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	04/07/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/07/25 Facility Number: 004550 Provider Number: 155736 AIM Number: 200526450 At this Emergency Preparedness survey, Mill Pond Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. At the time of the survey, the census was 36. Quality Review completed on 04/10/25	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth to 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 the survey visit on April 7, 2025. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/07/25 Facility Number: 004550 Provider Number: 155736 AIM Number: 200526450 At this Life Safety Code survey, Mill Pond Health Campus was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth to 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 the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Frye	Executive Director	05/01/2025

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, located on the south and east end of a one-story building, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 36 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/10/25		survey visit on April 7, 2025. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1.1 Delayed-Egress Locking Systems allows approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and	K 0222	**Immediate Action** The Director of Plant Operations was educated on 4/18/25 by the Executive Director on NFPA 101-2012 edition sections; LSC 7.2.1.6.1.1. This deficient practice had the potential to affect 36 residents, staff and visitors in the facility. **Corrective Action** The Director of Plant Operations contacted the vendor (SafeCare) to repair the service exit door; work	04/24/2025

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	where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) A readily visible, durable sign in letters not less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with		was completed on 4/22/25. **QAPI** The Director of Plant Operations or designee will audit the functionality of the service exit door 2x per week x3 months. The results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations made on 04/07/25 at 12:36 p.m. during a tour of the facility with the Acting Director of Plant Operations (ADPO) and the Director of Plant Operations in-training (DPOIT)., the service hall exit was provided with delayed egress lock and was provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the door was pushed, the irreversible process to release the lock was not initiated. Based on an interview on 04/07 25 at 12:38 p.m., the ADPO stated that he was unaware that the door was not functioning as intended and added that he would have his vendor come out and look at the door as soon as possible. This item was discussed with the facility Administrator, the ADPO and the DPOIT at the exit conference held on 04/07/25. 3.1-19(b)			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011	K 0324	**Immediate Action** The Director of Plant Operations was educated by Executive Director on NFPA 96, Section 12.1.2.3.1 and Section 11.2.1 The deficient practice had the potential to affect 12 residents, 6 staff and 2 visitors in the facility.	04/24/2025

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	Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 12 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made on 04/07/25 at 12:25 p.m. during a tour of the facility with the Acting Director of Plant Operations (ADPO) and the Director of Plant Operations in-training (DPOIT)., the six (6) burner stove and the 24 inch flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview on 04/07/25 at 12:27 p.m., the ADPO stated that he was aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he had ordered the wheel chalks to remedy		**Corrective Action** The Director of Plant Operations has marked the proper location of the flat top stove feet with floor paint. The semiannual kitchen exhaust system inspection was completed on 2/4/25 by Koorsen with documentation available in Life Safety binder. **QAPI** The Director of Plant Operations or designee will audit the proper placement of the flat top stove 2x per week x3 months. ED will ensure documentation is available in Life Safety binder for kitchen exhaust system inspection no later than one week following completion of semiannual work. The results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	the deficiency, but that have not arrived at the facility as of the time of this survey. This item was discussed with the facility Administrator, the ADPO and the DPOIT at the exit conference held on 04/07/25. 3.1-19(b) 2) Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. The deficient practice could affect as many as 12 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on review of the Koorsen Fire and Security documentation entitled "Restaurant System Inspection dated 09/24/2024 with the Acting Director of Plant Operations (ADPO) and the Director of Plant Operations in-training (DPOIT) at 11:26 a.m., documentation of semiannual kitchen exhaust system inspection six months after to the aforementioned inspection was not available for review. Based on an interview on 04/07/25 at 11:27 a.m., the ADPO acknowledged that documentation of semiannual kitchen exhaust system inspection six months prior was not			

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	available for review adding that the inspection had been scheduled for later this month. This item was discussed with the facility Administrator, the ADPO and the DPOIT at the exit conference held on 04/07/25. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1) Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors within the facility. Findings include: Based on record review on 04/07/25 at 10:40 a.m. with the Acting Director of Plant Operations (ADPO) and the Director of Plant Operations in-training (DPOIT)., the sprinkler systems 5 year internal pipe investigation inspection document titled "Sprinkler System Inspection" completed by Koorsen Fire and Security dated 02/10/2020 was the only documentation available for review. Thie	K 0353	**Immediate Action** The Director of Plant Operations was educated by Executive Director on NFPA 25, Section 14.2.1 and sections 4.3.1, 4.3.2 and 5.2.5. The deficient practice had the potential to affect 36 residents, staff, and visitors. **Corrective Action** The Director of Plant Operations immediately scheduled 5-year sprinkler inspection and quarterly sprinkler inspection, which was completed on 4/16/25 by Koorsen Fire Security. **QAPI** The Director of Plant Operations or designee will audit that required sprinkler inspections are completed timely with documentation available in the Life Safety binder each month x6 months following completion of any work from outside vendor. The results of these audits will be presented by Executive Director to the QAPI committee for further recommendations and continue	04/24/2025

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	most recent inspection should have been completed by 02/10/2025. Based on an interview on 04/07/25 at 10:42 a.m., the ADPO stated that he had several issues with the sprinkler system and while they were being repaired, the internal pipe investigation was put off to a later date and time. The ADOP also agreed that as of the time of this survey, the internal obstruction investigation had not yet been scheduled. This item was discussed with the facility Administrator, the ADPO and the DPOIT at the exit conference held on 04/07/25. 3.1-19(b) 2) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.		until the Quality Assurance Team determines substantial compliance has been achieved.	

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	5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 04/07/25 at 10:35 a.m. with the Acting Director of Plant Operations (ADPO) and the Director of Plant Operations in-training (DPOIT)., documentation could not be provided for a quarterly sprinkler system inspection report available for the fourth quarter (October, November, and December) of 2024. Based on an interview on 04/07/25 at 10:37 a.m., the ADPO acknowledged there was no written documentation available to show the sprinkler system had been inspected during the fourth quarter of 2024. This item was discussed with the facility Administrator, the ADPO and the ADPOIT at the exit conference held on 04/07/25. 3.1-19(b)			