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	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Home, The	206 E Marion St South Bend, IN 46601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review and interviews, the facility failed to ensure a resident's wheelchair was correctly secured in the facility van during transportation for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in the resident's wheelchair tipping during transportation requiring an evaluation by an acute care center emergency room and treatment for a skin tear to the elbow and an abrasion to the head.Finding includes:Review of a Nursing Progress Note, dated 10/27/2025 at 5:05 P.M., indicated Resident B had fallen over in his wheelchair while being transported from a medical appointment on the facility bus. The note indicated the Emergency Medical Staff had transported Resident B to a local emergency room where he had treated for minor injuries incurred during the accident and was admitted for an unrelated medical condition.Review of a Narrative Nursing Note from the local emergency department indicated the resident had an abrasion to the right side of his head and a skin tear to his right elbow related to his wheelchair falling over while on the facility bus. The two wounds did not have any drainage, were cleaned with soap and water and were bandaged.Resident B's record was reviewed on 11/6/2025 at 9:30 A.M. Diagnosis included, but was not limited to, Pressure Ulcer of the Sacrum, stage 4, chronic respiratory failure, chronic pain, atherosclerotic heart disease. coronary artery disease, post coronary artery bypass graft, gonococcal infection of the lower genitourinary tract and anxiety.The facility's investigative report related to the bus accident involving Resident B, which had occurred on 10/27/2025 , was reviewed on 11/5/2025 at 1:30 P.M. Review of the report included statements from Employee 2, the National Project Manager, who had confirmed the four point floor securement system and the seat belt had worked properly on 10/27/2025. There was also a statement from Employee 3, the Activity Director, who had been driving the bus when the accident had occurred. The statement from Employee 3 indicated all of the restraints had been secured prior to the transportation of Resident B, but the statements did not include if all of the safety restraints had still been in place after the resident's wheelchair had tipped over. The facility's investigation had not been able to determine any factor that had contributed to Resident B's wheelchair tipping during transportation.During an interview, on 11/5/2025 at 2:30 P.M., with the Regional Nurse Consultant (RNC), she indicated the facility had not identified a reason Resident B's wheelchair had been able to fall over while the facility bus had been in motion and all equipment related to securing the resident on the bus had been checked and was found to be in working condition.During an interview, on 11/6/2025 at 8:57 A.M. with Employee 3, she indicated she had been transporting Resident B back to the facility from a medical appointment (on 10/27/2025) and his wheelchair had fallen over while she was driving the facility vehicle. She indicated prior to transporting Resident B, she had secured his wheelchair with all 4 floor securement belts that had locked and a seatbelt. Employee 3 indicated when she had turned a corner, off of an access street, she had heard a noise from the back and when she lookedl in the rearview mirror, she saw Resident b and his wheelchair laying on their right sides, on the floor of the bus. She indicated Resident B's seatbelt and 3 of the 4 floor safety restraints were still properly secured, but the left front floor restraint was loosened. Employee 3 indicated Resident B had not complained of pain, but due to the scrapes on his head and right arm, she had called for EMS services.During an observation with Employee 3, of the process to secure a wheelchair in the facility bus, on 11/6/2025 at 10:00 A.M., a red level was noted under the front left footrest of the wheelchair and able to be accessed by the feet of resident's in the wheelchair. Employee 3 pushed the red lever and the floor security restraint strap loosened when the wheelchair was purposely tipped to the right side for demonstration. Once the wheelchair was completely placed on it's right side, on the floor of the bus, the security strap on the left front was still attached to the floor of the bus, but was extremely loose. The other 3 security restraint straps remained locked in place and had not loosened when the wheelchair was tipped to the side.During an interview, on 11/6/2025 with a Customer Service Representative (CSR) 4, for the wheelchair floor securement device manufacturer, they indicated the red lever on the floor securement was an emergency release level. CSR 4 indicated the floor securment device was designed so the passengers using the floor securement device were not to have access to the red release lever on the device. CSR 4 indicated if the wheelchair had been properly secured, the straps on the floor securement system would have been at a 45 degree angle, leaving too much room between the resident's foot and the emergency release lever, to prevent accidental engagement. CSR 4 indicated the emergency release lever was to be on the outside of the safety straps not on the inside of the safety straps. The CSR 4 representative indicated the wheelchair had been improperly installed by Employee 3, which had