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	11/21/2024

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: 11/21/24 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 22. Quality Review completed on 11/22/24	E 0000	The Milton Home respectfully requests a desk review for paper compliance with the citations associated with this survey.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, no documentation could be found to	E 0004	The Emergency Preparedness Plan (EPP) was reviewed by 11/29/2024. The Administrator was educated on the need to review the EPP annually The Administrator/Designee will review and maintain a log of the Emergency Preparedness Plan annually - scheduled for June 2025. The Safety committee will audit the log and the Emergency	12/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hemmington Mwanza	Administrator	12/17/2024

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

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	show the EPP was reviewed and updated within the last year. Based on interview during record review, the Administrator stated he had not been at the facility for a complete year and planned to review and update the EPP in December. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference.		Preparedness Plan binder annually - set for June 2025 Results will be sent to QAPI annually or until 100% compliance.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all resident, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, The Administrator, National Project Manager, and Maintenance Director each provided a distinctly different facility risk assessment; however, 3 of 3 documents failed to meet the requirements. Based on record review the surveyor located a Kaiser Permanente Hazard Vulnerability Analysis (HVA) document in the facility's "Disaster Manual"; however, the document was dated January 2022. The facility was not able to provide any additional	E 0006	The Hazard Vulnerability Assessment (HVA) was updated by 11/29/2024 and is on file. The Administrator was educated on the need to update the HVA annually The Administrator/Designee will review and maintain a log of the HVA annually - scheduled for June 2025. The Safety committee will audit the log and the Emergency Preparedness Plan binder annually - set for June 2025 Results will be sent to QAPI annually or until 100% compliance.	12/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	documentation to show a risk assessment had been completed within the last 12 months. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference.			
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(b). The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, no documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on interview during record review, the Administrator stated he had not been at the facility for a complete year and planned to review and update the EPP in December. This finding was reviewed with the Administrator, National Project Manager, and Maintenance	E 0013	The Emergency Plan, Policies and Procedures were reviewed by 11/29/2024. The Administrator was educated on the need to review the Emergency Plan Policies and Procedures annually The Administrator/Designee will review and maintain a log of the Emergency Plan, Policies and Procedures annually - scheduled for June 2025. The Safety committee will audit the log and the Emergency Preparedness Plan binder annually - set for June 2025 Results will be sent to QAPI annually or until 100% compliance.	12/21/2024

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	Director at the exit conference.			
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Preparedness Communication Plan at least annually in accordance with 42 CFR 483.73(c). The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually for LTC facilities. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, no documentation could be found to show the Emergency Preparedness Communication Plan was reviewed and updated within the last year. Based on interview during record review, the Administrator stated he had not been at the facility for a complete year and planned to review and update the EPP in December. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference.	E 0029	The Emergency Communication Plan was reviewed by 11/29/2024. The Administrator was educated on the need to review the Emergency Communication Plan annually The Administrator/Designee will review and maintain a log of the Emergency Communication Plan annually - scheduled for June 2025. The Safety committee will audit the log and the Emergency Preparedness Plan binder annually - set for June 2025 Results will be sent to QAPI annually or until 100% compliance.	12/21/2024
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency Preparedness Training and Testing Program at	E 0036	The Emergency Preparedness Training and Testing Program was reviewed by 11/29/2024.	12/21/2024

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	least annually in accordance with 42 CFR 483.73(d). The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, no documentation could be found to show the Emergency Preparedness Testing and training Program was reviewed and updated within the last year. Based on interview during record review, the Administrator stated he had not been at the facility for a complete year and planned to review and update the EPP in December. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference.		The Administrator was educated on the need to review the Emergency Preparedness Training and Testing program annually The Administrator/Designee will review and maintain a log of the Emergency Preparedness Training and Testing Program annually - scheduled for June 2025. The Safety committee will audit the log and the Emergency Preparedness Plan binder annually - set for June 2025 Results will be sent to QAPI annually or until 100% compliance.	
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: 11/21/24	K 0000	The Milton Home respectfully requests a desk review for paper compliance with the citations associated with this survey.	

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	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 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 22 at the time of this survey. Quality Review completed on 11/22/24			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 2 exit discharges from the first floor was constructed to prevent elevation changes in accordance with LSC 7.1.7. 7.1.7.2* Changes in level in means of egress not in excess	K 0271	The Maintenance Director was educated on the need to have a ramp on the exterior emergency exit to prevent elevation changes. A ramp will be installed by	12/21/2024

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	of 21 in. (535 mm) shall be achieved either by a ramp complying with the requirements of 7.2.5 or by a stair complying with the requirements of 7.2.2. This deficient practice affects 10 residents who reside on the first floor. Findings include: Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, the West exit egress from the first floor had a 4-inch change in level between the door threshold and the sidewalk outside. This was measured by the surveyor with the surveyor's tape measure and verified by the Maintenance Director when he measured the change in level with a tape measure he provided. The 4-inch change of level was acknowledged by the Administrator, National Project Manager, and Maintenance Director at the time of observation. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference. 3.1-19(b)		12/21/2024. The maintenance director will visually inspect the ramp for completion/integrity weekly and maintain log. The Administrator/Designee will audit the weekly logs monthly for the next 6 months. Results of completion will be sent to QAPI monthly for 6 months or until a 100% compliance.	
K 0293 SS=F Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 exit signs were continuously illuminated. LSC 7.10.5.1 states every sign required by 7.10.1.2, 7.10.1.5, or 7.10.8.1, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in	K 0293	The Maintenance Director was educated on the need to have an illuminous Exit sign for the 1st floor stairs exit Koorsen has been contracted for the installation and the Exit sign will be installed by 12/21/2024. The maintenance director will	12/21/2024

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	both the normal and emergency lighting mode. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, The West stairway exit on the first floor leading outside had a non-illuminated sign affixed to the exit door. Based on an interview with the National Project Manager, and Maintenance Director at the time of observation, it was stated the door did appear to have been added after original construction but had been there since prior to their employment at the facility. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference. 3.1.19(b)		visually inspect all illuminous exit signs for functionality every week for 3 months and maintain a log. A schedule was put in TELS for routine (weekly) visual inspection of the exit signs. The Administrator/designee will audit the logs monthly for the next 6 months. Results of completion will be sent to QAPI monthly for 6 months or until a 100% compliance.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in 18 of 18 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,	K 0300	A weekly test of all Battery-operated smoke alarms was put in TELS for timely testing and maintenance. All battery-operated smoke alarms will be tested by 12/21/2024 The Maintenance Director was educated regarding the weekly testing as per the manufacturer's recommendations. The Maintenance Director will keep a log of the weekly testing.	12/21/2024

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	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 all residents, staff, and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, documentation showed battery operated smoke alarms were tested on a monthly basis; however, the manufacturer's published instructions on a label affixed to the smoke detectors indicated weekly testing was required. Based on observation and interview the National Project Manager read the label of a battery-operated smoke detector in a resident room that stated it was to be tested weekly. Based on interview at the time of observation, Administrator, National Project Manager, and Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for weekly testing. Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference. 3.1-19(b)		The Administrator/Designee will audit the logs monthly for 6 months Results will be sent to QAPI monthly for 6 months or until 100% compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities			

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	1.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. The findings include: Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, cooking appliances including a gas 4-burner stove and oven with a flat-top grill was located under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved	K 0324	Finding #1 The Maintenance Director was educated on the need to have tethers for returning the stove in the event of cleaning or maintenance The tethers will be installed by 12/21/2024. The maintenance director or Administrator will visually inspect for completion and integrity monthly for 6 months. Results of completion will be sent to QAPI monthly X 6 months or until a 100% compliance. Finding #2 The Maintenance Director was educated on the need to have the ANSUL “Remote Pull Station” mounted at least 42in to 48in above the floor. Koorsen was contracted to do the correction and the deficiency was corrected 12/5/2024 The Maintenance Director and The Administrator will visually inspected the “Remote Pull Station” for completion and integrity. Results of completion will be sent to QAPI for 100% compliance.	12/21/2024

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	for maintenance and cleaning. Based on interview with the Administrator, National Project Manager, and Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. 2.) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 1067 mm and 1219 mm (42 in. and 48 in.) above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, the ANSUL "Remote Pull Station" was mounted at 60.5 inches above the floor in the path of egress out of the kitchen. Based on interview at time of observation, the National Project Manager discussed the location of the pull station and acknowledge the height when measured with a tape measure. These findings were reviewed with the Administrator, National Project Manager, and			

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	Maintenance Director at the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, National Project Manager, and Maintenance Director from 9:35 a.m. to 1:00 p.m. on 11/21/24, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. At the time of record review the National Project Manager contacted the facility's fire alarm service vendor. The fire alarm service vendor stated no semi-annual inspections had been completed by them; only annual testing and	K 0345	A Fire Alarm system semi-annual visual test was put in TELS for timely testing and maintenance. The Maintenance Director and Koorsen will visually test the Alarm system by 12/21/2024 The Maintenance Director was educated regarding the semi-annual testing of the Alarm System. The Maintenance Director will keep a log of the semi-annual visual inspections and maintain a log. The administrator/Designee will audit the logs semi-annually for the next year Results will be presented to QAPI semi-annually for the next year or until a 100% compliance.	12/21/2024

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	11/21/2024

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
	inspection had been completed. A semi-annual inspection was scheduled for December 2024 with a specific date to be determined. This finding was reviewed with the Administrator, National Project Manager, and Maintenance Director at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 10 corridor doors on the 200 hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 12 residents, staff and visitors. Findings include: Based on observation and interview with the Administrator, National Project Manager, and Maintenance Director from 1:30 p.m. to 2:35 p.m. on 11/21/24, resident room 217 corridor door was not able to be closed and latched. At the time of observation, the Maintenance Director attempted to close and latch the door more than three times but was unable to latch the door. It was then discovered by the National Project Manager that latching hardware was missing from the door assembly. The door was equipped with a handle without the latching mechanism. The National Project Manager advised the Maintenance Director to replace the hardware. This finding was reviewed with the Administrator, National Project Manager, and Maintenance	K 0363	The Maintenance Director was educated about the need for all fire doors to be able to close and latch and ensure no impediments. The door will be serviced by 12/21/2024 The Maintenance Director will test and inspect all fire doors weekly and keep a log. The Administrator/Designee will audit the logs monthly for the next 6 months. Results will be sent to QAPI monthly for the next 6 months or until 100% compliance.	12/21/2024

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	11/21/2024

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
	Director at the exit conference. 3.1-19(b)			