STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING 00 B. WING	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILL POND HEALTH CAMPUS	1014 MILL POND LANE GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00418482. This visit included a State Residential Licensure Survey. Complaint IN00418482 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 18, 19, 22, 23, and 24, 2024 Facility number: 004550 Provider number: 155736 AIM number: 200526450 Census Bed Type: SNF/NF: 32 SNF: 15 Residential: 35 Total: 82 Census Payor Type: Medicare: 9 Medicaid: 32 Other: 6 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2024.	F 0000		
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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

Timothy Yale | Executive Director | 02/12/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 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. Based on observation, interview, and record review, the facility failed to ensure an opened multi-dose vial of tuberculin (TB) protein derivative solution (a sterile solution containing the growth products or specific substances extracted from the tubercle bacillus and used in the diagnosis of tuberculosis) had documentation of the date the vial was opened for use for 1 of 1 medication storage room reviewed. Finding includes: During an observation tour of the medication storage room, on 1/22/24 at 10:50 a.m., no open	F 0761	Plan of Correction Text: The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.	01/24/2024

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	date was observed on an opened multi-dose vial of TB protein derivative solution. During an interview, on 1/22/24 at 10:55 a.m., the Assistant Director of Health Services (ADHS) indicated the TB vial would have been used for both residents and staff. The nurse who had opened the TB vial must have just forgotten to put the date opened on the vial. All the nurses should know that any multi-dose vial of medication should have an open date documented on the vial and discarded after 30 days. On 1/22/24 at 11:40 a.m., the Regional Director of Clinical Operations (RDCO) indicated the opened vial of the TB protein derivative solution should have been dated when opened and discarded after 30 days. The RDCO provided and identified a document as a current facility policy titled, "Medication Storage in the Facility," revised dated January 2018. The policy indicated, "...D. When the original seal of a manufacturer's container or vial is initially broken, the container will be dated ...1) A "date opened" sticker shall be placed on the medication. (OTE: the best stickers to affix contain both a "date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating...." 3.1-25(j) 3.1-25(k)(6)		The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **F761-Label/Storage Drugs and Biologicals** Completion Date: 1-22-24 Plan of Correction Text: 1 No residents were adversely effected by the alleged deficient practice. Undated TB solution was replaced with a new, dated vial at the time deficiency was identified. 2 Campus residents and staff using the solution have potential to be affected. No other improperly other undated TB solution was found in the community. 3 Nursing staff were educated on placing open dates on the TB solution vials when first dose is drawn. 4 As a measure of ongoing compliance, Director of Health Services (DHS) or designee will audit the medication room weekly	

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			for 4 weeks, then every other week for 2 months, and then monthly for 3 months. Lack of dates, improper storage will be recorded if and when observed. **5** As a quality measure, the DHS or designee will review any adverse findings and corrective actions taken at least quarterly. Ongoing audits will continue to ensure this and related concerns are managed within prescribed regulatory parameters. Review during Qualtiy Assurance Performance Improvement (QAPI) meetings will be incorporated into clinical compliance practices. Necessary plans and/or compliance protocols will be reviewed and updated as warranted. **6**	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given,	F 9999	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an	01/24/2024

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	date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual TB (tuberculin) skin test (a tool for screening for tuberculosis and for tuberculosis diagnosis) was completed for 3 out of 15 employees, failed to ensure a chest X-ray (CXR) (an imaging test that uses X-rays to look at the structures and organs in your chest) was completed every 5 years for an employee with a history of a positive TB skin test for 1 of 15 employees, and failed to ensure a pre-employment physical examination was completed for 1 of 15 employees reviewed.		economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1. Employee #20 had employee file updated with required physical. Employee #19 had employee file updated with required chest X-Ray, #21, #22, #23 had employee file updated with the required annual TB test. 2. No other employee files were identified with prescribed elements missing. 3. Employee Experience Manager was retrained to ensure employee records are complete. IP nurse was given responsibility for ensuring annual TB testing are completed and documented in files. The ED or designee will audit new employee files for completed physicals weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. DHS or designee will audit required annual TB tests weekly for 4 weeks, then every	

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	Findings include: A review of the facility's employee records was completed on 1/23/24 at 10:30 a.m. The record indicated Licensed Practical Nurse (LPN) 19 had a hire date of 3/19/09. The record lacked documentation of an annual TB assessment, education, or a CXR completed in the last five years. The record indicated Qualified Medication Aide (QMA) 21 had a hire date of 8/17/21. The record lacked documentation of an annual TB assessment, education, or skin test. The record indicated Environmental (Housekeeping) Employee 22 had a hire date of 5/18/22. The record lacked documentation of an annual TB assessment, education, or skin test. The record indicated Dietary Employee 23 had a hire date of 11/8/22. The record lacked documentation of an annual TB assessment, education, or skin test. The record indicated Registered Nurse (RN) Employee 20 had a hire date of 10/4/23. The record lacked documentation of a pre-employment physical exam. During an interview on 1/23/24 at 11:45 a.m., the Employee Experience Manager (EEM) indicated their policy required staff to have a two-step TB test upon hire, and a one-step TB test annually thereafter. Anyone who had a history of a positive TB test were required to have a CXR every five years.		other week for 2 months, and then monthly for 3 months. Corrective action will be taken as indicated by findings. 4. As a quality measure, the DHS or designee will review any adverse findings and corrective actions taken at least quarterly. Ongoing audits will continue to ensure this and related concerns are managed within prescribed regulatory parameters. Review during Qualtiy Assurance Performance Improvement (QAPI) meetings will be incorporated into clinical compliance practices. Necessary plans and/or compliance protocols will be reviewed and updated as warranted.	

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	During an interview on 1/23/24 at 1:39 p.m., the EEM indicated she confirmed with Employee 19 that the most recent CXR was completed on 12/11/18, before that was 3/20/09. The EEM confirmed that the last TB test completed for Employee 21 was on 8/22/21, the last annual TB test for Employee 22 was on 5/27/22, and the last TB test completed for Employee 23 was on 11/11/22. She indicated they could not find documentation to prove Employee 20 completed a pre-employment physical exam. During an interview on 1/24/23 at 2:33 p.m., the EEM indicated TB testing was completed by specially trained nursing staff. She indicated it was her responsibility to obtain the initial TB, CXR, and physical information and she was never told that she needed to monitor it annually. She was not sure who was responsible for the annual monitoring and suggested the Director of Health Services (DHS) would know. The Business Office Manager (BOM) indicated nursing staff used to have a tracking system called Biometric for annual screening, currently nothing was in place to monitor it. During an interview on 1/24/23 at 2:37 p.m., the DHS and the Regional Director of Clinical Operations (RDCO) both indicated that it was the responsibility of the Employee Experience manager to monitor annual employee TB testing. During an interview on 1/23/24 at 3:25 p.m., the Executive Director (ED) indicated he could not find a policy related to pre-employment physical exam requirements, but it is required of all employees. On 1/23/24 at 3:25 p.m., the ED provided a document dated 5/11/16, titled, "Guidelines for TB			

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	Results Summary Documentation: Staff," and indicated it was the policy currently being used by the facility. The policy indicated, " ...7. Keep a tickler file to ensure each employee is re-tested on their anniversary date with a one-step Mantoux or Tuberculosis Screening questionnaire if they were a previous converter with a negative CXR. 8. Facilities will also have a CXR administered no less than every 4-5 years for each employee who has had a positive Mantoux reaction. 9. Document results of annual evaluation on the TB results Summary in the employee health file ...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00418482. Complaint IN00418482 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 18, 19, 22, 23, and 24, 2024 Facility number: 004550 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 1, 2024.	R 0000		
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep			

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	and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure medications for a resident who's service plan (a personalized care plan designed for residents living in an assisted living community) indicated the resident was not capable for self-administration of medications, were kept secure, outside of the resident's room, for 1 of 7 resident apartments observed (Resident 016). Findings include: During an interview, on 1/24/24 at 9:51 a.m., in the apartment of Resident 016, two inhaler medications were observed on the resident's end table next to his recliner. At the same time, the resident indicated he administered the inhalers himself. The nurses had always allowed him to administer the inhalers, since he admitted to the facility. Resident 016's clinical record was reviewed on 1/24/24 at 10:24 a.m. The record indicated the resident had been admitted to the facility on 6/28/23. The profile indicated the resident's diagnoses included, but were not limited to, pneumonia (a form of acute respiratory infection that affects the lungs), bronchiectasis (a condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred), acute pulmonary edema (a condition in which too much fluid accumulates in the lungs, interfering with a person's ability to breathe normally), and chronic	R 0295	Plan of Correction Text: The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **R295 Pharmaceutical Services-Noncompliance** Completion Date: Plan of Correction Text: 1. Resident #016 had his service plan updated to reflect	01/24/2024

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	obstructive pulmonary disease-COPD (a group of diseases that cause airflow blockage and breathing-related problems). A physician's order, dated 8/3/23, indicated ipratropium-albuterol solution (a medication in a class called bronchodilators which works by opening the airways and reducing inflammation in the lungs to help the individual to breathe) for nebulization (a way liquid medications are changed into a very fine spray, so it can be breathed in by a patient), 0.5 milligrams (mg)-3 mg per 3 milliliters (ml) inhalation, four times daily. A physician's order, dated 8/3/23, indicated albuterol sulfate (a quick acting bronchodilator) aerosol (fine mist) inhaler 90 micrograms (mcg) per actuation (initiation). "Inhale two puffs every four hours as needed." A physician's order, dated 11/24/23, indicated Trelegy Ellipta (a prescription medicine used long term to treat COPD) 100-62.5-25 mcg, one inhalation daily. The physician's orders, lacked documentation of any orders for the resident to self-administer his own medications. An admission service plan, dated 6/28/23, indicated the resident was able to self-administer his medications. A service plan, dated 9/12/23, indicated staff were to provide medications to the resident and assist with administration. The resident required assistance to administer, organize, and store medications. During an interview, on 1/24/24 at 10:35 a.m., the		self-administration of medications, plan for related nursing observations and updated physician orders to support. 2. Like residents have the potential to be affected by the alleged deficient practice. Nursing staff were immediately instructed during survey to re-evaluate self-administration of medications for all residents. Administrative nursing staff were reminded to ensure service plans reflect current/updated plans of care for self-administration of medications, observations and current orders. 3. Training was completed with licensed nurses concerning service plan inclusion of Rx self-administration, nursing observations and maintenance of timely orders. The DHS or designee will audit service plans weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. Corrective action will be taken as indicated by findings. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	

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	Regional Director of Clinical Operations (RDCO) indicated the resident could self-administer his medications. She was not aware of the service plan, dated 9/12/23, which indicated the resident was not able to self-administer his medications. During an interview, on 1/24/24 at 11:22 a.m., the Assisted Living (AL) Director indicated she had only been in her position for about 6 months. The resident had always been able to self-administer his medication as far as she was aware. She was not aware of the service plan, dated 9/12/23, which indicated the resident required assistance with his medication administration. The inhalers had always been kept in the resident room, on his table, as far as she was aware. On 1/24/24 at 11:50 a.m., the RDCO provided a document, with a review date of 3/24/22, titled, "AL-Self Administration of Medications Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures: ...2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of medication(s) the resident is able to self-medicate...4. The medication will be kept in a locked drawer in the residents' room. The resident will maintain a key and a second key will be maintained by the licensed nurse or Qualified Medication Aide (QMA)...7. Periodic verification of administration compliance will be observed by nursing staff...."		indicated.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious			

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	symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure the infection control program was completed on the assisted living residents for 35 of 35 residents who resided at the facility. Finding includes: During an interview, on 1/22/24 at 9:35 a.m., the Infection Prevention (IP) nurse indicated she was responsible for the infection control surveillance program for the health care campus. She indicated she had two different logs that she kept regarding residents who were on antibiotics and another log for surveillance. The IP nurse indicated she would pull an antibiotic report from the computer system on the residents from the Assisted Living, but she did not pull the report when she was out on maternity leave for the months of October, November, and December 2023. She assumed the Assisted Living Director pulled the report during that time frame, but she was not sure if she did. She indicated there was no surveillance log that was completed for the residents who resided on the assisted living part of campus. During an interview, on 1/23/24 at 10:40 a.m., the IP nurse indicated she had gotten another binder to mimic what she was using for the health campus infection control program and was going to use it for the assisted living residents since they had not been using one previously.	R 0407	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	01/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING 00 B. WING	01/24/2024

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	During an interview, on 1/23/24 at 10:57 a.m., the Assisted Living (AL) Director indicated she had never pulled any reports from the computer system regarding any infections or antibiotics monitoring. She was unaware of how to even print the report. She was unaware of an infection control surveillance program that needed to be completed on the residents that resided in assisted living. She further indicated she had not gotten any formal training about her position and what duties she was to complete. During an interview, on 1/23/24 at 3:10 p.m., the Regional Director of Clinical Operations (RDCO) indicated the IP nurse had pulled some antibiotic reports from the computer system on the assisted living residents when she was not on maternity leave but there was no infection control surveillance program being completed on the residents who resided on the assisted living side of campus. She indicated they were not tracking the assisted living side like they were the health care campus side. We were going to separate out the two areas so they both had their own monitoring. On 1/23/24 at 11:18 a.m., the Executive Director, provided and identified a document as a current facility policy, titled, "AL-Infection Control Practice Guidelines," revised date 8/11/16. The policy indicated, " ...1. The campus shall establish an infection control program that enables the campus to analyze patterns of known infections ...."		1 No residents were affected by the alleged deficient practice. An infection monitoring binder for the licensed residential units was re-started for tracking/trending infections. 2 All residents have the potential to be affected by insufficient monitoring. Nursing administration team members became aware of oversight during survey and were immediately engaged with tracking. Nurses were taught to access specific residential tracking forms. 3 Infection Prevention Nurse will track and trend resident population infections in the associated binder. The DHS or designee will audit weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly until substantial compliance is maintained. AL infection control monitoring will be incorporated as an element of Quality Assurance Performance Improvement meetings. The plan will be reviewed and	

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			updated as indicated.	