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	11/20/2023

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: 11/20/23 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Emergency Preparedness Survey, The Milton Home was found not 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 30. Quality Review completed on 11/27/23	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hemmington Mwanza	Executive Director	12/11/2023

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the			

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	LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or			

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as			

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	needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.	E 0039	**E 039** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. **The Maintenance Director will contact other providers to identify a full Scale community based exercise that the facility can participate in.** **We are scheduled for full scale emergency preparedness drill on Wednesday December 27th 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 completion of the after-action improvement**	12/27/2023

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	b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., no documentation of a community based annual exercise or facility-based exercise in the event a community-based could not be conducted, was able to be found during the survey. Furthermore, documentation of a table-top exercise was provided that had two people attend which were the Maintenance Director and Administrator. A check-off sheet was provided on how they did. The documentation never explained how the facility responded, what emergency was practiced or if there were any changes needed. Based on interview at the time of record review, the Maintenance Director was unaware if any other documentation could be found as all he had was what had been provided. Later during the survey, the Administrator advised that he could obtain documentation, but could not be provided the day of the survey. Findings were discussed with the Administrator and Maintenance Director at exit conference.		**plan report, and the timeframe for completion of the tabletop and full-scale exercise.** **The tabletop exercise, including analysis, will be completed annually per regulation.** **The facility will maintain a scheduling tracker of tabletop and full-scale exercises.**	

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E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.			

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	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the 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 the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7,			

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(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
	2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., the generator lacked monthly load testing and weekly visual inspection required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director confirmed missing weekly inspections and monthly testing documentation. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	**E 041** What corrective actions will be accomplished for those residents 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 other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **No residents were affected.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	12/04/2023

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	11/20/2023

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey conducted was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/20/23 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Life Safety Code Survey, The Milton Home was found not in compliance with Requirements for Participation in	K 0000	**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 be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be 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**	

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	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 30 at the time of this survey. Quality Review completed on 11/27/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 2 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the	K 0211	**K211** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The PPE cart identified was**	11/21/2023

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	following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: 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. Findings include: Based on an observation during a tour of the facility with the Maintenance Director 11/20/23 between 1:47 p.m. and 2:35 p.m., in the second floor resident hall had a Personal Protective Equipment (PPE) cart in use but was not equipped with wheels allowing the cart to be move out of the hall during an emergency. The PPE cart was observed by room 121. Based on an interview at the time of observation, the Maintenance Director stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**replaced with one that had wheels immediately.** 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; **Facility will be toured to check for additional PPE carts with no wheels in corridors and hallways and correct any identified deficiencies. None found.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Inservice will be done with maintenance and central supply personnel to ensure that all PPE carts have wheels. Maintenance/designee will do rounds once a week for 8 weeks to ensure that no PPE carts with no wheels are being used.** 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; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** Date of Completion 11/21/2023	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 8 of 8 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect approximately 10 residents and staff on the first floor. Findings include: Based on observation with the Maintenance Director on 11/20/23 between 1:47 p.m. and 2:35 p.m., resident rooms on the first floor all contained battery-operated smoke detectors. During record review between 10:05 a.m. and 1:45 p.m., the smoke detector testing for the battery smoke detectors were missing the months of January 2023 to September 2023. One form from the online program TELS indicated battery smoke detector testing was done for October 2023. However, the	K 0300	**K300** What corrective actions will be accomplished for those residents found to have affected by the deficient practice **On 11/21/2023 all the smoke detectors indicated had new batteries installed and were all tested.** 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; **No other battery operated smoke detectors were found during a facility wide tour.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **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**	12/04/2023

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	form was not itemized or indicated when the last battery change or cleaning was done. Based on interview at the time of record review, the Maintenance Director confirmed the battery smoke detector testing and further confirmed that's the only recent form he has seen. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**manufacturer recommendation.** 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; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** Date of Completion 12/4/2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include:	K 0345	**K345** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **On 6/26/23 the Fire Alarm inspection was completed. The current report was unavailable @ the time the surveyor was inspecting the facility. Current report is attached.** How the facility will identify other	11/21/2023

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	Based on record review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., the annual fire alarm report dated 06/26/23 titled "Alarm System Inspection" indicated that the smoke detector in the elevator shaft was not tested. Based on interview at the time of record review, the Maintenance Director agreed the report stated the smoke detector was not tested and was unsure why it was as he was not employed by the facility at the time of the inspection. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **No residents effected** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance Director will be trained on putting together and keeping a life safety binder with readily viewable paper copies. 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 be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be 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 11/21/23	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves for the months of November 2022 to February 2023 as well as the months of May and June of 2023.	K 0353	**K353** What corrective actions will be accomplished for those residents 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 other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **No residents were affected.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance Director was in-serviced on the importance of having the reports available at all time.** How will the corrective action be	11/22/2023

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	During an interview at the time of record review, the Maintenance Director stated the inspection of gauges and valves before October 2023 were completed by previous Maintenance Directors and the paper work could not be found. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., no ducumentation was found to indicate that the 5-year internal pipe inspection had passed/failed its original inspection. Based on sprinkler inspection reports this year, the last indicated inspection was done May of 2021. Based on interview at the time of record review, the Maintenane Director stated that they were unware where the documentation could be and indicated that he was not the Maintenance Director at that time and all documentation he had been able to provide is what he has been able to find.		monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **The Maintenance Director will maintain a binder including critical inspections, which will include 5 year pipe inspection to be kept in the Administrator's office. Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** Date of Completion 11/22/23	

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	Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0511 SS=C Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 electrical panel in the service hall was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff all residents and staff. Findings include: Based on observation with the Maintenance Director on 11/20/23 between 1:47 p.m. and 2:35	K 0511	**K511** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The indicated electrical panels were locked immediately.** 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 electrical panels in the facility were checked with none others being open.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance Director was in-serviced on the importance of keeping all electrical panels locked and secure.** **Maintenance Director will do**	12/04/2023

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	p.m., the electrical panels on the first and second floors near the nurses stations were unlocked when tested. The panel included breakers to the lights, emergency lighting, and nurse call systems. Based on interview at the time of observation, the Maintenance Director confirmed the electrical panels were unlocked and was unable to lock them with the keys he had during the tour. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**rounds once a week for 8 weeks to ensure that no electrical panels are left unlocked.** 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; **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 0531 SS=F Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke			

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	detectors.) 19.5.3, 9.4.2, 9.4.3 1. Based on records review and interview the facility failed to ensure 1 of 1 elevators had current annual inspection documentation. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., the elevator permit provided in the elevator and binder indicated its expiration date as March of 2023. Based on interview at the time of records review, the Maintenance Director stated he was not aware if the permit has been renewed and would have to talk to the Administrator to see if an updated one could be provided. During an interview with the Administrator later, he stated that they were aware of the expiration of the permit and was in the process of trying to get it renewed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect all occupants.	K 0531	**K531** What corrective actions will be accomplished for those residents found to have affected by the deficient practice, **1 Elevator was tested and license is currently active.** 2 **The firefighter recall monitoring was being completed monthly as per the regulation.** 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; **1 No resident effected** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **1 Maintenance Director will make sure elevator is inspected before License is expiring.** **2 The maintenance director was educated on the importance specific to testing and dated the annual receptacle testing. He will be educated on elevator licensure and fire fighter's emergency operations. The item will be added to the facilities TELS system PM calendar and will be monitored in accordance with NFPA standards.** How will the corrective action be	12/04/2023

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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
	Findings include: 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 deficient practice will not recur, i.e. what quality assurance programs will be put into place; **1 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 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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	activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles in 15 of 15 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/20/23 between 1:47 p.m. and 2:35 p.m., the facility's 15 resident sleeping rooms contained four to eight	K 0914	**K914** What corrective actions will be accomplished for those residents 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 other resident having the potential to be affected by the same deficient practice and what corrective action 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 changes will be made to ensure that the deficient practice does not recur: **The maintenance director was educated on the importance specific to testing and dated the annual receptacle testing.**	12/04/2023

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	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 receptacles was past due. The provided 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)		**The item will be added to the facilities TELS system PM calendar and will be monitored in accordance with NFPA standards.** 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; **Maintenance Director will present any finding to the QAPI committee and progress will be assessed and adjusted as needed** Date of Completion 12/4/23	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 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			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 12 months and weekly inspection for 2 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:	K 0918	**K918** What corrective actions will be accomplished for those residents 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 other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **No residents were affected.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance Director was in-serviced on the importance of maintaining the paperwork**	12/04/2023

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	Based on records review with the Maintenance Director on 11/20/23 between 10:05 a.m. and 1:45 p.m., no documentation was available for the month of May 2023 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log was missing weekly check for September 3rd through September 9th of 2023 plus the week of February 19th through the 25th of 2023. Based on an interview at the time of record review, the Maintenance Director stated that they were not employed at the facility during that time and confirmed that no documentation could be found during the survey. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**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 be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be 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 2023	