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 _____	C 01/19/2023

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 This visit was for the Investigation of Complaint IN00399133. Complaint IN00399133 - Substantiated. Federal/State deficiencies related to the allegation are cited at F689. Survey dates: January 19, 2023 Facility number: 004550 Provider number: 155736 AIM number: 200526450 Census Bed Type: SNF: 09 SNF/NF: 35 Residential: 24 Total: 68 Census Payor Type: Medicare: 08 Medicaid: 28 Other: 08 Total: 44 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 26, 2023.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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.

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 _____	C 01/19/2023

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 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's bed was fully assembled which resulted in the resident having a fall from the bed and sustaining a hip fracture for 1 of 3 residents reviewed for accidents. (Resident B) The isolated actual harm deficient practice began on January 10, 2023 when the facility failed to ensure a resident's bed was fully assembled. The deficient practice was corrected on January 12, 2023, prior to the start of the survey, and was therefore Past Noncompliance. Findings include: Resident B's clinical records were reviewed on January 19, 2023 at 9:55 a.m. Diagnoses included, but were not limited to cancer, coronary artery disease, heart failure, hypertension, diabetes mellitus, thyroid disorder, and seizure disorder. The admission Minimum Data Set (MDS) assessment, dated January 04, 2023, indicated Resident B was cognitively intact. When communicating she was able to understand others with clear comprehension. She could independently walk, with a walker, in her room with staff's supervision. She had fallen at home prior to her admission. A Fall Risk Review (non-dated, identified by the Director of Nursing as completed upon	F 689	Past noncompliance: no plan of correction required.	

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 _____	C 01/19/2023

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 689	Continued From page 2	F 689		

admission) indicated identified fall risks that included, but were not limited to a history of falls prior to admission within the past month, falls within the past two to six months and had an unsteady gait (unsteady when walking). The review indicated the resident was a moderate risk for falls.

A Care plan, with start date January 09, 2023, indicated Resident B was at risk for falling related to history of falls prior to admission. The care plan goal, dated through April 09, 2023, indicated Resident B would remain free of falls with major injury. Care approaches staff would implement to achieve the established goal indicated:

January 09, 2023 start date:
-Therapy would evaluate and treat as needed.
-Staff to assist with transfers as needed.
-Provide non-skid footwear.
-Keep personal items and frequently used items within reach.
-Keep call light within reach.
-Ensure the floor was free of liquids and foreign objects.
-Encourage resident to assume standing position slowly.

January 10, 2023 start date:
-Bed frame changed.

Resident B's progress notes indicated:

January 02, 2023 at 5:33 p.m., Resident was able to walk with a walker and stand by assistance. Resident would use a wheelchair for long distance.

January 03, 2023 at 9:45 a.m., "Physician Admit

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 _____	C 01/19/2023

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 689	Continued From page 3	F 689		

Note. Patient admitted for rehab following seizure and subdural hematoma [brain injury with bleeding]. Patient unsteady..."

January 06, 2023 at 2:51 a.m., Resident ambulated with a walker and unsteady gait.

January 10, 2023 at 8:45 a.m., "Writer called to room and notified that resident had a fall. ... Resident had complaints of left hip pain. ... N.O. [new order] received for left hip/pelvis x-ray...."

January 11, 2023 at 5:27 p.m., "IDT Review [review committee] - Resident noted with fall in her room. Resident stated she was standing up with walker and went to sit down on the end of the bed and slid off on to the floor...."

Resident B's left hip X-ray, dated January 10, 2023, indicated an intertrochanteric left femoral fracture (type of hip fracture).

Resident B's discharge hospital notes, dated January 15, 2023, indicated, " ...she sustained a fall in her room at [nursing home].... Her fall appeared to be mechanical in nature [attribute fall to extrinsic factors in the environment]. She was found to have a left hip fracture and was admitted to Orthopedic surgery service for management...."

During the interview, on January 19, 2023 at 10:45 a.m., Employee 13 indicated on the morning of January 10, 2023 she entered Resident B's room and observed her to be on the floor at the foot end of her bed. The mattress had slid off the bed and was hanging off the foot end

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 _____	C 01/19/2023

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 689	Continued From page 4	F 689		

of the bed. No foot board was on the bed and the two bottom corner mattress guards, that would secure the mattress in place, were gone. Employee 13 then alerted Employee 7 of the fall.

During the interview, on January 19, 2023 at 10:25 a.m., Employee 7 indicated on the morning of January 10, 2023 Employee 13 reported Resident B had fallen in her room. Employee 7 went to Resident B's room and observed the resident to be on the floor at the foot end of the bed. No foot board was on the bed and the two bottom corner mattress guards, that would secure the mattress in place, were gone. The mattress was observed to have slid down from the top of the bed and hung over the foot end of the bed drooping towards the floor. Resident B had reported she went to sit down and "the bed moved on me." Employee 7 checked the bed frame wheels and the wheels had been in the locked position and the bed had not moved, only the mattress had.

On January 19, 2023 at 1:10 p.m., Resident B's roommate (identified from resident room census dated January 10, 2023) was interviewed. During the interview, the roommate indicated Resident B's bed foot board had been removed prior to her being admitted. The roommate pointed out two resident closets and a chest of drawers on the right side of the room when walking into the room. The roommate had not been able to freely maneuver her wheelchair between the chest and closets and previous roommates (prior to Resident B) bed on the left side of the room. Staff had come to the room and removed the foot board to allow her independent mobility.

The roommate's clinical records were reviewed

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 _____	C 01/19/2023

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 689	Continued From page 5	F 689		

on January 19, 2023 at 1:00 p.m. The quarterly Minimum Data Set Assessment indicated the roommate was cognitively intact.

On January 19, 2023 at 9:35 a.m., Resident B's family was interviewed. During the interview, the family indicated since Resident B's first day of admission through January 10, 2023, the foot board of her bed had been missing. The mattress had slide down and would need to be pulled up to be correctly positioned on the bed frame. Staff were aware of this issue, as staff had been observed to slide the mattress up from the bottom of the bed to correctly center it on the frame.

During the interview, on January 19, 2023 at 11:15 a.m., the Administrator indicated Resident B's bed from January 10, 2023 had been removed and was no longer in use. A bed similar to the Resident B's bed was observed. During the observation, the Administrator pointed at the foot board of the bed and indicated the foot board had not been on the bed at the time of the fall. On the bed frame, at the corner foot ends were plastic cups that fit around the bottom corners of the mattress. The cups may have been missing, and not on the bed, at the time of the fall.

On January 19, 2023 at 1:25 p.m. the Administrator provided a copy of Trilogy Service Standards (non-dated). The Administrator indicated the standards are utilized as a check list to ensure room readiness for each new resident. A review of the check list indicated a " ...Plant Operations ... Furniture in good repair; Bed functions properly."

The Past Noncompliance isolated actual harm

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 _____	C 01/19/2023

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 689	Continued From page 6 deficient practice began on January 10, 2023. The deficient practice was removed corrected by January 12, 2023 after the facility implemented a systemic plan that included the following actions: -Resident B's bed was removed from service. -A facility wide bed audit was completed. -Staff were in-serviced on correct implementation of Trilogy Service Standards that included ensuring all furniture was in good repair and beds function properly. -Staff were in-serviced on correct implementation of immediately reporting and to whom of resident equipment in need of repair. -Administrative staff auditing resident beds weekly and monitoring of systemic plan. This Federal tag relates to Complaint IN00399133. 3.1-45(a)(1)	F 689		