STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the ombudsman of resident's discharge for 2 of 2 residents reviewed for admission, transfer and discharge. (Residents 29 and 27). Findings include: 1. A record review was conducted, on 3/3/2020 at 02:20 P.M., for Resident 29 and indicated he was discharged from the facility on 2/17/2020. His [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 2/15/2020, indicated Resident 29 was cognitively intact. A care plan, dated 2/12/2020, indicated Resident 29 was a planning on returning to the community. A progress note, dated 2/14/2020, indicated Resident 29 planned to return home on 2/17/2020. A progress notes, dated 2/17/2020, indicated Resident 29 was discharged to home. The ombudsman notification indicated the facility did not notify the ombudsman of a planned discharge until 12/18/2020, the day after Resident 29's discharge. 2. A record review was conducted on 03/03/2020, at 11:56 AM, for Resident 27 and indicated an admission date of [DATE]. His [DIAGNOSES REDACTED]. The quarterly MDS assessment, dated 02/13/2020, indicated a BIMS score of 15, cognitively intact. Census indicated hospital leave from 02/08/2020 to 02/10/2020. No ombudsman notification was documented. During an interview, on 03/04/2020 at 2:15 PM, the SSD (Social Services Director) indicated she did not send monthly ombudsman notification for hospital transfers. During an interview, on 03/05/20 at 3:03 PM, the ED (Executive Director) indicated the SSD should have been sending monthly notification to the ombudsman, but she was not. During an interview, on 3/06/20 at 9:51 A.M., the UM (Unit Manager) indicated the ombudsman should be notified within a few days prior to a planned discharge. A policy was provided by the DON (Director of Nursing) on 03/06/2020 at 11:45 AM, titled Transfer or Discharge Notice, dated 12/2016, and indicated this was the policy currently used by the facility. The policy indicated .A copy of the notice will be sent to the Office of the State Long Term Care Ombudsman 3.1-12(a)(6)(A)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate, individualized care plans were in place related to hospice, anxiety, depression, and behaviors for 2 of 12 residents whose care plans were reviewed. (Residents 24 & 128) Findings Include: 1. A record review was conducted on 03/03/20, at 1:19 PM, for Resident 24 and indicated an admission date of [DATE]. Her [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment, dated 02/08/2020, indicated a BIMS (Brief Interview for Mental Status) score that could not be assessed. Alzheimer's, dementia, anxiety, depression, [MEDICAL CONDITION], failure to thrive, agitation, and pain were indicated as active diagnoses. Antidepressant, antianxiety, and opioid medications were taken all 7 days of the look back period. Hospice care was indicated. Care plans related to hospice, Alzheimer's, anxiety, depression, antianxiety and antidepressant medication use. Anxiety and hospice care plans were not individualized. No behavior care plan was in place. 2. A record review was conducted on 03/03/20, at 12:03 PM , for Resident 128 and indicated an admission date of [DATE]. Her [DIAGNOSES REDACTED]. The 5 day admission MDS assessment was not yet due to be completed. Care plans were in place reacted to depression, [MEDICAL CONDITION], pain, anxiety, mood, diabetes, [MEDICAL CONDITION], pneumonia, and antidepressant use. Anxiety and depression care plans were not individualized. During an interview, on 03/06/20 at 1:58 PM, the SSD (Social Services Director) indicated she was unaware of the care plans needing to be individualized and they would need to be corrected. She also indicated she was unaware of the hospice care plan requirements and she would need to correct the care plan. A policy was provided by the DON (Director of Nursing) on 03/06/2020 at 11:45 AM, titled Care Plans-Comprehensive, dated 09/2010, and indicated this was the policy currently used by the facility. The policy indicated .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident 3.1-35(a)

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.