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

| | AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155736 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | survey eted 2024 |
|--------------------------|--|---|-------|--|--|--|------------------------|
| | PROVIDER OR SUPPLIER | | | 1014 M | ADDRESS, CITY, STATE, ZIP COD ILL POND LANE ICASTLE, IN 46135 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION |
| E 0000 | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| Bldg | conducted by the In accordance with 42 Survey Date: 03/07 Facility Number: 0 Provider Number: 200: At this Emergency Pond Health Campu compliance with En Requirements for M Participating Provide 483.73 The facility has 68 of the survey, the cense Quality Review consumpliance with the survey of the survey | 04550 155736 526450 Preparedness survey, Mill as was found in substantial nergency Preparedness Iedicare and Medicaid Iters and Suppliers, 42 CFR Deertified beds. At the time of us was 45. | E 0 | 000 | Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth to the falleged or conclusions set for the Statement of Deficiencies. The Plan of Correction is prepand executed solely because required by the position of Fedand State Law. The plan of correction is submitted in orderespond to the allegation of noncompliance cited during the survey visit on March 7, 2024. | ment acts h on ared it is deral | |
| SS=C Bldg | =C 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Rachel Frye **Executive Director** 03/22/2024

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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| CENTERS FOR | R MEDICARE & MEDIC | | | | <u> </u> | MB NO. 0938-039 | |
|--|----------------------|-------------------------------------|---------------------|--|-----------|-----------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATI | E SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | <u></u> | COME | PLETED | |
| | | 155736 | B. WING | | 03/0 | 03/07/2024 | |
| | | | | | - | - | |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | ADDRESS, CITY, STATE, ZIP CC | DD | | |
| | | | 1014 MILL POND LANE | | | | |
| MILL PO | ND HEALTH CAMP | PUS | GREE | NCASTLE, IN 46135 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | | | (X5) | |
| PREFIX | | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO | | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE AP DEFICIENCY) | PROPRIATE | DATE | |
| IAG | | | IAG | | | DATE | |
| | 9491.12, and ESP | RD Facilities at §494.62]: | | | | | |
| | (O) Tasking The If | in allife. Il mannati a a malinnati | | | | | |
| | | acility] must conduct | | | | | |
| | | he emergency plan | | | | | |
| | I | ility] must do all of the | | | | | |
| | following: | | | | | | |
| | | | | | | | |
| | | full-scale exercise that is | | | | | |
| | community-based | | | | | | |
| | | nunity-based exercise is | | | | | |
| | | nduct a facility-based | | | | | |
| | functional exercise | e every 2 years; or | | | | | |
| | (B) If the [faci | lity] experiences an actual | | | | | |
| | natural or man-ma | ade emergency that requires | | | | | |
| | activation of the e | mergency plan, the [facility] | | | | | |
| | is exempt from en | gaging in its next required | | | | | |
| | community-based | or individual, facility-based | | | | | |
| | I - | e following the onset of the | | | | | |
| | actual event. | G | | | | | |
| | (ii) Conduct an ad | ditional exercise at least | | | | | |
| | l ' ' | posite the year the full-scale | | | | | |
| | | cise under paragraph (d)(2) | | | | | |
| | | s conducted, that may | | | | | |
| | 1 '' | limited to the following: | | | | | |
| | | scale exercise that is | | | | | |
| | · ' | or individual, facility-based | | | | | |
| | | | | | | | |
| | functional exercise | • | | | | | |
| | (B) A mock disaste | | | | | | |
| | | ercise or workshop that is | | | | | |
| | 1 | and includes a group | | | | | |
| | discussion using a | | | | | | |
| | 1 | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an er | | | | | | |
| | | acility's] response to and | | | | | |
| | maintain documer | ntation of all drills, tabletop | | | | | |
| | exercises, and em | nergency events, and revise | | | | | |
| | the [facility's] eme | rgency plan, as needed. | | | | | |

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Event ID:

3W2K21

Facility ID: 004550

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| CENTERSTOR | R MEDICARE & MEDIC | | OMB NO. 0938-039 | | | |
|--|----------------------|---------------------------------|------------------|---|-----------|------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CC | ONSTRUCTION | (X3) DATE SURVEY | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | <u></u> | COMPLETED | |
| | | 155736 | B. WING | | 03/07/ | 2024 |
| | | <u> </u> | | | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | ILL POND LANE | | |
| MILL PO | ND HEALTH CAMP | ขร | GREEN | ICASTLE, IN 46135 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | DE CLUBERIG DE ANTOE CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE |
| | *[For Hospices at | 418.113(d):1 | | | | |
| | | ospices that provide care in | | | | |
| | | e. The hospice must | | | | |
| | 1 | s to test the emergency | | | | |
| | | ally. The hospice must do | | | | |
| | the following: | ally. The hospice must do | | | | |
| | _ | a full-scale exercise that is | | | | |
| | community based | | | | | |
| | 1 | | | | | |
| | 1 ' ' | nunity based exercise is not | | | | |
| | | uct an individual facility | | | | |
| | | exercise every 2 years; or | | | | |
| | 1 ' ' | experiences a natural or | | | | |
| | | gency that requires activation | | | | |
| | | plan, the hospital is | | | | |
| | | aging in its next required full | | | | |
| | I | based exercise or individual | | | | |
| | · - | ctional exercise following the | | | | |
| | onset of the emer | - | | | | |
| | (ii) Conduct an ad | dditional exercise every 2 | | | | |
| | years, opposite th | ne year the full-scale or | | | | |
| | functional exercise | e under paragraph (d)(2)(i) | | | | |
| | of this section is c | conducted, that may | | | | |
| | include, but is not | limited to the following: | | | | |
| | (A) A second full- | -scale exercise that is | | | | |
| | community-based | l or a facility based | | | | |
| | functional exercise | e; or | | | | |
| | (B) A mock disas | ter drill; or | | | | |
| | (C) A tabletop ex | ercise or workshop that is | | | | |
| | led by a facilitator | and includes a group | | | | |
| | discussion using a | - - | | | | |
| | _ | emergency scenario, and a | | | | |
| | set of problem sta | | | | | |
| | I | pared questions designed | | | | |
| | to challenge an er | · | | | | |
| | | | | | | |
| | (3) Testing for hos | spices that provide inpatient | | | | |
| | 1 ' ' | e hospice must conduct | | | | |
| | I - | he emergency plan twice | | | | |
| | | spice must do the following: | | | | |
| | 1 ' ' | an annual full-scale exercise | | | | |

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Event ID:

 $3W2K21 \qquad {\tt Facility\ ID:} \quad 004550$

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY | | |
|--|---|---|--|-------------|--|--------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUII | A. BUILDING | | | COMPLETED | |
| | | 155736 | B. WIN | G | | 03/07/ | /2024 | |
| | | | - | CTREET A | DDDECC CITY CTATE ZID COD | | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| MILL DO | | 21.10 | | | LL POND LANE | | | |
| MILL PO | ND HEALTH CAMP | 705 | | GREEN | CASTLE, IN 46135 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | P. | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | that is community- | -based; or | | | | | | |
| | (A) When a comm | nunity-based exercise is not | | | | | | |
| | accessible, condu | ct an annual individual | | | | | | |
| | facility-based fund | ctional exercise; or | | | | | | |
| | (B) If the hospice | experiences a natural or | | | | | | |
| | man-made emerg | ency that requires activation | | | | | | |
| | of the emergency | plan, the hospice is | | | | | | |
| | exempt from enga | aging in its next required | | | | | | |
| | full-scale commun | nity based or facility-based | | | | | | |
| | functional exercise | e following the onset of the | | | | | | |
| | emergency event. | | | | | | | |
| | (ii) Conduct an ac | dditional annual exercise | | | | | | |
| | that may include, but is not limited to the | | | | | | | |
| | following: | | | | | | | |
| | (A) A second full- | scale exercise that is | | | | | | |
| | community-based | or a facility based | | | | | | |
| | functional exercise | e; or | | | | | | |
| | (B) A mock disast | ter drill; or | | | | | | |
| | (C) A tabletop ex | ercise or workshop led by a | | | | | | |
| | facilitator that inclu | udes a group discussion | | | | | | |
| | using a narrated, | - | | | | | | |
| | | rio, and a set of problem | | | | | | |
| | l ' | ed messages, or prepared | | | | | | |
| | questions designe | ed to challenge an | | | | | | |
| | emergency plan. | | | | | | | |
| | 1 ' ' | ospice's response to and | | | | | | |
| | | ntation of all drills, tabletop | | | | | | |
| | | nergency events and revise | | | | | | |
| | the hospice's eme | ergency plan, as needed. | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | l41.184(d), Hospitals at | | | | | | |
| | §482.15(d), CAHs | - , , - | | | | | | |
| | | PRTF, Hospital, CAH] must | | | | | | |
| | | to test the emergency | | | | | | |
| | 1 ' | ar. The [PRTF, Hospital, | | | | | | |
| | CAH] must do the | _ | | | | | | |
| | | an annual full-scale exercise | | | | | | |
| | that is community- | | | | | | | |
| | (A) When a comm | nunity-based exercise is not | | | | | | |

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| | | X1) PROVIDER/SUPPLIER/CLIA | | | |) DATE SURVEY | |
|-----------|-----------------------|--|------|-------------|---|---------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | A. BUILDING | | | LETED |
| | | 155736 | B. W | ING | | 03/07/2024 | |
| NAME OF E | PROVIDER OR SUPPLIER | | _ | STREET A | ADDRESS, CITY, STATE, ZIP COD | - | |
| NAME OF F | NO VIDER OR SUFFLIER | | | | ILL POND LANE | | |
| MILL PO | ND HEALTH CAMF | PUS | | GREEN | ICASTLE, IN 46135 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCE | | DATE |
| | | ct an annual individual, | | | | | |
| | facility-based fund | | | | | | |
| | | Hospital, CAH] experiences | | | | | |
| | | or man-made emergency ation of the emergency | | | | | |
| | - | is exempt from engaging in | | | | | |
| | | ull-scale community based | | | | | |
| | | ty-based functional exercise | | | | | |
| | | et of the emergency event. | | | | | |
| | _ | an [additional] annual | | | | | |
| | , , | at may include, but is not | | | | | |
| | limited to the follow | - | | | | | |
| | | scale exercise that is | | | | | |
| | community-based | | | | | | |
| | facility-based fund | | | | | | |
| | | ock disaster drill; or | | | | | |
| | , , | exercise or workshop that | | | | | |
| | , , | or and includes a group | | | | | |
| | discussion, using | — · | | | | | |
| | _ | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | - | pared questions designed | | | | | |
| | to challenge an er | · | | | | | |
| | | he [facility's] response to | | | | | |
| | and maintain docu | umentation of all drills, | | | | | |
| | tabletop exercises | s, and emergency events | | | | | |
| | and revise the [fac | cility's] emergency plan, as | | | | | |
| | needed. | | | | | | |
| | *[For PACE at §46 | 60.84(d):1 | | | | | |
| | _ | PACE organization must | | | | | |
| | | s to test the emergency | | | | | |
| | plan at least annu | 9 | | | | | |
| | organization must | - | | | | | |
| | _ | an annual full-scale exercise | | | | | |
| | that is community | | | | | | |
| | 1 | nunity-based exercise is not | | | | | |
| | | ict an annual individual, | | | | | |
| | facility-based fund | • | | | | | |
| | | xperiences an actual natural | | | | | |

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Event ID:

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|-----------|--|---|---|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | <u></u> | COMPLETED | |
| | | 155736 | B. WING | | 03/07/2024 | |
| NAME OF T | PROVIDER OR SUPPLIER | | STREET | ADDRESS, CITY, STATE, ZIP COD | • | |
| | | | | MILL POND LANE | | |
| MILL PO | ND HEALTH CAMP | PUS | GREE | NCASTLE, IN 46135 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | RIATE | |
| TAG | i | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY | DATE | |
| | | ergency that requires | | | | |
| | | mergency plan, the PACE | | | | |
| | - | gaging in its next required | | | | |
| | | nity based or individual, stional exercise following the | | | | |
| | | _ | | | | |
| | onset of the emer | n additional exercise every | | | | |
| | , , | he year the full-scale or | | | | |
| | | e under paragraph (d)(2)(i) | | | | |
| | | onducted that may include, | | | | |
| | but is not limited to | • | | | | |
| | | scale exercise that is | | | | |
| | , , | or individual, a facility | | | | |
| | based functional e | - | | | | |
| | (B) A mock disas | | | | | |
| | | ercise or workshop that is | | | | |
| | . , | and includes a group | | | | |
| | discussion, using | — · | | | | |
| | | emergency scenario, and a | | | | |
| | set of problem sta | - · | | | | |
| | | pared questions designed | | | | |
| | to challenge an er | nergency plan. | | | | |
| | (iii) Analyze the P | ACE's response to and | | | | |
| | maintain documer | ntation of all drills, tabletop | | | | |
| | exercises, and em | nergency events and revise | | | | |
| | the PACE's emero | gency plan, as needed. | | | | |
| | *[For LTC Facilitie | es at §483.73(d):1 | | | | |
| | | ty] must conduct exercises | | | | |
| | · · · | ency plan at least twice per | | | | |
| | _ | announced staff drills using | | | | |
| | - | ocedures. The [LTC facility, | | | | |
| | ICF/IID] must do t | = - | | | | |
| | (i) Participate in a | n annual full-scale exercise | | | | |
| | that is community- | -based; or | | | | |
| | (A) When a comm | unity-based exercise is not | | | | |
| | | ct an annual individual, | | | | |
| | facility-based fund | tional exercise. | | | | |
| | (B) If the [LTC fac | ility] facility experiences an | | | | |
| | actual natural or n | nan-made emergency that | | | | |

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| CENTERS FOI | R MEDICARE & MEDIC | CAID SERVICES | | | | OM | IB NO. 0938-039 |
|-------------|----------------------|---|--------|------------|--|------------|-----------------|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPI | LETED |
| | | 155736 | B. Wl | NG | | 03/07/2024 | |
| | | <u> </u> | | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ILL POND LANE | | |
| MILL PO | ND HEALTH CAME | PUS | | | ICASTLE, IN 46135 | | |
| IVIILLI | T | | | | 1 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | - | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | l . | n of the emergency plan, the | | | | | |
| | 1 | mpt from engaging its next | | | | | |
| | - | ale community-based or | | | | | |
| | 1 | based functional exercise | | | | | |
| | I - | et of the emergency event. | | | | | |
| | ` ' | dditional annual exercise | | | | | |
| | | but is not limited to the | | | | | |
| | following: | | | | | | |
| | ` ' | -scale exercise that is | | | | | |
| | 1 | l or an individual, facility | | | | | |
| | based functional | | | | | | |
| | (B) A mock disas | | | | | | |
| | ` ' | ercise or workshop that is | | | | | |
| | led by a facilitator | | | | | | |
| | discussion, using | | | | | | |
| | I | emergency scenario, and a | | | | | |
| | · · | atements, directed | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an e | | | | | | |
| | . , , | LTC facility] facility's | | | | | |
| | - | naintain documentation of | | | | | |
| | | exercises, and emergency | | | | | |
| | | e the [LTC facility] facility's | | | | | |
| | emergency plan, | as needed. | | | | | |
| | *[For ICF/IIDs at § | SA83 A75(d)1: | | | | | |
| | _ · | - · · · - | | | | | |
| | . , - | CF/IID must conduct | | | | | |
| | | the emergency plan at least ne ICF/IID must do the | | | | | |
| | following: | ie iCF/iiD iliust do tile | | | | | |
| | _ | n annual full-scale exercise | | | | | |
| | that is community | | | | | | |
| | | nunity-based exercise is not | | | | | |
| | | uct an annual individual, | | | | | |
| | | | | | | | |
| | - | ctional exercise; or. | | | | | |
| | 1 ' ' | experiences an actual | | | | | |
| | | ade emergency that requires | | | | | |
| | activation of the e | mergency plan, the ICF/IID | I | | | | |

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is exempt from engaging in its next required full-scale community-based or individual,

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| | VT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 03/07/2024 | | |
|-------------------|--|--|--|---|---------------------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 1014 MILL POND LANE GREENCASTLE, IN 46135 | | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | PRIATE COMPLETION | | |
| TAG | facility-based fundonset of the emery (ii) Conduct an ad that may include, following: (A) A second full-scommunity-based facility-based fundonset of the by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (A) When a community-based (B) If the HHA and the incompany full-scale community-based is not accessible, individual, facility-levery 2 years; or. (B) If the HHA activation of the energy full-scale community-based fundonset of the emergent from engagent facility based fundonset of the emergent from engagent for the emergent from engagent full-scale community facility based fundonset of the emergent from engagent full-scale community facility based fundonset of the emergent from engagent facility based fundonset of the emergent from engagent facility based fundonset of the emergent facility facilit | ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or excise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed exercise or events, and revise expency plan. 25/IID's response to and extended exercise exercise exercise that is exercise that is exercise that is exercise exercise that is exercise exercise that is exercise exercis | TAG | DEFICIENCY | DATE | | |

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Event ID:

 $3W2K21 \qquad {\tt Facility \, ID:} \quad 004550$

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

PRINTED: 03/27/2024 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155736 | | UILDING | NSTRUCTION | COMPI 03/07 | LETED |
|-------------------|--|--|--|--------------|--|----------------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | DDRESS, CITY, STATE, ZIP COD | | |
| MILL PO | ND HEALTH CAMP | PUS | | | CASTLE, IN 46135 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · · | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | DATE |
| | years, opposite th | e year the full-scale or | | | | | |
| | functional exercise | e under paragraph (d)(2)(i) | | | | | |
| | of this section is c | onducted, that may | | | | | |
| | include, but is not | limited to the following: | | | | | |
| | , , | full-scale exercise that is | | | | | |
| | community-based | | | | | | |
| | | ctional exercise; or | | | | | |
| | , , | isaster drill; or | | | | | |
| | | exercise or workshop that | | | | | |
| | I - | or and includes a group | | | | | |
| | discussion, using | | | | | | |
| | clinically-relevant emergency scenario, and a | | | | | | |
| | set of problem statements, directed | | | | | | |
| | messages, or prepared questions designed to challenge an emergency plan. | | | | | | |
| | _ | HA's response to and | | | | | |
| | 1 ' ' | ntation of all drills, tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | | ency plan, as needed. | | | | | |
| | *[For OPOs at §48 | 86 3601 | | | | | |
| | | e OPO must conduct | | | | | |
| | 1 ' ' ' ' | he emergency plan. The | | | | | |
| | OPO must do the | | | | | | |
| | | er-based, tabletop exercise | | | | | |
| | | ast annually. A tabletop | | | | | |
| | exercise is led by | a facilitator and includes a | | | | | |
| | group discussion, | using a narrated, clinically | | | | | |
| | relevant emergen | cy scenario, and a set of | | | | | |
| | problem statemen | its, directed messages, or | | | | | |
| | prepared question | ns designed to challenge an | | | | | |
| | | If the OPO experiences an | | | | | |
| | | nan-made emergency that | | | | | |
| | | n of the emergency plan, the | | | | | |
| | I | om engaging in its next | | | | | |
| | | xercise following the onset | | | | | |
| | of the emergency | | | | | | |
| | 1 ' ' | PO's response to and | | | | | |
| | | ntation of all tabletop | | | | | |
| | exercises, and em | nergency events, and revise | | | | | 1 |

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| | T OF HEALTH AND HU R MEDICARE & MEDIC | | | | | | RM APPROVED IB NO. 0938-039 |
|---------------|---|--|-------------|---------------------------------------|--|-------------------|-----------------------------|
| | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER 155736 A. BUILDING B. WING | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 03/07/2024 | | | |
| | PROVIDER OR SUPPLIED ND HEALTH CAMF | | | 1014 N | ADDRESS, CITY, STATE, ZIP COD MILL POND LANE NCASTLE, IN 46135 | | (X5) |
| PREFIX TAG | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| | needed. *[RNCHIs at §40. (d)(2) Testing. The exercises to test to the RNHCI must do the control of the exercises to test to the control of the exercises to test to the RNHCI must do the control of the exercises and a second of the exercises, and enthe RNHCI's ementated to analyze the maintain document exercises, and ementated to analyze the maintain document exercises. Endings include: Based on record record record of the exercises and Second of the exercises | e RNHCI must conduct he emergency plan. The | E 00 |)39 | Immediate action Facilities Management Suppo provided education to the Executive Director on complet an after-action report for each facility-based exercise/drill. Eafter-action report should be fi in the electronic DPO tracking tool. This deficient practice has the potential to affect all residents Corrective action Each facility-based exercise whave an after-action report documented and kept on reco | ing ach led | 03/22/2024 |

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interview at the time of records review, the Senior

Director of Plant Operations stated the facility

based drill took place on 02/09/24 but an after

This finding was reviewed with the Executive

Director, Senior Director of Plant Operations and

actions report was not completed.

Event ID:

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Facility ID: 004550

QAPI

The Executive Director or

designee will audit facility-based

exercise documentation monthly for 6 months to ensure after-action

report is present for all exercises.

ED will present finding to QAPI

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | | |
|--|--|--|---|--|---|--------|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | COMPL | |
| | | 155736 | B. W. | | | 03/07/ | ZUZ 4 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| MILL POI | ND HEALTH CAMP | PUS | | 1014 MILL POND LANE GREENCASTLE, IN 46135 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | TAG | | DEFICIENCY) | | DATE |
| | Director of Plant Op | perations at the exit conference. | | | team for any recommendation | S. | |
| K 0000 | | | | | | | |
| Bldg. 01 | | | | | | | |
| 2.29.01 | A Life Safety Code | Recertification and State | K 0 | 000 | Preparation or execution of the | is | |
| | - | as conducted by the Indiana | | | plan of correction does not | | |
| | Department of Heal | th in accordance with 42 CFR | | | constitute admission or agree | ment | |
| | 483.90(a). | | | | of provider of the truth to the fa | | |
| | G | 1/0.4 | | | alleged or conclusions set fort | | |
| | Survey Date: 03/07 | 7/24 | | | the Statement of Deficiencies. | | |
| | Facility Number: 0 | 04550 | | | The Plan of Correction is prep | | |
| | Provider Number: 155736 AIM Number: 200526450 | | | | and executed solely because required by the position of Fed | | |
| | | | | | and State Law. The plan of | Jerai | |
| | 2000 | 20.00 | | | correction is submitted in orde | r to | |
| | At this Life Safety (| Code survey, Mill Pond Health | | | respond to the allegation of | | |
| | | not in compliance with | | | noncompliance cited during th | ·е | |
| | Requirements for Pa | articipation in | | | survey visit on March 7, 2024. | | |
| | | , 42 CFR Subpart 483.90(a), | | | | | |
| | - | re and the 2012 edition of the | | | | | |
| | | etion Association (NFPA) 101, | | | | | |
| | | SC), Chapter 19, Existing ancies and 410 IAC 16.2. | | | | | |
| | neatth Care Occupa | ancies and 410 IAC 16.2. | | | | | |
| | This facility, located | d on the south and east end of | | | | | |
| | - | g, was determined to be of | | | | | |
| | | ruction and fully sprinklered. | | | | | |
| | | re alarm system with smoke | | | | | |
| | | ridors and areas open to the | | | | | |
| | | ty has smoke detectors hard | | | | | |
| | | rm system installed in all | | | | | |
| | | oms. The facility has a | | | | | |
| | of this survey. | nad a census of 45 at the time | | | | | |
| | or uns survey. | | | | | | |
| | All areas where the | residents have customary | | | | | |
| | | ered and all areas providing | | | | | |
| | facility services wer | | | | | | |
| | • | | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|--|--|----------------------------|---|--|-------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMP | | | | |
| 155 | | 155736 | B. WING | | | 03/07 | /2024 |
| NAME OF P | DOWNER OF CLIEBY TER | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1014 M | IILL POND LANE | | |
| MILL POND HEALTH CAMPUS | | | | GREEN | NCASTLE, IN 46135 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | Quality Review con | npleted on 03/12/24 | | | | | |
| K 0345 | NFPA 101 | | | | | | |
| SS=C | Fire Alarm System - Testing and | | | | | | |
| Bldg. 01 | Maintenance | | | | | | |
| g | Fire Alarm System - Testing and | | | | | | |
| | Maintenance | | | | | | |
| | A fire alarm system is tested and maintained | | | | | | |
| | in accordance with an approved program | | | | | | |
| | | e requirements of NFPA 70, | | | | | |
| | National Electric C | Code, and NFPA 72, | | | | | |
| | National Fire Aları | m and Signaling Code. | | | | | |
| | Records of systen | n acceptance, maintenance | | | | | |
| | and testing are rea | - | | | | | |
| | | FPA 70, NFPA 72 | | | | | |
| | | view and interview, the facility | K 0 | 345 | Immediate action | | 03/22/2024 |
| | | f 1 fire alarm systems was | | | The Director of Plant Operatio | | |
| | | dance with LSC 9.6.1.3. LSC | | | immediately removed plastic b | - | |
| | - | re alarm system to be installed, | | | from covering the smoke dete | | |
| | · · | ned in accordance with NFPA | | | This deficient practice has the | | |
| | 70, National Electrical Code and NFPA 72, National Fire Alarm Code. This deficient practice | | | potential to affect al Corrective action | | | |
| | | - | | | All smoke detectors will remain | n | |
| | could affect all occupants. Findings include: | | | | free of obstacles that would no | | |
| | | | | | allow proper activation. | | |
| | 1 maniga merada. | | | | The Director of Plant Operatio | ns | |
| | Based on observation | on with the Senior Director of | | | was educated by the Executiv | | |
| | | d Director of Plant Operations | | | Director on LSC 9.6.1.3. | | |
| | _ | facility at 1:05 p.m. on | | | LSC 9.6.1.3 requires a fire ala | ırm | |
| | | room was equipped with a | | | system to be installed, tested, | | |
| | ceiling mounted sm | oke detector, however a plastic | | | and maintained in accordance | | |
| | bag was taped over | the detector. The smoke | | | NFPA 70, National Electrical 0 | Code | |
| | | red by a plastic bag would | | | and NFPA72, National Fire Ala | arm | |
| | _ | detector from activating. Based | | | Code. | | |
| | | time of the observation, the | | | QAPI | | |
| | | Plant Operations confirmed a | | | Director of Plant Operations o | r | |
| | | ering the smoke detector and | | | designee will inspect smoke | | |
| | | ing done on the copper piping | | | detector in riser room 1x/week | | 1 |
| | | ek and the bag was placed over to prevent a false fire alarm. | | | a month; 1x/month for 3 month | | |
| | i the smoke detector | to prevent a taise tire alarm. | 1 | | LED will present findings to OA | 닏 | i . |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 03/07/2024 | |
|---|--|---|--|---|---|--|
| | PROVIDER OR SUPPLIE | | 1014 | T ADDRESS, CITY, STATE, ZIP COD MILL POND LANE ENCASTLE, IN 46135 | | |
| (X4) ID PREFIX | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | BE COMPLETION | |
| TAG | The plastic bag wa detector at the time This finding was r Director, Senior D Director of Plant (3.1-19(a) | as removed from the smoke the of observation. The eviewed with the Executive the irrector of Plant Operations and Operations at the exit conference. | TAG | team for any recommendat | ions. | |
| K 0355 SS=D Bldg. 01 | installed, inspect accordance with Portable Fire Ext 18.3.5.12, 19.3.5 | inguishers nguishers are selected, ed, and maintained in NFPA 10, Standard for inguishers12, NFPA 10 | | | | |
| | failed to inspect 1 in the facility. NFI Extinguishers, Sec extinguishers shall by means of an eleminimum of 30-da practice could affe visitors in the beau Findings include: Based on observat Plant Operation an Operations on 03/0 the facility, the moportable fire exting an annual mainten This fire extinguis being inspected Ju Based on interview Senior Director of | ion and interview, the facility of 17 portable fire extinguishers PA 10, Standard for Portable Fire tion 7.2.1.2 says Fire be inspected either manually or extronic device / system at a sy intervals. This deficient ct two residents, staff, and aty shop. ions made with the Director of Id Senior Director of Plant 107/24 at 12:50 p.m. during a tour onthly inspection tag on the guisher in the beauty shop had ance tag dated June 13, 2023. There was not documented as ly through December 2023. We at the time of observation, the Plant Operations confirmed that er in the beauty shop had not | K 0355 | Immediate action Director of Plant Operations immediately updated check tool to ensure all fire exting were noted for monitoring. The Director of Plant Operations was educated by the Executorizector on NFPA 10, Stand Portable Fire Extinguishers Section 7.2.1.2 says Fire extinguishers shall be inspecified in a section of the extinguisher of the | clist uishers ations utive dard for , ected s of an at a s. the nts. s to ns of all | |

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Event ID:

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

PRINTED: 03/27/2024 FORM APPROVED OMB NO. 0938-039

| 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 03/07/2024 | |
|--|--|--|--|--------|---|---------------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP COD 1014 MILL POND LANE GREENCASTLE, IN 46135 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | | DEFICIENCY) | | DATE |
| | been inspected monthly from July to December 2023. | | | | inspections are complete. Executive Director or designee | 7 | |
| | This finding was re Director, Senior Dir | viewed with the Executive rector of Plant Operations and perations at the exit conference. | | | present findings to QAPI team any recommendations. | | |

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