a) overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. F 0690 483.25(e)(1)-(3) SS=D Bowel/Bladder Incontinence, Catheter, UTI Bldg. 00 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

FORM CMS-2567(02-99) Previous Versions Obsolete

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 26 of 63

i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETS						
		155738	B. WING 08/01/2		2022			
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE				206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST I BEND, IN 46601			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	ensure that- (i) A resident who an indwelling cath unless the resider demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possibility of catheterization is considered to prevent urinary restore continence §483.25(e)(3) For incontinence, based comprehensive as ensure that a reside bowel receives appropriate to prevent urinary restore continence function as possib. Based on interview failed to ensure a received the necessive related to not change catheter care daily a output as ordered for urinary catheters. (Interview with Residential for the properties of the prop	necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible. a resident with fecal ed on the resident's essessment, the facility must dent who is incontinent of opropriate treatment and e as much normal bowel ble. and record review, the facility esident with a urinary catheter ary treatment and services ging the catheter, completing and not assessing urinary or 1 of 1 residents reviewed for	F 00	590	F 690 Bowel. Bladder, Incontinence, Catheter, UTI 1. What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice? Resident #9 was provide with catheter care and suprapicatheter changed per MD ord. Resident did not have a negaroutcome related to the alleged deficient practice 2. How will you identify other.	ed ubic ers. tive	08/26/2022	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711 Facility ID: 001141 If continuation sheet Page 27 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPI			ETED	
		155738	B. W	ING		08/01/	2022
		l .	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			MARION ST		
MII TON	HOME, THE				BEND, IN 46601		
	I IOIVIL, IIIL			550111	1 DE14D, 114 40001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e facility told him they didn't			residents having the potentia	al	
		able because they were locked			to be affected by the same		
	up and they could n	ot get to them.			deficient practice and what		
	D1 ' C F	0:4+0			corrective action will be take		
		Resident 9 was completed on			All residents in the facility w		
		n. Diagnoses included, but			Catheters have the potential	το	
		stroke, obstructive uropathy,			be affected by alleged		
	renal insufficiency	and hypertension.			deficient practice	·h	
	The Questants Mini	mum Data Sat (MDS)			An Audit of residents wit	.[1]	
		mum Data Set (MDS) /19/22, indicated the resident			catheters to ensure that all		
		act. The resident required an			residents have all appropriate catheter care and maintenance		
		assist for toilet use and the			orders.	-	
	resident had an indy				orugis.		
	1051dent nad an max				3.What measures will be put		
	A Care Plan, revise	d on 11/9/21, indicated the			into place or what systemic		
		welling suprapubic urinary			changes you will make to		
		ons included to complete			ensure that the deficient		
		r the physician's orders and to			practice does not recur?		
	provide catheter car				Nursing staff educated compared to the staff and the	n	
					Catheter care, emphasis on da		
	The July 2022 Phys	sician's Order Summary			catheter care, daily output	,	
	indicated orders for				monitoring and following MD		
	- cleanse the suprap	oubic catheter site and tubing			orders related to changing		
		r, pat dry, apply drain sponge			suprapubic catheters.		
	and anchor daily an	d when necessary			Nursing staff educated c	n	
	- Urinary Output Ev	very shift. Record output.			documentation with emphasis	of	
	- Catheter orders: ca	atheter care every shift every			signing out EMAR/ETAR after		
	shift				treatment has been complete		
		c catheter every 14 days and			· Audit completed to ensu	re	
	when necessary for	blockage.			that all appropriate catheter		
					supplies are present and nurs	ing	
		lication Administration Record			staff education on location of		
		ent Administration Record			supplies.		
	(TAR) indicated the	_			· IDT to review EMAR/ET		
		c catheter every 14 days: was			compliance reports and follow	•	
	_	/4/22 and refused on 6/18/22			with any missing documentation	on	
		c daily: was not completed at			as necessary		
		, 6/27/22, and 6/29/22			4.How the corrective action (-	
	L - catheter orders: ca	theter care every shift was	1		will be monitored to encure t	ha	l

						T	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>00</u> COMPI			LETED
	155738		B. W	ING		08/01	/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	ROVIDER OR SULLEIE			206 E N	MARION ST		
MILTON	HOME, THE			SOUTH	I BEND, IN 46601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	\TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	 	ays: 6/14/22 and 6/29, and			deficient practice will not		
	evenings: 6/27/22 a				recur, i.e., what quality		
	_					4	
		as not completed on days:			assurance program will be p	out	
		22, 6/13/22, 6/14/22, 6/29/22;			into place?		
	_	/14/22, 6/27/22, and 6/29/22;			· DON/ designee will		
	nights: 6/9/22				complete the Catheter audit to	ool to	
					ensure that all residents have	!	
	The July 2022 MA	R and TAR indicated the			necessary catheter orders,		
	following:				documentation and treatment	s are	
	- change suprapubi	c catheter every 14 days: was			in place and have been comp	leted.	
	not completed on 7	•			· Audit will be completed		
	_				daily x 5, weekly x 4 weeks,		
	- cleanse suprapubic catheter site and tubing one time a day at bedtime: was not completed on				, ,	thly	
	1	•			bi-monthly for 2 months, mon	шпу	
	7/1/22, 7/3/22, and				for 6 and then quarterly to		
		atheter care every shift: was			encompass all shifts until		
	_	ays 7/1/22; evenings: 7/1/22,			continued compliance is		
	7/3/22, and 7/5/22				maintained for 2 consecutive		
	-urinary output eve	ry shift: was not recorded on			quarters.		
	days: 7/1/22, 7/5/22	2, 7/12/22, 7/14/22, 7/20/22,			· The results of these aud	dits	
	7/21/22; evenings:	7/1/22, 7/3/22, 7/5/22, 7/12/22,			will be reviewed by the CQI		
	7/18/22				committee overseen by the E	D. If	
					threshold of 95% is not achieve		
	Interview with the	Interim Director Of Nursing on			an action plan will be develop		
		., indicated she could not find			ensure compliance.	cu to	
	_	entation the catheter care had			ensure compliance.		
	_						
	•	ordered on the above dates					
	and times.						
		se Consultant on 7/29/22 at					
		ed she could not provide any					
		the urinary catheters care had					
	been completed as	ordered on the above dates					
	and times.						
	3.1-41(a)(2)						
							1
F 0695	483.25(i)						
SS=D	` '	neostomy Care and					
Bldg. 00		loostoring Gale and					
Diug. 00	Suctioning						
	§ 483.25(I) Respii	ratory care, including					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 29 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPLETED	
		155738	B. WING 08/01/2022				2022
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE		STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	tracheostomy care	e and tracheal suctioning.					
	1	ensure that a resident who					
	needs respiratory						
	1	e and tracheal suctioning,					
	1	are, consistent with					
	_ ·	dards of practice, the					
		erson-centered care plan,					
		ls and preferences, and					
	483.65 of this sub	•		605	F005 B 0.		00/06/0000
		on, record review, and	F 0695		F695 Resp Care	,	08/26/2022
		ty failed to ensure a Physician's for a resident who received			1.What corrective action(s)		
					will be accomplished for tho		
	oxygen for 1 of 2 residents reviewed for oxygen. (Resident 23)				residents found to have been	"	
	(Resident 23)				affected by the deficient practice?		
	Finding includes:				• MD was notified and		
	i manig merades.				Resident # 23 received appro	nriate	
	On 7/26/22 at 11:30	a.m., Resident 23 was			oxygen orders, residents care		
		xygen via a nasal cannula with			was updated. Resident # 23 d	-	
	_	rs. The resident indicated she			not have a negative outcome		
	always wore her ox				related to the alleged deficien	t	
					practice		
	On 7/28/22 at 2:27	p.m., Resident 23 was still			2.How will you identify other	.	
		xygen with a flow rate at 4			residents having the potenti		
	liters.				to be affected by the same		
					deficient practice and what		
		Resident 23 was completed on			corrective action will be take	en?	
	_	. The resident was admitted to			All residents in the facility w	rith	
	the facility on 6/8/2	2.			oxygen have the potential to		
					be affected by alleged		
		ed the resident had chronic			deficient practice		
	_	ary disease (COPD) and			·An Audit of residents in the		
		The care plan did not reflect			facility completed to ensure the		
	oxygen use.				all residents with oxygen have		
	m 11 1 1	1			appropriate physician orders i	n	
		iny documentation of a			place. order.	,	
	Physician's Order fo	or the use of oxygen.			3. What measures will be put	t	
	Intomiore:!41. NT	se Consultant on 7/29/22 at			into place or what systemic		
					changes you will make to		
	11:11 a.m., indicate	ed the resident did not have a	1		ensure that the deficient		

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING <u>00</u> COM			(X3) DATE S COMPLI 08/01/2	ETED	
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
	HOME, THE				MARION ST I BEND, IN 46601		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		or oxygen in place when she		TAG	DEFICIENCY)		DATE
	-	ing the oxygen, but should			practice does not recur? ·Licensed Nursing Staff wer	_	
		They have since put in an			educated on appropriate		
		e of 4 liters every shift.			necessary respiratory orders,		
	, ,	•			following MD Orders related to	0 02	
	3.1-47(a)(6)				use, oxygen and nebulizer		
					maintenance with emphasis o	n	
					changing, labeling, and dating	the	
					equipment		
					·IDT team educated on IDT		
					admission/ Readmission review		
					and Clinical Meeting Agenda emphasis on daily Huddle for	with	
					observation and order review	and	
					verifications.	and	
					4.How the corrective action	(s)	
					will be monitored to ensure	` '	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					·DON/ designee will comple		
					the Respirator audit tool to en		
					that all residents have necess	,	
					respiratory orders are in place	and	
					followed per MD Order ·Audit will be completed		
					weekly x 4 weeks, bi-monthly	for 2	
					months, monthly for 6 and the		
					quarterly to encompass all sh		
					until continued compliance is		
					maintained for 2 consecutive		
					quarters.		
					·The results of these audits		
					be reviewed by the CQI comm		
					overseen by the ED. If thresh		
					95% is not achieved an action		
					plan will be developed to ensu	ıre	
					compliance.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 31 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COMPLETED			ETED		
		155738				08/01/	
				_	<u> </u>	00/01/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					MARION ST		
MILTON HOME, THE				SOUTH	I BEND, IN 46601		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0757	483.45(d)(1)-(6)						
SS=D	Drug Regimen is F	Free from Unnecessary					
Bldg. 00	Drugs						
	§483.45(d) Unnec	essary Drugs-General.					
	Each resident's dr	ug regimen must be free					
		drugs. An unnecessary					
	drug is any drug w						
	3 , 3						
	§483.45(d)(1) In e	xcessive dose (including					
	duplicate drug the						
	aapaata a. ag aa	. ap					
	§483.45(d)(2) For	excessive duration; or					
	• ()()						
	§483.45(d)(3) With	nout adequate monitoring;					
	or	,					
	§483.45(d)(4) With	nout adequate indications					
	for its use; or	·					
	,						
	§483.45(d)(5) In th	ne presence of adverse					
	- , , , ,	ich indicate the dose					
	•	d or discontinued; or					
	§483.45(d)(6) Any	combinations of the					
	- , , , , .	paragraphs (d)(1) through					
	(5) of this section.						
	` '	view and interview, the facility	F 07	757	F757- Free of Unnecessary		08/26/2022
		dents were free from		131	Drugs		00/20/2022
	unnecessary medica				1.What corrective action(s) w	rill	
		nt on an anticoagulant			be accomplished for those		
	-	giving insulin and checking			residents found to have been		
		ered for 2 of 5 residents			affected by the deficient		
	-	essary medications. (Residents			practice?		
	15 and 11)	essary medications. (Residents			Resident # 11 and resident	# 15	
	13 and 11)				**		
	Findings include:				did not have a negative outcor		
	r manigs menae:				related to the alleged deficient		
	1 On 7/26/22 at 10.	16 a m. Dagidant 15 was			practice.		
		116 a.m., Resident 15 was			2.How will you identify other		
		He had tubigrips on his			residents having the potentia	II	
	torearms and elbow	s, and there were numerous	1		to be affected by the same		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet Page 32 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/01/2022 155738 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 206 E MARION ST MILTON HOME, THE SOUTH BEND, IN 46601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE red discolorations visible on his upper arms. He deficient practice and what indicated he was taking an anticoagulant corrective action will be taken? medication and thought that was what caused the All residents in the facility that are discolorations. on anticoagulants and that are receiving insulin have the potential The resident's record was reviewed on 7/27/22 at to be affected by alleged deficient 1:39 p.m. The resident was admitted on 12/10/21. practice Diagnoses included, but were not limited to, ·Audit of residents that are Diabetes Mellitus and chronic deep vein receiving an anticoagulant thrombosis of the lower extremities. completed to ensure that side effect monitoring is in place The Quarterly Minimum Data Set (MDS) ·Diabetic residents that are assessment, dated 5/3/22, indicated the resident receiving insulin will be reviewed was on anticoagulant medication daily. and audited to ensure accu check orders are in place The July 2022 Medication Administration Record ·IDT team will review EMAR indicated monitoring for side effects of an compliance report in daily clinical anticoagulant started on July 26, 2022. There was meeting to identify any late or no previous monitoring documented. missed medication administrations including insulin Interview with the MDS nurse on 7/27/22 at 2:14 and accu check orders. p.m., indicated that monitoring for anticoagulant 3.What measures will be put side effects had not began until the previous day. into place or what systemic 2. Record review for Resident 11 was completed changes you will make to on 7/27/22 at 3:31 p.m. Diagnoses included, but ensure that the deficient were not limited to, diabetes management and practice does not recur? anemia. Licensed Nursing Staff will be educated on Medication The Admission Minimum Data Set (MDS) Administration policy with assessment, dated 5/30/22, indicated the resident emphasis MD orders, insulin was cognitively intact. The resident had received administration, correct time and insulin (diabetes medication). completing documentation on the MARs The July 2022 Physician's Order Summary ·Clinical IDT team educated on indicated an order for the following: clinical morning meeting and - Humalog (insulin) to inject per the sliding scale reviewing EMAR / ETAR reports before meals and at bedtime. daily ·IDT team will review EMAR

The July 2022 Medication Administration Record

(MAR) had blanks on the following dates and

compliance report in daily clinical

meeting to identify any late or

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

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/01/2022	
	PROVIDER OR SUPPLIEF	t	206 E	T ADDRESS, CITY, STATE, ZIP COD MARION ST TH BEND, IN 46601	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION times for the administration of the Humalog 7/1, 7/2, 7/8/22 at 8:30 p.m 7/17/22 at 7:30 a.m., and 11:30 a.m 7/22/22 at 8:30 a.m. Interview with the Nurse Consultant on 7/28/22 at 10:49 a.m., indicated she could not find any documentation the resident's blood sugar was checked and if she had received any Humalog on the above dates and times. A policy titled, "Diabetes - Clinical Protocol", and received as current from the Administrator on 7/28/22, indicated, "Monitoring and Follow - Up" "3monitor 3 to 4 times a day if on intensive insulin therapy or sliding scale insulin"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) missed medication administrations. 4. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place? DON/ designee will completed the Medication Administration audit tool to ensure that resid are receiving medication appropriately Audit will be completed weekly x 4 weeks, bi-monthly months, monthly for 6 and the	(s) the out ete ents for 2
F 0880 SS=D Bldg. 00	infection prevention designed to provide comfortable environment and communicable discommunicable discommunica	on & Control		quarterly to encompass all sh until continued compliance is maintained for 2 consecutive quarters. The results of these audits be reviewed by the CQI commoverseen by the ED. If thresh 95% is not achieved an action plan will be developed to ensicompliance.	will nittee old of n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 34 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> COMPLET			LETED	
		155738	B. WI	NG		08/01	/2022
NAME OF T	DROVIDED OF GUIDELTO	D.		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIE	К			MARION ST		
MILTON	HOME, THE			SOUTH	I BEND, IN 46601		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		establish an infection					
	-	ontrol program (IPCP) that					
		a minimum, the following					
	elements:						
	\$483.80(a)(1) A s	system for preventing,					
	- ' ' ' '	ring, investigating, and					
		ons and communicable					
		esidents, staff, volunteers,					
		r individuals providing					
		contractual arrangement					
		acility assessment					
	•	ding to §483.70(e) and					
		d national standards;					
	- ' ' ' '	itten standards, policies,					
	1	or the program, which must					
	include, but are n						
		rveillance designed to					
	• •	communicable diseases or					
		they can spread to other					
	persons in the fac						
	` '	whom possible incidents of					
		sease or infections should					
	be reported;	transmission has a					
	• •	transmission-based					
	of infections;	followed to prevent spread					
		w isolation should be used					
	, ,	luding but not limited to:					
		duration of the isolation,					
	, ,	the infectious agent or					
	organism involved						
	1 •	t that the isolation should be					
		e possible for the resident					
	under the circums						
	(v) The circumsta	inces under which the facility					
	must prohibit emp						
		sease or infected skin					
	lesions from direc	ct contact with residents or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If

If continuation sheet Page 35 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPI			LETED
155738		B. Wl	NG		08/01	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			MARION ST		
MILTON	HOME, THE			SOUTH	H BEND, IN 46601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	The state of the s	t contact will transmit the					
	disease; and	ana pragaduras ta ba					
	. ,	ene procedures to be nvolved in direct resident					
	contact.	TVOIVEU III UIIECT TESIGETT					
	oomast.						
	§483.80(a)(4) A s	ystem for recording					
		d under the facility's IPCP					
	and the corrective	actions taken by the					
	facility.						
	0400 00/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
	§483.80(e) Linens						
		andle, store, process, and one of as to prevent the spread					
	of infection.	as to prevent the spread					
	or imposion.						
	§483.80(f) Annual	I review.					
	The facility will co	nduct an annual review of					
	its IPCP and upda	ate their program, as					
	necessary.						
		on, record review, and	F 08	380	F 880		08/26/2022
		ty failed to ensure infection vere in place and implemented,			The Remedy of a Directed Pla		
		orevent and/or contain			Correction (DPOC) is imposed accordance with 42 CFR §	ın c	
		to not placing newly admitted			488.424 effective September	5th	
		unvaccinated for COVID-19			2022. The DPOC and any	· · · · · ·	
	on transmission bas	sed precautions (TBP) as			supporting documentation sho	ould	
	recommended for 2	of 2 new admissions reviewed			be submitted to		
	for infection contro	l. (Residents 125 and 126)			ltcproviderservices@isdh.in.ge		
	TO 11 1 1 1				The Milton Home must include		
	Findings include:				following as part of the submit		
	On 7/26/22 at 3.48	p.m., Room 111 was observed.			POC for the deficient practice cited at F880:		
		the outside wall had Resident			GIEU at FOOU.		
	_	26's names. There was no			Specific/Immediate:		
		n door related to any TBP or a			Immediately implement		
		Equipment (PPE) bin located			specific plan for		
	anywhere outside th				resident/residents/area/othe	rs	
					identified in the deficiency to)	
	On 7/29/22 at 1:41	p.m., Resident 125 was			correct.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 36 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155738	B. W	ING		08/01/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				MARION ST		
MILTON	HOME, THE				H BEND, IN 46601		
	Г	CT L TEL CENT OF DEFICIENCE	ı		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION 11 with TBP signage on the	+	TAG	Barolaker,		DATE
		bin outside of room. Resident			1. Residents #125 and resi	dont	
	I -	n Room 110 with TBP signage			# 126 completed isolation per	ueni	
		a PPE bin outside of room.			CDC guidance. Facility is not		
	on the doorway and	at TE on outside of foom.			currently in outbreak status.		
	1. Record review for	r Resident 125 was completed			Sarronay in Salbroak Status.		
		o.m. The resident was admitted			2. All residents that admitte	ed	
		19/22 and was not vaccinated			in last 30 days were reviewed		
	for COVID-19.				ensure all isolation requiremen		
					were met and follow up compl		
	A Physician's Order	r, dated 7/26/22, indicated:			as necessary.		
		olation as per CDC and			,		
	_	th Guidelines for COVID 19					
	exposure/observation	on or new admission to the			3. The Director of Nursing		
	facility. All meals a	nd services provided in room.			(DON), Infection Preventionist	(IP)	
	Every shift for Cov	id-19 Isolation Color Yellow for			or Designee will educate the		
	10 Days				admissions director on how to		
					correctly read CHIRP vaccinate	tions	
		r Resident 126 was completed			and CDC guidance related to		
	· ·	o.m. The resident was not			up-to-date vaccination status	and	
	vaccinated for COV	TD-19.			isolation requirements		
					a. Educational Resources f	or	
	1	r, dated 7/25/22, indicated:			this education: CDC Interim		
		olation as per CDC and			Infection Prevention and Cont		
		th Guidelines for COVID 19			Recommendations to Prevent		
		on or new admission to the			SARS-CoV-2 Spread in Nursin	ng	
	1	nd services provided in room.			Homes		
	· ·	id-19 Isolation Color Yellow for			4 Equility staff will be		
	10 Days				Facility staff will be educated on Transmission Ba	eed	
	Interview with the	Administrator and Interim			Precautions according to CDC		
		during the entrance			IP recommendations and ensu		
	I -	22 at 9:45 a.m., indicated they			care giving staff are educated		
		sidents who were on TBP.			isolation procedures. Education		
	ara not have any lot	The wife on 1D1.			will ensure all staff are aware		
	Interview with the	Administrator and Regional			who is on isolation and approp		
		ata Set) Coordinator on 7/28/22			signage implemented.		
	1	ted the nurse who admitted the			a. Educational Resources f	or	
	_	accination record incorrectly			this education: CDC Interim		
		ere both vaccinated. The			Infection Prevention and Cont	rol	

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE (A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 08/01/2022
	PROVIDER OR SUPPLIER		206 E	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and should have be	vaccinated prior to admission en put in TBP immediately facility and were not put on		Recommendations to Preven SARS-CoV-2 Spread in Nurs Homes	
	Recommendation to in Nursing Homes a and updated Februa "Empiric use of T (quarantine) is reco are newly admitted who have had close SARS-CoV-2 infec	nfection Prevention and Control of Prevent SARS - CoV-2 Spread and Long-Term Care Facilities, any 2, 2022, indicated, transmission-Based Precautions ammended for residents who to the facility and for residents contact with someone with tion if they are not up to date aled COVID-19 vaccine doses"		5. The DON, IP, or design facility leadership will conduct facility rounds at a minimum daily to ensure Infection Compractices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership enforce corrective measures education if deficiencies are observed.	et of trol
				A. Systemic	
				1). A root cause analysis (RC was conducted by the Infection Preventionist (IP), with input review from the Medical Director Conductive Director, Director of Nursing/IP, MDS, and VP of Clinical Operations to determ the root cause resulting in the	on and ctor, of
				facilities Infection Control citals. Through staff interviews was determined that Admissi director was reviewing COVII vaccine documentation in CF	ation. s it on D

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 38 of 63

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/29/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
1		155738	B. WING		08/01/2022
		.557.55	2 1.0		30/01/2022
NAME OF I	PROVIDER OR SUPPLIEI		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	ROVIDER OR SUPPLIED	· ·	206 E N	MARION ST	
MILTON	HOME, THE		SOUTH	H BEND, IN 46601	
	· · · · · · · · · · · · · · · · · · ·			1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				to confirm status prior to	
				admission, however admission	n
				director was incorrectly readin	
				the information on CHIRP. Th	-
				dates that are entered were un	
				the past due section.	
				·	244
				Admission Director is ne to the organization and engree	
				to the organization and approp	
				training on CHIRP did not occ	
				· IDT team failed to comp	
				IDT admission reviews to conf	īrm
				Vaccination status and	
				documentation	
				 Increased Staffing 	
				challenges have made the clir	nical
				IDT participation challenging	
				resulting in IDT failing to follow	v
				facility process	
				b). The solutions and systemic	,
				changes developed by the DC	
				ADON and facility IP include:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
				ADON and facility if include.	
				The Discrete of No. 1	
				The Director of Nursing	((D)
				(DON), Infection Preventionist	(IP)
				or Designee will educate the	
				admissions director on how to	
				correctly read CHIRP vaccinal	tions
				and CDC guidance related to	
				up-to-date vaccination status	and
				isolation requirements	
				o Educational Resources for	this
				education: CDC Interim Infect	tion
				Prevention and Control	
				Recommendations to Prevent	
				SARS-CoV-2 Spread in Nursin	
				Homes	· ʊ
				1.511103	
				· Facility staff will be	
i	1		ı	I domey stan win bo	i

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

educated on Transmission Based

Page 39 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/01/2022
	PROVIDER OR SUPPLIER		206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST	
MILTON	HOME, THE		SOUTH	H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Precautions according to CDC	DATE Cand
				Precautions according to CDC IP recommendations and ensure agiving staff are educated isolation procedures. Education will ensure all staff are aware who is on isolation and appropriage implemented. o Educational Resources for education: CDC Interim Infect Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursin Homes The DON, IP, or designate facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Contropractices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership will enforce corrective measures are education if deficiencies are observed. 2). The DON/ IP Nurse, and of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes we made to so the assessment wow be an accurate reflection the facility. This assessment is	c and ure on on on of oriate this tion and will and VP d ere ould of
				be submitted with the DPOC documentation. B. Training:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 40 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/01/2022
NAME OF P	ROVIDER OR SUPPLIE	ZR.		ADDRESS, CITY, STATE, ZIP COD	
MILTON	HOME, THE			MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 1) Por the LTC infection control	DATE
				1).Per the LTC infection contrassessment review and Roof Cause Analysis, VP of Clinica ED, Medical Director, MDS, a DON/IP. The following trainin needs were identified and implemented by facility IP and DON with training resources a polices provided and submitte part of the DPOC documentary. The Director of Nursing (DON), Infection Preventionis or Designee will educate the facility staff facility staff relate but not limited to, PPE use, Isolation requirements as it re	t (IP)
				to New/ Readmissions, isolatisignage and equipment use. The Director of Nursing (DON), Infection Preventionis or Designee will educate the admissions director on how to correctly read CHIRP vaccina and CDC guidance related to up-to-date vaccination status isolation requirements The Nurse consultant/ designee will educate the IDT team on IDT admission reviewemphasis on verification of Covaccination status and documentation	t (IP) tions and v with

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/01/2022
	ROVIDER OR SUPPLIE	R	206 E	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				C. Monitoring: Monitoring approaches to ensure Infect Control Practices are maintained.	
				The DON, IP, or designated facility leadership will conduct visual facility rounds at a minit of daily to ensure Infection Corpractices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership enforce corrective measures are observed. Rounds will be conducted daily for a minimum six weeks and will continue uncompliance is maintained.	mum introl will and
				E. Quality Assurance and Performance Improvement (QAPI):	
				The IP Nurse/Director of Nurs will present the results of thes audits monthly to the QAPI committee for no less than 6 months. The facility through t QAPI program will review, upon and make changes to the DPC as needed for sustaining substantial compliance for no than 6 months. Any patterns are identified will have an Actiplan initiated. The QAPI committee will determine whe 100% compliance is achieved	he date, OC less that on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet Page 42 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155738	B. WING		08/01/2022
			CTREET	CADDRESS SITY STATE TIP SOD	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
MII TONI	HOME THE			MARION ST	
WILTON	HOME, THE		3001	H BEND, IN 46601	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				ongoing monitoring is required	d.
				Elizabeth Kegg, VP of Clinical	1
				Frank Bensema, Executive	
				Director	
				Lisa Cook , Director of Nursin	g/ IP
				Jody Braun , MDS	
				Shaya Mokfi , Medical Director	or
				Milissa Scully, Admissions	
				Director	
				· Resident 125 admitted t	0
				the facility on 7/19/2022 and v	vas
				not placed in droplet precaution	ons
				until 7/26/2022	
				· Resident 125 was admit	tted
				to the facility on 7/25/2022 an	d
				was not placed in droplet	
				precautions until 7/26/2022	
				· Isolation signage and	
				equipment was not placed	
				appropriately for resident 125	or
				126 until 7/26/2022	
				Lack of understanding from	
				admissions team on reading	
				COVID vaccine documentatio	n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Lack of IDT admission review to

Page 43 of 63

08/29/2022 PRINTED:

	Γ OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMEN	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/01/2022
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD MARION ST	
MILTON	HOME, THE		SOUTI	H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				confirm COVID vaccine documentation after admissio	
				A root cause analysis (RCA) was conducted by the Infection Preventionist (IP), with input a review from the Medical Direct Executive Director, Director of Nursing, Unit Manager and Regional Director of Clinical Operations to determine the recause resulting in the facilities Infection Control citation. Through staff interviews was determined that Admission	ind tor, f oot it
				director was reviewing COVID vaccine documentation in CHI to confirm status prior to admission, however admission director was incorrectly reading	n 1g
				the information on CHIRP. The dates that are entered were use the past due section. Admission Director is not to the organization and appropriate the control of the contr	nder ew priate
				training on CHIRP did not occ IDT team failed to comp IDT admission reviews to com Vaccination status and documentation Increased Staffing	olete
				challenges have made the clir IDT participation challenging	nical

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

resulting in IDT failing to follow

facility process

Page 44 of 63

PRINTED: 08/29/2022

EPARTMENT OF HEALTH AND HU		FORM APPROVED	
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>	COMPLETED
	155729	R WING	09/04/2022

		155738	B. WING		08/01	1/2022
	ROVIDER OR SUPPLIE	R	206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST I BEND, IN 46601	-	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETIO DATE	
				The solutions and systemi changes developed by the and facility IP include: 1.) The Director of Nursi (DON), Infection Prevention or Designee will educate the admissions director on how correctly read CHIRP vacce and CDC guidance related up-to-date vaccination statistical isolation requirements Educational Resources for education: CDC Interim In Prevention and Control Recommendations to Prevention SARS-CoV-2 Spread in Not Homes	e, DON, ng point (IP) he w to cinations d to tus and r this nfection	
				2.) Facility staff will be ed on Transmission Based Precautions according to CIP recommendations and Care giving staff are educational procedures. Education procedures. Education is on isolation and apsignage implemented. Educational Resources for education: CDC Interim Intervention and Control Recommendations to Prevention SARS-CoV-2 Spread in Not Homes	CDC and ensure ated on cation are of propriate r this infection	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 45 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/01/2022
	ROVIDER OR SUPPLIEF		206 E I	ADDRESS, CITY, STATE, ZIP COD MARION ST H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				2.) The DON, IP, or designal facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Contrustrations are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership enforce corrective measures a education if deficiencies are observed.	f rol will and
				The DON, IP, or designated falleadership will conduct rounds minimum of daily for 6 weeks until compliance is maintained to ensure staff are following prinfection control practices related to PPE use, Isolation signage equipment availability	s at a and l: roper ted
				The IP Nurse/Director of Nurs will present the results of thes audits monthly to the QAPI committee for no less than 6 months. The facility through t QAPI program will review, upout and make changes to the DPG as needed for sustaining substantial compliance for no than 6 months. Any patterns that are identific will have an Action Plan initiat The QAPI committee will determine when 100% complicits achieved or if ongoing	he date, DC less ed ed.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 46 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>		00	COMPLETED		
		155738	B. WI	NG		08/01/2022
			_	STREET .	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIE	.R		206 E N	MARION ST	
MILTON HOME, THE			_	SOUTH	H BEND, IN 46601	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG		DATE
					monitoring is required.	
					Root Cause Analysis Works	heet
					for Planning a Performance	
					Improvement Project	
					Date of meeting: 8/12/2022 The Milton Home Center F880	,
					Citation	, l
					Oltation	
					Steps:	
					1. Identify the event to be	
					investigated and gather	
					preliminary information.	
					Events and issues can come	from
					many sources (i.e. incident	
					reports, risk management	
					referrals, resident or family	
					concerns, health department	
					citations) The Remedy of a Directed Pla	an of
					Correction (DPOC) is imposed	
					accordance with 42 CFR §	
					488.424 effective September	5th,
					2022 . The Milton home must	
					include the following in their P	oc
					for the deficient practice cited	
					F880:	
					Based on observation, record	
					review, and interview, the faci	-
					failed to ensure infection cont	rol
					guidelines were in place and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

If continuation sheet

Page 47 of 63

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/29/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPI	ETED
		155738	B. WI	NG		08/01	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			MARION ST		
MILTON	HOME, THE				H BEND, IN 46601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					implemented, including those	to	
					prevent and/or contain COVID)-19,	
					related to not placing newly		
					admitted residents who were		
					unvaccinated for COVID-19 or	n	
					transmission-based precaution	ns	
					(TBP) as recommended for 2	of 2	
					new admissions reviewed for		
					infection control		
					2. Charter Team Members		
					involved in planning:		
					(Appointed by Leadership du	ıe	
					to personal knowledge of		
					systems involved.) List name	es	
					and title below		
					3.Describe what happened		
					Collect and organize the facts		
					surrounding the event to		
					understand what happened.		
					4.Identify contributing factor	s	
					The situations, circumstances		
					conditions that increased the		
					likelihood if the events are		
					identified.		
					5. Identify root cause		
					A thorough analysis of		
					contributing factors leads to		
					identification of the underlying		
					process of system issues (roo		
					causes).		
					6. Design and implement		
					changes to eliminate the roo	t	
					causes		
					The team determines how bes	st to	
					change processes and system	ıs to	
					reduce the likelihood of another		
					similar event.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2ZC711

Facility ID: 001141

changes

If continuation sheet

7. Measure the success of

Page 48 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE C A. BUILDING B. WING	00	COM	E SURVEY PLETED 11/2022	
	PROVIDER OR SUPPLIER		206 E	TADDRESS, CITY, STATE, ZIF MARION ST TH BEND, IN 46601	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				Like all improvement success of improvem is evaluated.		
R 0000						
Bldg. 00	Survey. This visit ir State Licensure Sur Survey dates: July 2 2022 Facility number: 00 Residential Census:	26, 27, 28, 29, and August 1, 1141 14 14 14 1Atial Findings are cited in 0 IAC 16.2-5.	R 0000			
R 0026	410 IAC 16.2-5-1.	2(a)				
Bldg. 00	rights recognized licensee shall esta regarding resident responsibilities in and shall be responding administrator, for the policies and any a changes thereto sethe resident, staff, general public. Ear advised of resident admission and shall establication.	e the right to have their by the licensee. The ablish written policies s' rights and accordance with this article ansible, through the their implementation. These dopted additions or hall be made available to legal representative, and ch resident shall be				

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 49 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155738	B. WI	NG		08/01	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIE	R			MARION ST		
MILTON	HOME, THE			SOUTH BEND, IN 46601			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	d or changed. There shall be					
		at each resident is in					
	· ·	cribed residents ' rights and					
	responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.						
			R 00	026	P 026 Posidonte Pichto		08/26/2022
	Based on record review and interview, the facility failed to ensure there were signed copies of the		K U	020	R 026- Residents Rights		08/26/2022
		the records for 4 of 4 residents			1.What corrective action(s) will be accomplished for those		
	reviewed for resident rights. (Residents 2, 4, 6 and 8)				residents found to have bee		
					affected by the deficient		
					practice?		
	Findings include:				·Residents #2,#4,#8 and #	8	
	g:				have been provided with a co		
	1. Resident 2's reco	ord was reviewed on 7/29/22 at			residents rights and they have		
	12:27 p.m. The res	sident was admitted on 8/18/21.			been signed and placed in th		
	_	documentation of a signed			medical record.		
	copy of the Reside	_			1.How will you identify oth	ner	
					residents having the potent		
	2. Resident 4's reco	ord was reviewed on 8/1/22 at			to be affected by the same		
		sident was admitted on 5/14/22.			deficient practice and what		
		documentation of a signed			corrective action will be tak	en?	
	copy of the Resider	9			All residents in the	•	
		for Resident 6 was completed on			facility have the potential to		1
	_	The resident was admitted to			affected by alleged deficien	t	
	the facility on 1/12	/22.			practice		
	Th 11 1 1				All markets are as a second	. .	
		any documentation to indicate			All residents in the ALF facili	-	
	Rights on admission	ed a copy of the Resident			were provided with a copy of		
	Rights on admissio	on to the facility.			residents rights and they hav		
	4 Record review f	or Resident 8 was completed on			been signed and placed in the medical record.	C	
		n. The resident was admitted to			medical record.		
	the facility on 11/1						
	are ruemity on 11/1	,,,,,,,			1.What measures will be p	out	
	The record lacked:	any documentation to indicate			into place or what systemic		
		ed a copy of the Resident			changes will you make to		
	Rights on admission				ensure that the deficient		

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 50 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155738	B. W	NG		08/01/	/2022
	ROVIDER OR SUPPLIER HOME, THE	STATEMENT OF DEFICIENCIE	1	206 E M	ADDRESS, CITY, STATE, ZIP COD MARION ST BEND, IN 46601		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	12:38 p.m., indicate documentation the	Nurse Consultant on 8/1/22 at ed she could not find any residents had received a copy hts when they were admitted			Practice does not recur? IDT team provided education requirement with emphasis on ensuring that that the resident has signed a copy of resident rights upon admission. 1.How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be printo place? SS/ designee will complete Resident Right audit to ensure that all new admissions have resident rights signed and place in medical record upon admission Audit will be completed westimes 4 weeks, monthly times months, and quarterly until continued compliance is maintained for 2 consecutive quarters. Executive Director or Designee will audit log after eacompleted admission provided the Director of Nursing or Designee.	ty ut ced sion ekly 5	
R 0214	410 IAC 16.2-5-2(Evaluation - Defic	•					
Bldg. 00	each resident sha admission and sha semiannually and change in the resi	of the individual needs of Il be initiated prior to all be updated at least upon a known substantial dent's condition, or more					

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 51 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155738		JILDING	00	COMPLETED 08/01/2022	
	PROVIDER OR SUPPLIER HOME, THE			206 E M	ADDRESS, CITY, STATE, ZIP COD MARION ST BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	needs of the reside Based on record reversal failed to ensure their screening completed reviewed for pre-add 4) Finding includes: The record for Reside at 10:00 a.m. The restriction of the record for Reside at 10:00 a.m. The record for Reside at 10:00	chall evaluate the nursing ent. iew and interview, the facility e was pre-admission if for 1 of 4 resident records mission screenings. (Resident dent 4 was reviewed on 8/1/22 esident was admitted on 5/14/22. Stion a pre-admission completed prior to admission. Interim Director of Nursing on indicated there was no on available for the resident.	R 02	214	R 0214- Evaluation What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 4 was provided a of service plan. A signed copy the service plan was placed in residents medical record How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents in the facility have the potential to be affected by alleged deficient practice All residents have the potential be affected by this alleged deficient practice. All Nursing Staff in-serviced on Admission protocol which includes Admis Service Plan. A copy was provided to all Nursing Staff. An audit of all admissions/ readmissions in last 60 days completed to ensure admission service plan completed and si by resident What measures will be put in place or what systemic	copy of al al sin?	08/26/2022

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 52 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155738	B. WI			08/01/	ZUZZ	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP COD			
MILTON	HOME, THE		206 E MARION ST SOUTH BEND, IN 46601					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
mo	REGELITORI GR	ESC ISENTING IN GRANTING.		mo	changes will you make to ensure that the deficient practice does not recur?		BILLE	
					Director of Nursing will completed the Service Plan or will assign Licensed Nurse to complete unadmission. Nursing Admission Checklist with signature and submitted the Director of Nursing for audithin 24 hours of admission. How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?	a pon will f to lit n		
R 0217	410 IAC 16.2-5-2(e)(1-5)			IDT/DON to log and monitor compliance for all new admiss to the facility. Audit will be completed weekly x 4, monthly 5 Executive Director or Designe audit log after each completed admission provided by the Director of Nursing or Designee.	y x e will I		
Bldg. 00	Evaluation - Defici (e) Following complete facility, using approximate members, shall ideal services to be proved follows:							

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 53 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING 00 COMPLE B. WING 08/01/2					
	F PROVIDER OR SUPPLIER N HOME, THE	2	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	revised as appropresident and facilichange. Either the request a service (3) The agreed upsigned and dated of the service plan resident upon req (4) No identification services provided subsequent to the no need for a characteristic provision of reside both, is needed, a involved in identification the services to be Based on record regalled to ensure the for 1 of 7 resident reservice plans. (Resident provision of the service plans of the record for Resident provision.) The record for Resident provision of the record for Resident provision. (Resident provision of the record for Resident provision of the record for Resident provision. (Resident provision of the record for Resident provision.)	offered shall be reviewed and rriate and discussed by the try as needs or desires a facility or the resident may plan review. It is plan shall be by the resident, and a copy in shall be given to the uest. It is needed if evaluation of its needed if evaluations initial evaluation indicate ringe in services. In of medications or the rential nursing services, or alicensed nurse shall be cation and documentation of provided. It is was a signed service plan records reviewed for signed dent 4) In dent 4 was reviewed on 8/1/22 resident was admitted on 5/14/22. It is desired a service plan in the resident's	R 02	217	R 0217- Evaluation What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 4 was provided a cof service plan. A signed copy the service plan was placed in residents medical record How will you identify other residents having the potentiat to be affected by the same deficient practice and what	copy of	08/26/2022

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 54 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	_	SURVEY LETED /2022
	ROVIDER OR SUPPLIER		206 E I	ADDRESS, CITY, STATE, ZIP C MARION ST H BEND, IN 46601	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				All residents in the father the potential to affected by alleged depractice	acility be	
				All residents have the be affected by this alle deficient practice. All I Staff in-serviced on Adprotocol which include Service Plan. A copy provided to all Nursing An audit of all admissions in last 60 completed to ensure a service plan completed by resident What measures will be place or what system changes will you makensure that the deficipractice does not rec	ged Nursing Imission s Admission was Staff. ons/ O days admission d and signed re put into ic se to ent	
				Director of Nursing will the Service Plan or wil Licensed Nurse to con admission. Nursing Admission Ch be completed by Nursi with signature and sub the Director of Nursing within 24 hours of adm How will the correctiv (s) be monitored to endeficient practice will recur, i.e., what quality	I assign a Inplete upon ecklist will ing Staff omitted to I for audit hission we action insure the not	

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 55 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155738		ILDING	00	COMPL 08/01/	ETED
	PROVIDER OR SUPPLIER			206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0240 Bldg. 00	410 IAC 16.2-5-4(regregation of the property o	d) Deficiency and assistance with ving, shall be provided dual needs and preferences. on, record review and by failed to ensure a Physician's for a resident receiving oxygen reviewed for oxygen and failed stomy tube and change the for 1 of 1 residents reviewed tube. (Residents 2 and 4) 5 p.m., Resident 2 was n. She was wearing a nasal was flowing at 3 liters per and she wore oxygen at all d was reviewed on 7/29/22 at dent was admitted on 8/18/21. but were not limited to,	R 02	240	assurance program will be printo place? IDT/DON to log and monitor compliance for all new admiss to the facility. Audit will be completed weekly x 4, monthly 5 Executive Director or Designer audit log after each completed admission provided by the Director of Nursing or Designee. R240- Health Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? MD was notified and orders obtained for oxygen for Resident # 8's nephrostomy tubes, appropriate follow up initiated. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken.	sions y x e will dector	08/26/2022

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 56 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/01/	ETED	
	PROVIDER OR SUPPLIER HOME, THE	R	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	oxygen use. Interview with the	Interim Director of Nursing on indicated she was not aware der for the oxygen.			All residents in the facility have the potential to be affected by alleged deficient practice		
	observed in her roo bilateral nephrostor the kidney to drain collection bags. Bo empty. The right side root been working for stopped draining a stopped draining Note, da [company] RN at [group of the stops draining stopped d	as a.m., Resident 4 was m laying on her bed. She had my tubes (a tube inserted into urine) that attached to urine th urine collection bags were de tube dressing was dated nt indicated the right tube had or some time, and the left tube couple days ago. In the desired of the tube desired on the desired of the tube desired on the left tube couple days ago. In the desired of the tube desired on the left tube desired on			All residents have the potential be affected by this alleged deficient practice. Audit completed of all ALF residents to ensure that any residents with oxygen had appropriate oxygen orders. Audit completed on all ALF residents to ensure that any resident with nephrostomy tub have physician orders and that they are carried out as necess. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?	oes at sary	
	day. The July 2022 Trea (TAR) indicated the on 7/30/22, althoug was dated 7/28/22. sites were being me infection and that the draining. Interview with LPN indicated he wasn't draining, that was the control of the c	tment Administration Record e dressing had been changed h the dressing on the resident The TAR also indicated the onitored every shift for signs of ne nephrostomy tubes were If 1 on 8/1/22 at 10:42 a.m., aware the tubes weren't he first he had heard of it. He the dressing not being			All Nursing Staff in-serviced of Oxygen use with emphasis or requirement of physician order All Nursing Staff in-services of Following Physician orders with emphasis on monitoring nephrostomy tube and complet treatment orders How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be proceeded.	n r n th eting on ne	

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 57 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING <u>00</u> COM			(X3) DATE COMPL 08/01/	ETED	
	ROVIDER OR SUPPLIEF		.	STREET A 206 E M	ADDRESS, CITY, STATE, ZIP COD MARION ST BEND, IN 46601	00/01/	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION didn't work over the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT O THE APPROPRIA DEFICIENCY) into place?	TE	(X5) COMPLETION DATE
					DON/Designee will complete Oxygen audit to ensure that al residents have appropriate ox orders in place. DON/ Designee will complete nephrostomy audit to ensure t physicians orders have been followed, including notification sites are not draining and ensi that treatments have been completed per order o Audits will be completed weekly times 4 weeks, monthl times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. Executive Director or Designee will audit log after ea completed admission provided the Director of Nursing or Designee.	ygen hat if uring y	
R 0354 Bldg. 00	(1) Identification d(2) Name of the tr(3) Name of the reof transfer.	Noncompliance a shall include the following:					
	transferred to an a (5) Nurses ' notes (A) functional abili	relating to the resident 's:					

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 58 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		a. building <u>00</u> com			(X3) DATE COMPL 08/01/	ETED	
	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	(6) Diagnosis. (7) Date of chest of tuberculosis. Based on record revisited to ensure a tree completed for 1 of 2 (Resident 7) Finding includes: Record review for I 8/1/22 at 11:28 a.m. the facility on 4/14/2 The facility census discharged from the 1 discharged from the 2 discharged from the 3 discharged from the 4 discharged from the 4 discharged from the 5 discharged from the 6 discharged	Acray and skin test for view and interview, the facility ansfer/discharge form was 2 closed records reviewed. Resident 7 was completed on . The resident was admitted to /21.	RO	354	F354 Clinical Records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 7 no longer reside the facility How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents in the facility have the potential to be affected by alleged deficient practice All residents have the potential be affected by this alleged deficient practice. Audit of residents that have been transferred or discharge last 60 days completed to ensithat discharge summary/ assessment was provided or completed. IDT will follow up	nes at al en? d in eure	08/26/2022
	8/1/22 at 12:30 a.m	., indicated she could not find			correct any irregularities noted	d if	

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 59 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155738	A. BUILDING B. WING	00	COMPLETED 08/01/2022	
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
IAU		related to the resident's	IAG	applicable What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Licensed nursing staff educated on Discharge, proceand procedures and requirem for documentation, discharge assessment to be sent with residents at time of transfer/discharge IDT educated on use of Clinical meeting process with emphasis on IDT discharge reprocess IDT team educated on discharge process including discharge assessment and documentation requirements How will the corrective active (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? SSD/ designee will complete the Discharge/ Transfer Audit ensure that discharge documentation was complete	ess ents f eview on he out te to	
				·Audit will be completed weekly x 4 weeks, bi-monthly	for 2	

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 60 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING	COMPLETED 08/01/2022			
NAME OF PROVIDER OR SUPPLIER 206 E MARION ST	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601			
DDEELY (EACH DEFICIENCY MIIST BE DDECEDED BY FILL I DDEELY (EACH CORRI	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY) CX5) COMPLETION DATE			
R 0409 ### A 10 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. ###################################	onthly for 6 and then of encompass all shifts for 2 consecutive described for 4 consecutive described for 6 de			

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 61 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/01/2022			
NAME OF P	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CO	D			
				206 E MARION ST				
IVIILTON	HOME, THE		5001	TH BEND, IN 46601				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE	ection (X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE COMPLETION			
TAG			TAG	_	BATTE			
		ord was reviewed on 8/1/22 at		be affected by this allege	ed			
		ident was admitted on 5/14/22.		deficient practice.				
		a Physician's annual health		Audit completed of all ALF				
	statement.			residents and annual health				
	1 Dagidant 51a maga	ord was reviewed on 8/1/22 at		assessment schedule				
	-	ident was admitted on 12/20/19.		implemented				
	_	a Physician's annual health		MD notified of requirement need for annual health	ents and			
		rd review for Resident 6 was		assessment				
		22 at 1:40 p.m. The resident was		What measures will be	nut into			
	admitted to the faci	_		place or what systemic	-			
	admitted to the faci	inty on 1/12/22.		changes will you make				
	The record lacked any documentation of an			ensure that the deficier				
	annual Health Statement.			practice does not recui	· · ·			
	amaa Heam State	onicit.		team educated on requir				
	6. Record review for	or Resident 7 was completed on		Health assessment bein				
	8/1/22 at 11:28 a.m. The resident was admitted to			prior to admission and th				
	the facility on 4/14/21.			thereafter. MD educated on				
	the facility of wit will.			requirement of Health as				
	The record lacked any documentation of an			being required yearly with				
	annual Health Statement.			emphasis on statement that				
				resident shows no evide				
	7. Record review for	or Resident 8 was completed on		tuberculosis in an infecti	ious			
	8/1/22 at 12:16 p.m. The resident was admitted to			stateHow will the corre	ctive			
	the facility on 11/17/21.			action (s) be monitored	l to			
				ensure the deficient pro	actice			
	The record lacked any documentation of an annual Health Statement.			will not recur, i.e., what	t quality			
				assurance program wil	-			
				into place?DON/Design				
		Nurse Consultant on 8/1/22 at		complete Health assess				
	• .	ed she could not find any		Audit to ensure that scho	edule is			
		annual Health Statement was		being followed.				
	completed for the a	above residents.		·Audit will be comp				
				weekly x 4 weeks, bi-mo	-			
				months, monthly for 6 ar				
				quarterly to encompass				
				until continued complian				
			maintained for 2 consec	uuve				
				quarters.				
			1	 Executive Director 	UI			

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 62 of 63

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155738	B. WING		08/01/2022		
NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE			STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATIO		ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Designee will audit log after eacompleted admission provided the Director of Nursing or Designee.		

State Form Event ID: 2ZC711 Facility ID: 001141 If continuation sheet Page 63 of 63