STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING _____ B. WING _____	R-C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	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}	INITIAL COMMENTS	{F 000}		

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.

This visit was in conjunction to the Investigation of Nursing Home Complaint IN00386247 and Residential Complaint IN00386247.

Complaint IN00383221 unrelated deficiency - Corrected.

Complaint IN00386247 - Substantiated. No deficiencies related to the allegations are cited.

Survey date: August 25, 2022

Facility number: 004550
Provider number: 155736
AIM number: 200526450

Census Bed Type:
SNF: 08
SNF/NF: 34
Residential: 30
Total: 72

Census Payor Type:
Medicare: 07
Medicaid: 25
Other: 10
Total: 42

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING _____ B. WING _____	R-C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	**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}		