

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155736</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILL POND HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 MILL POND LN GREENCASTLE, IN 46135</b>	
(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	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/29/12</p> <p>Facility Number: 004550 Provider Number: 155736 AIM Number: 200526450</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mill Pond Health Campus was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility located on the south end of a one story building determined to be of Type V (111) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in spaces open to the corridors. The facility has a capacity for 68 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety</p>	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.

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K 000	Continued From page 1 Code Specialist-Medical Surveyor on 10/30/12.	K 000			