STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					LETED
		155738	B. W	NG		11/20	/2023
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MILTON	HOME, THE		206 E MARION ST SOUTH 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 APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG E 0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
□ 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 11/20 Facility Number: 0 Provider Number: 200 At this Emergency Milton Home was f Emergency Prepare Medicare and Mediand Suppliers, 42 C	0/23 001141 155738 905640 Preparedness Survey, The found not in compliance with edness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of	E 00	000			
	Quality Review con	mpleted on 11/27/23					
E 0039 SS=F Bldg	441.184(d)(2), 482.15(d)(2), 483.475(d)(2),						

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

(X6) DATE

TITLE

Hemmington Mwanza Executive Director 12/11/2023

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.

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	OF CORRECTION	IDENTIFICATION NUMBER 155738	ľ í	UILDING	NSTRUCTION	COMPL 11/20/	ETED
	ROVIDER OR SUPPLIER HOME, THE			206 E M	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
	(2) Testing. The [fexercises to test the annually. The [fact following: (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-material activation of the ending exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, opport functional exercise actual event. (ii) Conduct an addevery 2 years, opport functional exercise (ii) of this section is include, but is not (A) A second full-secommunity-based functional exercise (B) A mock disaste (C) A tabletop exelled by a facilitator	acility] must conduct ne emergency plan ility] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based e every 2 years; or lity] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) as conducted, that may limited to the following: cale exercise that is or individual, facility-based e; or er drill; or croise or workshop that is and includes a group			CROSS-REFERENCED TO THE APPROPRIA	TE	
	set of problem sta messages, or prep to challenge an er	emergency scenario, and a tements, directed pared questions designed nergency plan.					
	maintain documer exercises, and em	acility's] response to and nation of all drills, tabletop nergency events, and revise rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					

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	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738		UILDING	NSTRUCTION	(X3) DATE COMPI 11/20	LETED	
	F PROVIDER OR SUPPLIEIN HOME, THE	₹	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based functional (B) If the hospice man-made emerge of the emergency exempt from engascale community-facility-based functional exercis of this section is of include, but is not (A) A second full community-based functional exercis (B) A mock disast (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an el (3) Testing for hose care directly. The exercises to test to per year. The hose	nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Idditional exercise every 2 to e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is for a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. Spices that provide inpatient to hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise						

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted '2023	
	PROVIDER OR SUPPLIER HOME, THE		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 LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	accessible, conduracility-based functional exercise emergency event. (ii) Conduct an activate manity-based functional exercise emergency event. (iii) Conduct an activate may include, following: (A) A second full-community-based functional exercise (B) A mock disastic) A tabletop exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emithe hospice's emergency sementations.	experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an cospice's response to and station of all drills, tabletop bergency events and revise rgency plan, as needed.						
	§482.15(d), CAHs (2) Testing. The [Foundation of the conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community. (A) When a community.	PRTF, Hospital, CAH] must to test the emergency ir. The [PRTF, Hospital, following: n annual full-scale exercise						

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIEI	R		206 E M	ADDRESS, CITY, STATE, ZIP COD IARION ST 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 APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	ctional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
		ration of the emergency					
		is exempt from engaging in					
		ull-scale community based					
		ity-based functional exercise et of the emergency event.					
	_	an [additional] annual					
	l ' '	nat may include, but is not					
	limited to the follo						
		-scale exercise that is					
	community-based						
	1	ctional exercise; or					
		ock disaster drill; or					
		p exercise or workshop that					
		tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	mergency plan.					
		he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60.84(d):1					
		PACE organization must					
	_ , ,	s to test the emergency					
	plan at least annu						
	organization must	_					
	1 -	an annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	1 ' '	ıct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					
	or man-made em	ergency that requires					

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CENTERS FOR	R MEDICARE & MEDIC					OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA'	TE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COM	COMPLETED		
		155738	B. WING		11/2	20/2023		
	PROVIDER OR SUPPLIER	.	206 E I	ADDRESS, CITY, STATE, ZIP (MARION ST H BEND, IN 46601	COD			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S	SHOULD BE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE		
1110		mergency plan, the PACE	1110			Bille		
		gaging in its next required						
		nity based or individual,						
	I	ctional exercise following the						
	onset of the emer							
	, ,	n additional exercise every						
		the year the full-scale or						
		e under paragraph (d)(2)(i)						
	of this section is c	onducted that may include,						
	but is not limited to	o the following:						
	(A) A second full-	scale exercise that is						
		or individual, a facility						
	based functional e	exercise; or						
	(B) A mock disas	ter drill; or						
	(C) A tabletop ex	ercise or workshop that is						
	led by a facilitator	and includes a group						
	discussion, using							
	_	emergency scenario, and a						
	set of problem sta							
	· ·	pared questions designed						
	to challenge an er	·						
	_	PACE's response to and						
	, ,	ntation of all drills, tabletop						
		nergency events and revise						
		gency plan, as needed.						
		geney plan, as needed.						
	*[For LTC Facilitie	es at \$483 73(d):1						
		ity] must conduct exercises						
	` '	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do t	_						
		an annual full-scale exercise						
	that is community							
	' '	nunity-based exercise is not						
		ict an annual individual,						
	facility-based fund							
		ility] facility experiences an						
	actual natural or n	nan-made emergency that						

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requires activation of the emergency plan, the

Event ID:

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2023
	PROVIDER OR SUPPLIE	ER	206 E	ET ADDRESS, CITY, STATE, ZIF E MARION ST TH BEND, IN 46601	PCOD
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	
	LTC facility is exe	empt from engaging its next			
	required a full-sc	ale community-based or			
	-	-based functional exercise			
	_	et of the emergency event.			
	' '	additional annual exercise			
	1	, but is not limited to the			
	following:				
	' '	l-scale exercise that is			
	-	d or an individual, facility			
	based functional	•			
	(B) A mock disas				
		xercise or workshop that is			
		r includes a group			
	discussion, using				
		t emergency scenario, and a			
	1	atements, directed			
	to challenge an e	epared questions designed			
		[LTC facility] facility's			
		maintain documentation of			
	· ·	exercises, and emergency			
		se the [LTC facility] facility's			
	emergency plan,				
	*[For ICF/IIDs at	\$483,475(d)1·			
		ICF/IID must conduct			
		the emergency plan at least			
		he ICF/IID must do the			
	following:				
	_	an annual full-scale exercise			
	that is community				
		nunity-based exercise is not			
	, ,	uct an annual individual,			
	facility-based fun	ctional exercise; or.			
		experiences an actual			
	natural or man-m	nade emergency that requires			
		emergency plan, the ICF/IID			
	is exempt from e	ngaging in its next required			
	full-scale commu	nity-based or individual,			
	facility-based fun	ctional exercise following the			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. Σ	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUIL	A. BUILDING			COMPLETED	
		155738		B. WING	G	<u></u>	11/20/	2023	
					CTDEET A	DDDEGG CITY CTATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹				ADDRESS, CITY, STATE, ZIP COD			
TON						MARION ST			
MILTON	HOME, THE				SOUTH	BEND, IN 46601			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			•	ID	DROWINEDS DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FU	LL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATI	ION		TAG	DEFICIENCY)		DATE	
	onset of the emer	gency event.							
		ditional annual exercise							
	' '	but is not limited to the							
	following:								
	_	scale exercise that is							
	community-based								
	· ·	ctional exercise; or							
	(B) A mock disast								
	' '	er drill, or ercise or workshop that is							
		and includes a group							
	discussion, using								
	_	emergency scenario, and	<u> </u>						
	set of problem sta		۵						
		pared questions designed							
	to challenge an er								
	_	CF/IID's response to and							
		ntation of all drills, tabletop							
			I .						
		nergency events, and revis	e						
		rgency plan, as needed.							
	*[For HHAs at §48	24 1021							
	_	e HHA must conduct							
		he emergency plan at							
		e HHA must do the							
	following:	full apple exercise that is							
		full-scale exercise that is							
	community-based								
	` '	ommunity-based exercise							
		conduct an annual							
		based functional exercise							
	every 2 years; or.	A averagion and a second of							
		A experiences an actual							
		ade emergency that require	I .						
		mergency plan, the HHA is	6						
		aging in its next required							
		nity-based or individual,							
	_	tional exercise following th	ne						
	onset of the emer								
	' '	ditional exercise every 2							
	years, opposite th	e year the full-scale	or						

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155738	r í	UILDING		COMPL 11/20/	ETED	
	F PROVIDER OR SUPPLIER	t	STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST					
MILTO	N HOME, THE			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
	of this section is of include, but is not (A) A second community-based facility-based function (B) A mock do (C) A tableton is led by a facilitated discussion, using clinically-relevant set of problem statemessages, or preto challenge an erection (iii) Analyze the Homaintain documer exercises, and enthe HHA's emerged *[For OPOs at §44 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. I actual natural or requires activation OPO is exempt for required testing exercises, and emergency (ii) Analyze the Olymaintain documer exercises, and emergency and emergency (iii) Analyze the Olymaintain documer exercises, and emergency activation of the emergency (iii) Analyze the Olymaintain documer exercises, and emergency activation of the emergency (iii) Analyze the Olymaintain documer exercises, and emergency activation of the emergency (iii) Analyze the Olymaintain documer exercises, and emergency (iiii) Analyze the Olymaintain documer exercises, and emergency (iiii) Analyze the Olymaintain documer exercises, and emergency (iiiii) Analyze the Olymaintain documer exercises, and emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and station of all drills, tabletop sergency events, and revise ency plan, as needed. 36.360] e OPO must conduct she emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of sts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155738	B. WI	NG		11/20/	2023
	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 APPROPRIATE		ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	needed.						
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually, a group discussion I narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and em the RNHCI's emer Based on record reversal failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community of the emergency pleased from engaging its necommunity-based of the emergency pleased functional the onset of the actual (ii) Conduct an addinclude, but is not lia. A second full-scale functional and a second full-scale functional and a second full-scale functional the onset of the actual (iii) Conduct an addinclude, but is not lia.	e RNHCI must conduct the emergency plan. The the following: er-based, tabletop exercise A tabletop exercise is a ted by a facilitator, using a trelevant emergency to of problem statements, so, or prepared questions ringe an emergency plan. NHCI's response to and thatation of all tabletop tergency events, and revise rigency plan, as needed. The response to test the emergency the recises to test the emergency the recises to test the emergency to facility must do the annual full-scale exercise that the control of the requires an actual natural tency that requires activation and the LTC facility is exempt the exercise for 1 year following that exercise that may the exercise that is the control of the requires that the control of the requires that the control of the requires that the control of the requires activation and the LTC facility is exempt the required full-scale in a transitional exercise that may the control of the requires that the required that the following that event. The representation of the required that is the control of the required that is the control of the required that is the control of the required that is the required that is the representation of the required that is the required that is the representation of the required that is the representation of the required that is the representation of the	E 00)39	E 039 What corrective actions will be accomplished for those resider found to have been affected by deficient practice. The Maintenance Director will contact other providers to identify a full Scale communi based exercise that the facilitican participate in. We are scheduled for full scale emergency preparedness drion Wednesday December 276 with the Instructor of an Disaster/Emergency Management Disaster Drill company. The Maintenance Director and Administrator will be educated on the process of completing and analyzing the tabletop exercise, including completic of the after-action improvement.	nts y the II Ity tle III th	12/27/2023

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IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	r í	JILDING	NSTRUCTION	(X3) DATE : COMPL 11/20/	ETED	
PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH BEND, IN 46601					
Based on record revent a community conducted, was able survey. Furthermor exercise was provide which were the Ma Administrator. A chow they did. The chow the facility respracticed or if there Based on interview the Maintenance Di other documentatio was what had been survey, the Administrator.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, a statements, directed red questions designed to ency plan. CC facility's response to and ation of all drills, tabletop regency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.		206 E M	MARION ST	e o	(X5) COMPLETION DATE	
1	ssed with the Administrator irector at exit conference.						

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	OF CORRECTION	IDENTIFICATION NUMBER 155738	A. BUILDING B. WING	onstruction 	COMP	LETED 0/2023
	PROVIDER OR SUPPLIER		206 E I	ADDRESS, CITY, STATE, ZII MARION ST H BEND, IN 46601	P 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Conditi (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and iii) of this section for this section in paragraph systems based on forth in paragraph systems based	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Indicate the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) expected in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new of when an existing				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155738	B. W	NG		11/20/	2023
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD MARION ST		
MILTON	HOME, THE			SOUTH 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 DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	1 ,,,,	3.73(e)(3), §485.625(e)(3)					
		ator fuel. [Hospitals, CAHs that maintain an onsite fuel					
	_	mergency generators must					
		w it will keep emergency					
	1	perational during the					
	emergency, unles	-					
	omorgonoy, amoo	on ovacation.					
	*[For hospitals at §	§482.15(h), LTC at					
		AHs §485.625(g):]					
	, , , ,	corporated by reference in					
	this section are ap	pproved for incorporation by					
		Director of the Office of the					
	Federal Register in accordance with 5 U.S.C.						
	552(a) and 1 CFR	part 51. You may obtain					
	the material from t	the sources listed below.					
	You may inspect a	a copy at the CMS					
	Information Resoเ	urce Center, 7500 Security					
	Boulevard, Baltime	ore, MD or at the National					
	Archives and Rec	ords Administration					
	(NARA). For inforr	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
	1 -	es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	o .					
	l ' '	Protection Association, 1					
	Batterymarch Parl						
	Quincy, MA 02169	9, www.ntpa.org,					
	1.617.770.3000.	th Cara Facilities Code					
		th Care Facilities Code,					
		ed August 11, 2011.					
	l ` '	im amendment (TIA) 12-2 to					
	NFPA 99, issued /	August 11, 2011. FPA 99, issued August 9,					
	(III) TIA 12-3 10 NF 2012.	TA 99, ISSUEU AUGUST 9,					
		FPA 99 issued March 7					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 11/20/2023			
	PROVIDER OR SUPPLIER		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, S Standby Power Sy including TIAs to 2009. Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice complete the confirmed missing the monthly testing documents of the confirmed missing the monthly testing documents of the findings were refailed to the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirmed missing the confirmed missing the confirmed missing the findings were refailed to the confirmed missing the confirm	FPA 101, issued August FPA 101, issued October PA 101, issued October FPA 101, issued October FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, Eview and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This build affect all occupants. Eview with the Maintenance 3 between 10:05 a.m. and 1:45 lacked monthly load testing anspection required by LSC and con interview at the time of Maintenance Director weekly inspections and sumentation.	E 0041	E 041 What corrective actions will be accomplished for those resider found to have affected by the deficient practice; Monthly generator load tests and weekly inspections will be completed and documented weekly and monthly in an updated Life Safety binder for review. How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective as will be taken; No residents were affected. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reci	nts pe r per pe pe ction ces

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			LETED
		155738	B. WING 11/20/2023				
MILTON	PROVIDER OR SUPPLIED HOME, THE		_	206 E N	ADDRESS, CITY, STATE, ZIP COD MARION ST I BEND, IN 46601		(VE)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	`				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
K 0000 Bldg. 01	A Life Safety Code Licensure Survey of the Indiana Departr with 42 CFR 483.9 Survey Date: 11/20 Facility Number: 0 Provider Number: 2009	0/23 01141 155738 905640	K 0	TAG	Maintenance Director was in-serviced on the importance of maintaining the paperwork for all the generator test logs. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance. How will the corrective action monitored to ensure the defici practice will not recur, i.e. what quality assurance programs we put into place; Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed Date of Completion 12/4/23	k s. be ent at ill be	DATE
	1	Code Survey, The Milton ot in compliance with articipation in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 11/20/2023		
	ROVIDER OR SUPPLIER		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 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	
TAG	Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupa This two-story facil sprinklered and was (111) construction. constructed in 1952 located on the first a 1975. The facility h smoke detection in sleeping rooms on t areas open to the co rooms on the first fl smoke detectors. The	the and the 2012 edition of the extion Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2. The original building was with the nursing addition and second floors added in as a fire alarm system with the corridors, in resident the second floor and in all rridor. Resident sleeping oor have battery operated are facility is protected by a 10	TAG	DEFICIENCY	DATE	
		nerator. The facility has a nad a census of 30 at the time npleted on 11/27/23				
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1	W 0211	KOM		
	failed to ensure 2 of were continuously r obstructions. LSC 1 into the required wi	on and interview, the facility of 2 corridor means of egresses maintained free of 9.2.3.4 (4) states projections dth shall be permitted for provided that all of the	K 0211	K211 What corrective actions will be accomplished for those reside found to have affected by the deficient practice; The PPE cart identified was		

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	WIEDICAKE & WIEDIC				OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155738	B. WING		11/20/2023	
		.55, 65	<u> </u>		1 1/20/2020	
NAME OF I	PROVIDER OR SUPPLIER		STREI	ET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
TWINE OF I	NO VIDER OR BUILDER		206	E MARION ST		
MILTON	HOME, THE		SOU	TH BEND, IN 46601		
(VA) ID	CIDANADY	CTATEMENT OF DEFICIENCIE	ID.	1	(VE)	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	COMPLETION COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		2.112	
	following condition			replaced with one that had		
		uipment does not reduce the		wheels immediately.		
	clear unobstructed	corridor width to less than 60		How the facility will identify of	other	
	in.(1525 mm).			resident having the potential	I to be	
	(b) The health care	occupancy fire safety plan and		affected by the same deficie		
	1 1	ldress the relocation of the		practice and what corrective		
		during a fire or similar		will be taken;		
	emergency.	and or similar		Facility will be toured to ch	oock	
		inment is limited to the		for additional PPE carts wi		
	(c)The wheeled equipment is limited to the				un no	
following:				wheels in corridors and		
	 i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. 			hallways and correct any		
				identified deficiencies. Nor	ne	
				found.		
				What measures will be put in	nto	
				place or what systemic char	nges	
				will be made to ensure that	the	
	Findings include:			deficient practice does not re	ecur:	
				Inservice will be done with		
	Based on an observ	ation during a tour of the		maintenance and central		
		intenance Director 11/20/23		supply personnel to ensure	o that	
	1	and 2:35 p.m., in the second		all PPE carts have wheels.	e that	
	1	and a Personal Protective			4-	
				Maintenance/designee will	ao	
		art in use but was not equipped		rounds once a week for 8	_	
		ng the cart to be move out of		weeks to ensure that no PF		
		mergency. The PPE cart was		carts with no wheels are be	eing	
		21. Based on an interview at		used.		
		tion, the Maintenance Director		How will the corrective actio	n be	
	stated the PPE cart	was not equipped with wheels		monitored to ensure the defi	cient	
	and would need to b	be replaced with a PPE cart		practice will not recur, i.e. w	hat	
	with wheels.			quality assurance programs	will be	
				put into place;		
	The finding was rev	viewed with the Administrator		Maintenance/designee will	1	
		e Director during the exit		present 3 months of audit		
	conference.			results to QAPI committee	and	
	Comoronoc.			progress will be assessed		
	2 1 10/b)			1	allu	
	3.1-19(b)			adjusted as needed.		
				Date of Completion 11/21/2	2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIER		STREET 206 E SOUT		
(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
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMAR Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NR should be included Based on record rev observation, the fact documentation for t of 8 of 8 battery oper rooms was complete existing life safety f if not required by th NFPA 72, 29.10 Ma Fire-warning equipt tested in accordance published instructio of Chapter 14. NFP testing, and mainter the requirements of equipment manufac This deficient practi 10 residents and sta Findings include: Based on observation Director on 11/20/2 p.m., resident room battery-operated sm review between 10: smoke detector testi detectors were miss 2023 to September 1 program TELS indi-	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. riew, interview, and ility failed to ensure the preventative maintenance terated smoke alarms in resident te. NFPA 101 in 4.6.12.3 states features obvious to the public, the Code, shall be maintained. Anintenance and Tests. The ment shall be maintained and the with the manufacturer's and per the requirements A 72, 14.2.1.1.1 Inspection, thance programs shall satisfy this Code and conform to the turer's published instructions. The could affect approximately	K 0300	K300 What corrective actions will be accomplished for those reside found to have affected by the deficient practice On 11/21/2023 all the smoke detectors indicated had new batteries installed and were tested. How the facility will identify of resident having the potential to affected by the same deficient practice and what corrective a will be taken; No other battery operated smoke detectors were found during a facility wide tour. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconstructed as a schedule was put in our preventative maintenance program TELS, for timely testing and maintenance of battery operated smoke detectors. Maintenance Director was re-educated regarding yearly testing and change of batteries as per	all her to be to contain the c

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 206 E MARION ST SOUTH 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)	(X5) COMPLETION DATE	
	battery change or cl interview at the time Maintenance Direct smoke detector testi that's the only recent Findings were discu	ted or indicated when the last eaning was done. Based on the of record review, the or confirmed the battery and and further confirmed to the form he has seen. The sessed with the Maintenance distrator at exit conference.		manufacturer recommendation. How will the corrective action monitored to ensure the deficipractice will not recur, i.e. what quality assurance programs with put into place; Maintenance/designee will present 3 months of audit results to QAPI committee as progress will be assessed a adjusted as needed. Date of Completion 12/4/202	ent at rill be nd nd	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record reversiled to ensure 1 of maintained in accor 9.6.1.3 requires a fin tested, and maintain 70, National Electri National Fire Alarm 14.2.1.2.2 requires to	in - Testing and in is tested and maintained in an approved program is requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. in acceptance, maintenance adily available. FPA 70, NFPA 72 riew and interview, the facility if fire alarm systems was dance with LSC 9.6.1.3. LSC re alarm system to be installed, ited in accordance with NFPA cal Code and NFPA 72, in Code. NFPA 72, Section that system defects and the corrected. This deficient	K 0345	K345 What corrective actions will be accomplished for those reside found to have affected by the deficient practice; On 6/26/23 the Fire Alarm inspection was completed. T current report was unavailable the time the surveyor was inspecting the facility. Currer report is attached. How the facility will identify other	rhe ole nt	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING B. WING	01	COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIER HOME, THE		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
	Director on 11/20/2. p.m., the annual fire titled "Alarm Syster the smoke detector it tested. Based on into review, the Mainten report stated the smoand was unsure why employed by the factinspection. This finding was rev	iew with the Maintenance 3 between 10:05 a.m. and 1:45 alarm report dated 06/26/23 in Inspection" indicated that in the elevator shaft was not erview at the time of record ance Director agreed the oke detector was not tested it was as he was not cility at the time of the viewed with the Administrator frector at the exit conference.		resident having the potential affected by the same deficient practice and what corrective will be taken; No residents effected What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not remove the made to ensure that the deficient practice does not remove the made to ensure that the deficient practice does not remove the made to ensure that the deficient practice does not remove the made to ensure that the deficient practice will be trained on putting together with readily viewable paper copies. Life Safety book will audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance. How will the corrective action monitored to ensure the deficient practice will not recur, i.e. who quality assurance programs where the progress will present 3 months of audit results to QAPI committee a progress will be assessed a adjusted as needed. Date of Completion 11/21/23	to ges ne cur: e and be be ient at vill be
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing	Maintenance and Testing Maintenance and Testing Frand standpipe systems Frand maintained in FPA 25, Standard for the Frotection Systems			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155738	B. WING 11/20/2023				/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			MARION ST		
MII TON	HOME, THE		SOUTH BEND, IN 46601				
			_		1		1
(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 APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	•	n design, maintenance,					
	inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked						
	b) Who provided	evetem teet					
	b) who provided	system test					
	c) Water system	supply source					
	o) water system	supply source					
	Provide in REMAR	RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the						
			K 0	353	K353		11/22/2023
	facility failed to ma	intain 1 of 1 sprinkler system in			What corrective actions will be	9	
	accordance with LS	C 9.7.5. LSC 9.7.5 requires all			accomplished for those reside	ents	
	automatic sprinkler	systems shall be inspected			found to have affected by the		
	and maintained in a	ccordance with NFPA 25,			deficient practice;		
	Standard for the Ins	spection, Testing, and			On 11/21/2023 the folder with	ı	
	Maintenance of Wa	ter-Based Fire Protection			the monthly inspections was	3	
	Systems. NFPA 25	, 2011 edition, Table 5.1.1.2			located after the surveyor le	ft.	
	-	ed frequency of inspection and			All monthly inspections per		
	testing. NFPA 25, 5	5.2.4.1 states gauges on wet			regulation have been		
		ms shall be inspected monthly			completed as required. (plea	se	
		systems (5.2.4.2) shall be			see the attached)		
		ensure normal water or air			How the facility will identify otl		
	-	aintained. NFPA 25 13.3.2.1			resident having the potential t		
		be inspected weekly or			affected by the same deficient		
		s or supervised (13.3.2.1.1)			practice and what corrective a	ction	
	•	o be inspected monthly. This			will be taken;		
	deficient practice co	ould affect all occupants.			No residents were affected.		
	Findin 1 1 1				What measures will be put int		
	Findings include:				place or what systemic chang		
	Dagad an	wiony with the Maintenan			will be made to ensure that the		
		eview with the Maintenance			deficient practice does not rec	cur:	
		3 between 10:05 a.m. and 1:45			Maintenance Director was	_	
	-	monthly inspection of the wet			in-serviced on the important		
		m's gauges and valves for the			of having the reports availab	oie	
		er 2022 to February 2023 as			at all time.	ha	
	well as the months	of May and June of 2023.			How will the corrective action	pe	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155738	B. WIN	NG		11/20/	2023
		<u> </u>		CTDEET 4	ADDRESS, CITY, STATE, ZIP COD	l	
NAME OF F	PROVIDER OR SUPPLIER	8					
MIL TON	LIOME THE				MARION ST		
IVIIL I ON	HOME, THE			5001H	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	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
	During an interview at the time of record review,				monitored to ensure the defici	ent	
	the Maintenance Director stated the inspection of				practice will not recur, i.e. wha	ıt	
	gauges and valves b	pefore October 2023 were			quality assurance programs w	ill be	
	completed by previ-	ous Maintenance Directors			put into place;		
	and the paper work	could not be found.			The Maintenance Director wi	II	
					maintain a binder including		
	Findings were discu	assed with the Administrator			critical inspections, which w	ill	
	and Maintenance D	irector at exit conference.			include 5 year pipe inspectio	n	
					to be kept in the		
	3.1-19(b)				Administrator's office.		
	2. Based on record review and interview, the				Maintenance/designee will		
					present 3 months of audit		
	facility failed to maintain 1 of 1 sprinkler system in				results to QAPI committee ar	nd	
	accordance with 19	.3.5.3. NFPA 25, 2011 Edition,			progress will be assessed ar	nd	
	14.2.1 states except	as discussed in 14.2.1.1 and			adjusted as needed.		
	14.2.1.4 an inspecti	on of piping and branch line			•		
	conditions shall be	conducted every 5 years by			Date of Completion 11/22/23		
	opening a flushing	connection at the end of one					
	main and by remov	ing a sprinkler toward the end					
	of one branch line f	for the purpose of inspecting					
	for the presence of	foreign organic and inorganic					
	material. This defic	ient practice could affect all					
	occupants.						
	Findings include:						
		view with the Maintenance					
	Director on 11/20/2	3 between 10:05 a.m. and 1:45					
	1 ~	ation was found to indicate that					
	the 5-year internal p						
	1 ~	ginal inspection. Based on					
		reports this year, the last					
	_	n was done May of 2021.					
		at the time of record review,					
		ector stated that they were					
	unware where the d	ocumentation could be and					
	indicated that he wa	as not the Maintenance					
	Director at that time	e and all documentation he had					
	been able to provide	e is what he has been able to					
	find.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIER HOME, THE		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=C Bldg. 01	Findings were discupirector and Admir 3.1-19(b) NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using goomplies with NFF Code, electrical words with the complies with NFF Code. Existing insurvice provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 2 of service hall was seen personnel. NFPA 70 Energized parts of senclosed as specified in 230.620 (A) Enclosed. Energized parts of senclosed as specified in 230.620 (A) Enclosed. Energized parts of senclosed as specified in 230.620 (B) Guarded. Energized parts of senclosed as specified in 230.620 (C) Enclosed. Energized parts of senclosed as specified in 230.620 (C) Enclosed. Energized parts of senclosed as specified in 230.620 (C) Enclosed. Energized parts of senclosed as specified in 230.620 (C) Enclosed. Energized parts of sencent and sencent an	Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 on and interview, the facility E2 electrical panel in the ured from non-authorized 0, 2011 edition states 230.62 tervice equipment shall be d in 230.62(A) or guarded as	K 0511	K511 What corrective actions will be accomplished for those resider found to have affected by the deficient practice; The indicated electrical panel were locked immediately. How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective ac will be taken; All electrical panels in the facility were checked with none others being open. What measures will be put into place or what systemic change	12/04/2023 Is er o be ction
	and staff. Findings include:	ould affect staff all residents		will be made to ensure that the deficient practice does not recommend to the manner of keeping all electrical panels.	ur: e
	Based on observation with the Maintenance Director on 11/20/23 between 1:47 p.m. and 2:35			locked and secure. Maintenance Director will do	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		A. BUILDING B. WING	01	COMPI 11/20		
	PROVIDER OR SUPPLIER		206 E I	ADDRESS, CITY, STATE, ZIP COD MARION ST I 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	floors near the nurse when tested. The pa lights, emergency lights, emergency lights assed on interview Maintenance Direct panels were unlocked them with the keys light findings were discussed.	es stations were unlocked nel included breakers to the ghting, and nurse call systems. at the time of observation, the or confirmed the electrical ed and was unable to lock he had during the tour. Seed with the Maintenance istrator at exit conference.		rounds once a week for weeks to ensure that no electrical panels are left unlocked. How will the corrective as monitored to ensure the correctice will not recur, i.e. quality assurance program put into place; Maintenance/designee woresent 3 months of aucoresults to QAPI committed progress will be assessed adjusted as needed. Date of Completion 12/4	etion be deficient what ms will be vill lit ee and ed and	
K 0531 SS=F Bldg. 01	Elevators are insp specified in ASME Elevators and Esc Service is operate record. Existing elevators A17.3, Safety Cod and Escalators. Al a travel distance obelow the level the emergency persor purposes, conform Requirements of A (Includes firefighter recall and smoke of the specified of the sp	n with Firefighter's Service ASME/ANSI A17.3. or's service Phase I key detector automatic recall, e Phase II emergency in-car chine room smoke				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL		
155738		155738	B. WING			11/20/2023	
NAME OF PROMINER OF GURNATER				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					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 DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	detectors.)						
	19.5.3, 9.4.2, 9.4.3						
	1. Based on records review and interview the		K 0	531	K531		12/04/2023
	_	sure 1 of 1 elevators had			What corrective actions will be		
	_	ection documentation. This			accomplished for those reside	ents	
	deficient practice co	ould affect all occupants.			found to have affected by the		
	Findings 1 1 1				deficient practice,		
	Findings include:				1 Elevator was tested and		
	Događov	eview with the Maintenance			license is currently active.		
		3 between 10:05 a.m. and 1:45			2 The firefighter recall		
					monitoring was being		
		ermit provided in the elevator d its expiration date as March			completed monthly as per th	16	
		interview at the time of records			regulation.	.	
					How the facility will identify of		
	review, the Maintenance Director stated he was				resident having the potential t		
	not aware if the permit has been renewed and				affected by the same deficien		
	would have to talk to the Administrator to see if				practice and what corrective a	action	
	an updated one could be provided. During an interview with the Administrator later, he stated				will be taken; 1 No resident effected		
		re of the expiration of the			1 No resident effected What measures will be put int	•	
		he process of trying to get it			place or what systemic chang		
	renewed.	the process of trying to get it			will be made to ensure that th		
	Tellewed.				deficient practice does not rec		
	This finding was re	viewed with the Administrator			1 Maintenance Director v		
		irector at the exit conference.			make sure elevator is	****	
		at the entrement			inspected before License is		
	3.1-19(b)				expiring.		
					2 The maintenance director	or	
	2. Based on record	review and interview, the			was educated on the		
	facility failed to maintain testing of 1 of 1 elevator				importance specific to testing	na	
	firefighter recall in accordance with 9.4.6, Elevator				and dated the annual		
	Testing. LSC 9.4.6.2 states that all elevators with				receptacle testing. He will be	€	
	fire fighters' emergency operations in accordance				educated on elevator licensu		
	with 9.4.3 shall be subject to a monthly operation				and fire fighter's emergency		
	with a written record of the findings made and				operations. The item will be		
		es as required by ASME			added to the facilities TELS		
	A17.1/CSA B44, Safety Code for Elevators and				system PM calendar and will	I	
	·	ficient practice would affect all			be monitored in accordance		
	occupants.				with NFPA standards.		
				How will the corrective action	he		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/20/2023		
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE		
	Based on record review of the form titled "Monthly Elevator Fire Service Test Log" with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., the monthly testing for the elevator firefighter recall for the main elevator was missing testing for 10 of 12 months. Testing for the Months of November and December of 2022 was provided, however all testing in 2023 was unable to be located. Based on interview at the time of record review, the Maintenance Director stated that he did not know testing was supposed to be done and stated some of the months missing should have been done by another Maintenance Director The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		monitored to ensure the deficie practice will not recur, i.e. wha quality assurance programs w put into place; 1 Maintenance/designee w present 3 months of audit results to QAPI committee ar progress will be assessed ar adjusted as needed. Date of Completion 12/4/23	t ill be ill		
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
155738		B. WING 11.			11/20	/2023	
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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
			K 0'	914	K914 What corrective actions will be accomplished for those reside found to have affected by the deficient practice; On 11/21/2023 the folder with the monthly inspections was located after the surveyor left. All monthly inspections per regulation have been completed as required. (please see the attached) How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective a will be taken; There is only one required annual receptacle test so no other additional reviews needed. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recomplete the annual receptacle test incomplete the annual receptacle testing and dated	ents n ft. ner o be t netion o es e cur:	12/04/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155738			A. BUILDING B. WING	01	COMPLETED 11/20/2023		
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	(EACH DEFICIEN REGULATORY OR	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		
K 0918 SS=F Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION non-hospital-grade electrical receptacles. Based on records review between 10:05 a.m. and 1:45 p.m., the annual electrical receptacle testing for non-hospital grade electrical receptacle testing documentation had a completion date of 05/16/22. Based on interview at the time of record review, the Maintenance Director stated that's the only documentation available for review. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent			The item will be added to the facilities TELS system PM calendar and will be monitor in accordance with NFPA standards. How will the corrective action monitored to ensure the defici practice will not recur, i.e. wha quality assurance programs w put into place; Maintenance Director will present any finding to the Q/committee and progress will assessed and adjusted as needed Date of Completion 12/4/23	ed be ent it ill be		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155738		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/20/2023			
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE		
	energy power sour accordance with No circuit breakers are program for period components is estimated and readily availated and circuits are mand separate from Minimizing the power generation for 16.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record revisited to maintain a monthly generator land weekly inspect 6.4.4.1.1.4(a) of 20 testing of the general electrical system to 110, the Standard for Powers Systems, Crequires diesel generator land to 30 minutes. Section Power Supply Systems appurtenant compoweekly and exercise aperformance, exercised for inspection by the	(NFPA 99), NFPA 110, 0 (NFPA 70) riew and interview, the facility complete written record of oad testing for 1 of 12 months from for 2 of 52 weeks. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. NFPA 110 8.4.2 reator sets in service to be nee monthly, for a minimum of 8.4.1 requires an Emergency em (EPSS) including all ments, shall be inspected ed monthly. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the ularly maintained and available	K 0918	K918 What corrective actions will accomplished for those reside found to have affected by the deficient practice; Monthly generator load test and weekly inspections will completed and documente weekly and monthly in an updated Life Safety binder review. How the facility will identify or resident having the potential affected by the same deficie practice and what corrective will be taken; No residents were affected What measures will be put in place or what systemic char will be made to ensure that deficient practice does not remain the month of maintaining the paperway.	dents e its II be d for other I to be int into action into ages ithe ecur:		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155738	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/20/2023	
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		P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL				for all the generator test logs Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance. How will the corrective action to monitored to ensure the deficite practice will not recur, i.e. what quality assurance programs with put into place; Maintenance/designee will present 3 months of audit results to QAPI committee ar progress will be assessed at adjusted as needed Date of Completion 12/4 2023	oe ent t ill be nd	

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