STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING -- B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILTON HOME, THE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/22/22 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Emergency Preparedness Survey, The Milton Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 34 certified beds. At the time of the survey, the census was 29. Quality Review completed on 08/25/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey conducted was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/22/22 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Life Safety Code Survey, The Milton Home was found not in compliance with	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a basement is fully sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975. The facility has a fire alarm system with smoke detection in the corridors, in resident sleeping rooms on the second floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility is protected by a 10 kW Natural Gas generator. The facility has a capacity of 34 and had a census of 29 at the time of this survey. Quality Review completed on 08/25/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure all doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 3 occupants in unit managers office. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/22/22 between 12:05 p.m. and 1:45 p.m., the Unit Managers Office Door was equipped with two latching devices, a regular door handle with a turn down latching mechanism and a separate dead bolt type locking latch. The Maintenance Director agreed that, when locked, to exit the unit managers office area it would require two separate actions to open the door. These findings were acknowledged by the Maintenance Director at the time of observation	K 0222	**What corrective actions will be accomplished for those residents found to have affected by the deficient practice;** The Facility removed the dead bolt on the Nurse Managers Door. Bringing the door into compliance (see attached pictures) **How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor or designee will conduct an audit of all exterior egress doors. 2x weekly for 3 months, then 1x monthly for 3 months. **How will the corrective action be monitored to ensure the deficient practice will not**	08/26/2022

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	and again at the exit conference with the Maintenance Director and Executive Director present at 2:10 p.m. 3.1-19(b)		**recur, i.e. what quality assurance programs will be put into place;** The Maintenance Supervisor or designee will report monthly to the QAPI committee the results of the Audits. The QAPI will determine the need for ongoing audits or action plan.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 3 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects at least 10 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/22/22 between 12:05 p.m. and 1:45 p.m., the latch on the Basement Stairwell Therapy door on the west side, equipped with a self-closing device, failed to self-close and latch positively into the door frame. These findings were acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present at 2:10 p.m.	K 0225	**What corrective actions will be accomplished for those residents found to have affected by the deficient practice;** The facility adjusted the door closure ensuring door would properly close and be in compliance. **How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor or	08/26/2022

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	3.1-19(b)		designee will conduct an audit of all exterior egress doors. 2x weekly for 3 months, then 1x monthly for 3 months. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place;** The Maintenance Supervisor or designee will report monthly to the QAPI committee the results of the Audits. The QAPI will determine the need for ongoing audits or action plan.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler			

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	Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 6 staff in the basement. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/22/22 between 12:05 p.m. and 1:45 p.m., the housekeeping basement storage closet on the south side, a room greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this room was not provided with a self-closing device. These findings were acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present at 2:10 p.m. 3.1-19(b)	K 0321	**What corrective actions will be accomplished for those residents found to have affected by the deficient practice;** Maintenance director installed a self-closure to the door. The ensured that the door was brought back into compliance and self-closed like it should **How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor or designee will conduct an audit of all exterior egress doors. 2x weekly for 3 months, then ix	08/26/2022

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			monthly for 3 months. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place;** The Maintenance Supervisor or designee will report monthly to the QAPI committee the results of the Audits. The QAPI will determine the need for ongoing audits or action plan.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/22/22 between 12:05 p.m. and 1:45 p.m., the following corridor doors had holes which penetrated completely through the door: A) A 1/2 inch hole through the door above the latching hardware in the 2nd floor janitors closet. B) Two 1 inch hole through the door above the latching hardware and around the knob in the 2nd floor dining room. These findings were acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the	K 0363	**What corrective actions will be accomplished for those residents found to have affected by the deficient practice;** **The three holes identified in the cited doors were filled with approved fire rating caulk. This ensured that they were brought back into compliance.** **How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	08/26/2022

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	Maintenance Director and Executive Director present at 2:10 p.m. 3.1-19(b)		**practice does not recur:** The Maintenance Supervisor or designee will conduct an audit of all exterior egress doors. 2x weekly for 3 months, then ix monthly for 3 months. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place;** The Maintenance Supervisor or designee will report monthly to the QAPI committee the results of the Audits. The QAPI will determine the need for ongoing audits or action plan.	