

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

PRINTED: 09/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/25/2022
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LANE GREENCASTLE, IN 46135		
(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	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the PSR (Post Survey Revisit) to the unrelated deficiency cited during the Investigation of Nursing Home Complaint IN00383221 completed on June 30, 2022.</p> <p>This visit was in conjunction to the Investigation of Nursing Home Complaint IN00386247 and Residential Complaint IN00386247.</p> <p>Complaint IN00383221 unrelated deficiency - Corrected.</p> <p>Complaint IN00386247 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: August 25, 2022</p> <p>Facility number: 004550 Provider number: 155736 AIM number: 200526450</p> <p>Census Bed Type: SNF: 08 SNF/NF: 34 Residential: 30 Total: 72</p> <p>Census Payor Type: Medicare: 07 Medicaid: 25 Other: 10 Total: 42</p> <p>Mill Pond Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the unrelated deficiency cited during the Investigation</p>	{F 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.

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

PRINTED: 09/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/25/2022
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LANE GREENCASTLE, IN 46135		
(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	
{F 000}	Continued From page 1 of Complaint IN00383221. Quality review completed on September 6, 2022.	{F 000}			