

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/16/2016
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NAME OF PROVIDER OR SUPPLIER  MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00193233.</p> <p>Complaint #IN00193233-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: February 9, 10, 11, 12, 15, and 16, 2016</p> <p>Facility number: 004550 Provider number: 155736 Aim number: 200526450</p> <p>Census bed type: SNF: 19 SNF/NF: 36 Residential: 37 Total: 92</p> <p>Census payor type: Medicare: 10 Medicaid: 35 Other: 10 Total: 55</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00193233) Survey on February 16, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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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F 0242 SS=D Bldg. 00	<p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 2/18/16 by 29479.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents' preferences were obtained and/or followed pertaining to showers for 3 of 3 residents reviewed for choices. (Resident #30, #17, and #50.)</p> <p>Findings include:</p> <p>1.) During an interview on 2/10/16 at 10:13 a.m., Resident #30 indicated he had not been asked by staff what his personal preferences were for frequency</p>	F 0242	<p><b>F 242 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #30, #17 and #50 were interviewed and their preference of when to bathe / shower was updated and is being honored. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents and/or family members will be interviewed to ensure their preference of when</p>	03/17/2016	

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	<p>of showers. He further indicated he was placed on a twice a week shower schedule.</p> <p>Resident #30's clinical record was reviewed on 2/11/16 at 3:32 p.m. The annual Minimum Data Set (MDS), dated 12/31/15, indicated the resident had no cognitive impairment and required assistance of one person for bathing.</p> <p>A Certified Nurses Assistant (CNA) assignment sheet provided by the Unit Manager on 2/15/16 at 11:45 a.m., indicated Resident #30 received showers on Wednesday and Saturday evenings weekly.</p> <p>The "Life Enrichment Assessment" form was provided by Director of Nursing (DON) on 2/15/16 at 1:16 p.m. The form lacked documentation of Resident #30's personal preference for frequency of showers weekly.</p> <p>2.) During an interview on 2/10/16 at 1:44 p.m., Resident #17 indicated she had not been asked by staff what her personal preferences were for frequency of showers. She further indicated she would like more than two showers a week.</p> <p>Resident #17's clinical record was reviewed on 2/12/16 at 3:01 p.m. The</p>		<p>to bathe/shower is being honored. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Nursing staff on the following: 1). Bill of Residents Rights 2). Guidelines for Bathing Preference 3). Personal Preference Form <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and observations will be conducted for 5 residents by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Residents will be interviewed or observed to ensure their choice of when to bathe/shower is being honored The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p>	

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	<p>annual Minimum Data Set (MDS), dated 12/15/15, indicated the resident had no cognitive impairment and required assistance of one person for bathing.</p> <p>A Certified Nursing Assistant (CNA) assignment sheet provided by the Unit Manager on 2/15/16 at 11:45 a.m., indicated Resident #17 received showers on Tuesday and Thursday mornings weekly.</p> <p>The "Life Enrichment Assessment" form was provided by Director of Nursing (DON) on 2/15/16 at 11:37 a.m., the form lacked documentation of Resident #17's personal preference for frequency of showers weekly.</p> <p>During an interview on 2/15/15 at 10:34 a.m., Activities Director indicated she did not ask residents what their preferences were for frequency of showers per week. The activities director further indicated she used a form when a resident is newly admitted called, "Life Enrichment Assessment."</p> <p>During an interview on 2/15/16 at 10:38 a.m., RN #2 indicated staff asked newly admitted residents if they had a preference for a morning or evening shower, but did not ask about their preferences on frequency of showers. She</p>			

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	<p>further indicated residents were placed on the CNA assignment sheet for two showers weekly.</p> <p>3. On 2/10/15 at 1:59 p.m., during a family interview, Resident #50's daughter indicated no one had ever asked the number of showers her mother preferred weekly.</p> <p>On 2/15/16 at 11:37 a.m., the Director of Nursing (DON) indicated the facility did not ask the residents' their preference as to how many showers they preferred each week. At the same time the Director of Health Services (DHS) provided a current copy of a form titled, "New Admission Resident Preferences." The form did not ask how many showers the resident preferred weekly.</p> <p>The Certified Nursing Assistant (CNA) Assignment Sheet, provided by the DON on 2/15/16 at 11:45 a.m., indicated the resident was to receive a shower on Monday and Friday. The form indicated the hospice provider would provide the shower.</p> <p>The resident's quarterly Minimum Data Set (MDS) assessment dated 12/17/15, indicated the resident had severe cognitive deficit and was totally dependent with bathing and required physical assist of two persons.</p>						

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F 0278 SS=D Bldg. 00	<p>A facility policy titled, "Resident Rights," (undated), provided by the DON on 12/15/16 at 12:58 p.m., indicated "...You have the right to choose activities, schedules, and care...THIS MEANS THAT: 2. The facility will allow you to choose when...you wish to participate in activities...You have the right to receive services with reasonable accommodation of individual needs and preferences...."</p> <p>3.1-3(p)(2)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual</p>			

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	<p>who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the functional status used for the coding the Quarterly Minimum Data Set for 1 of 1 resident reviewed for MDS assessment of Activities of Daily Living (ADL's.) (Resident #30.)</p> <p>On 2/12/16 at 10:24 a.m., a review of Resident #30's Quarterly Minimum Data Set (MDS), dated 09/30/15, Section G (G0110), titled "Activities of Daily Living (ADL) Assistance," indicated a code 0 (independent)-for bed mobility, 0 for transfers, 0 for walk in room, 0 for walk in corridor, 0 for locomotion on unit, 0 for locomotion off unit, 0 for eating, 0 for toilet use, and 2 for bathing.</p> <p>Section G- of the ADL grid was provided by MDS Coordinator on 2/12/16 at 11:10 a.m., the grid indicated Resident # 30 had a score of 1(supervision) for bed</p>	F 0278	<p><b>F 278</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #30 Quarterly MDS with ARD of 9/30/15 has been corrected to reflect the accurate functional status coding for this resident. Any MDS with ARD after 9/30/15 has been reviewed to ensure the coding for functional status is accurate.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> The MDS Coordinator will review the most recent MDS of residents to ensure the coding for functional status is accurate.</p>	03/17/2016

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	<p>mobility, 1 for transfers, 1 for walk in room, 1 for locomotion on unit, 1 for locomotion off unit, 1 for eating, 2 for toilet use, and 3 for bathing. The ADL grid was from the time frame of 09/18-09/24/15.</p> <p>During an interview on 2/12/16 at 11:25 a.m., the MDS Coordinator indicated Resident #30's functional status had not been coded correctly on his quarterly MDS assessment completed on 09/30/15.</p> <p>The CMS RAI Version 3.0 Manual, G0110: "Activities of Daily Living (ADL) Assistance," Coding Instructions for G0110, Column 1, ADL Self-Performance, indicated "Code 0, independent if resident completed activity with no help or oversight every time during the 7 day look back period and the activity occurred at least three times." Code 1, supervision if oversight, encouragement, or cueing was provided three or more times during the last 7 days." Code 2, limited assistance, if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other no weight bearing assistance on three or more times during the last 7 days." Code 3, extensive assistance, if resident performed part of the activity over the last 7 days and help of the following</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Assessment Support Nurse or Designee with will re-educate the MDS staff on the following: CMS RAI Version 3.0 Manual, G0110: Activities of Daily Living (ADL) Assistance, Coding Instructions</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 resident MDS will be conducted by the MDS Coordinator or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure accurate: Coding for functional status</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 0431 SS=D Bldg. 00	<p>types was provided three or more times - weight-bearing support provided three or more times OR - Full staff performance of activity three or more times during part but not all of the last 7 days...."</p> <p>3.1-31(d)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976</p>			

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	<p>and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to label an opened bottle of eye drops with the date it had been opened. This practice had the potential to affect 1 of 20 residents whose medications were stored in 1 of 3 medication carts observed for medication storage (Residents #13). Finding includes: During an observation on 02/11/2016 at 11:48 a.m., the 200 hall medication cart with the UM (Unit Manager), one bottle of Genteal Eye Drops prescribed for resident #13 had been opened and was stored in the medication cart. The medication did not indicate a date it was opened. During an interview with UM at 11:48 a.m., UM indicated she was not sure why the drops were not labeled and that she would have to look into it. She also indicated that eye drops that are opened are disposed of 30 days after they are opened. The UM removed the eye drops from the medication cart. A policy titled "Eye Medications" from the In-service Manual Provided by the PCA Pharmacy Consultants to the facility</p>	F 0431	<p><b>F 431</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The multi-dose medications with no open date were destroyed and new medications ordered.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> An audit will be conducted of all multi-dose opened medications on all medication carts. Any multi-dose medication that is noted to not be labeled with an open date will be destroyed and new medications will be ordered.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the</p>	03/17/2016

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F 0465 SS=D Bldg. 00	<p>dated 03/2012 and received on 2/12/16 at 3:35 p.m. from the Nurse Consultant and deemed current indicated "...Eye medications must be dated when opened..." 3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure a resident's bedroom wall was maintained</p>	F 0465	<p>Licensed Nurses and QMAs on the following: The campus guideline for Specific Medication Administration Procedures</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Audit of all opened multi-dose medications on all medication carts to ensure that it is labeled with an open date.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	03/17/2016

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	<p>in good repair for 1 of 36 residents' rooms (room 207A.)</p> <p>Finding includes:</p> <p>On 2/10/16 at 2:53 p.m., the wall in room 207A was observed to have six areas of spackling repair by the resident's bed.</p> <p>Resident #18, on 2/10/16 at 2:55 p.m., indicated the unsightly, spackling repair to the wall was done before she moved into room 207A and she would like the wall to be finished and painted.</p> <p>During an environmental tour with the Director of Plant Operations, on 2/15/16 at 1:16 p.m., room 207A was observed to have six areas of spackling on the wall by the resident's bed. The Director of Plant Operations indicated he had spackled the wall prior to the resident moving into the room and had not gotten back to finish the repair and paint the wall.</p> <p>On 2/15/16 at 2:32 p.m., the Administrator indicated the spackling repair for room 207A was done on 12/11/15 and should have been painted and completed.</p> <p>On 2/16/16 at 11:15 a.m., the Nurse Consultant provided a current policy, dated 1/1/08, titled "Preventative</p>		<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Room 207 A was wall was repaired and painted.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DPO or designee will inspect all rooms to ensure painting was complete after repair.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Executive Director will re-educate the Director of Plant Operations on the following: 1). Resident Room PM Inspection 2). Preventative Maintenance Procedures Campus Interiors</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following inspections for 5 rooms will be conducted by the Director of Plant Operations or designee 2 times</p>	

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R 0000 Bldg. 00	<p>Maintenance Procedures," indicated "...Preventive maintenance is a systematic process aimed at prolonging the life expectancy of the campus' fixed assets and minimizing equipment failures. This goal can be accomplished by having the campus team all working together detecting and correcting minor defects prior to becoming serious issues. It is imperative that scheduled maintenance be followed to ensure the processes listed above can be performed...."</p> <p>3.1-19(f)(5)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 37 Sample: 7</p> <p>Mill Pond Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>per week times 8 weeks, then monthly times 4 months to ensure compliance: inspect rooms to ensure painting was complete after repair.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00193233)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/16/2016
NAME OF PROVIDER OR SUPPLIER  MILL POND HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135		
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			<p>Survey on February 16, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>		