STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING **01** B. WING _____	R **01/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON HOME, THE	**206 E MARION ST** **SOUTH BEND, IN 46601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Initial Comments A Post Survey Revisit (PSR) for the Emergency Prepardness Survey conducted on 11/20/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/11/24 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Emergency Preparedness PSR, The Milton Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 34 certified beds. At the time of the survey, the census was 30 Quality Review completed on 01/12/24	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/20/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 01/11/24 Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640 At this Life Safety Code PSR, The Milton Home was found in compliance with Requirements for	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING **01** B. WING _____	R **01/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON HOME, THE	**206 E MARION ST** **SOUTH BEND, IN 46601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	Continued From page 1 Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a basement is fully sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975. The facility has a fire alarm system with smoke detection in the corridors, in resident sleeping rooms on the second floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility is protected by a 10 kW Natural Gas generator. The facility has a capacity of 34 and had a census of 30 at the time of this survey. Quality Review completed on 01/12/24	{K 000}		