PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155736		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/22/2024		
	PROVIDER OR SUPPLIEI		1014 M	ADDRESS, CITY, STATE, ZIP COD MILL POND LANE NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
R 0000	REGULATORY OF	K LSC IDENTIFFING INFORMATION	TAG		DA	.Е
Bldg. 00	IN00431685 and IN Complaint IN0043 to the allegations at R0048. Complaint IN0043: the allegations are of Survey date: April Facility number: 00 Residential Census These State Reside accordance with 41 Quality review con	1685 - State deficiencies related re cited at R0044, R0045, and 2056 - No deficiencies related to cited. 19 and 22, 2024 04550 s: 27 ential Findings are cited in 10 IAC 16.2-5. Inpleted on May 2, 2024.	R 0000	The submission of this plan of correction does not indicate ar admission by Mill Pond Health Campus that the findings and allegations contained herein at accurate, true representation of the quality of care provided, ar living environment provided to residents of Mill Pond Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as a matter of statute only. The facil respectfully requests from the department a desk review for substantial compliance.	re of nd the es and r. is the or o this a	
R 0044	410 IAC 16.2-5-1 Residents' Right	,,,				
Bldg. 00	failed to allow a res	view and interview, the facility sident to remain in the facility reviewed for discharges	R 0044	Residents C did not return to the facility. Discharged residents have to potential to be affected by the alleged deficient practice and	03/22	/2024

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

TITLE

(X6) DATE

Any defiency statement 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.

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 1 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155736	B. W	NG		04/22/	2024
				CTD FFT A	ADDRESS SITE OF THE SOL		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MILL DO	NID LIE AL TILLOANAE	21.0			ILL POND LANE		
MILL PO	ND HEALTH CAMP	708		GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					through alterations in processe	es	
	Finding includes:				and in servicing the campus w		
					ensure follow up with discharg		
	An Indiana State Department of Health Survey System report, dated 3/25/24 at 4:35 p.m.,				residents are completed timely		
					potential return to campus.	101	
	submitted by the facility indicated Resident C was				3. An in-service has been		
	1	eated on a shower chair in the			completed with Interdisciplinar	V	
	shower with lacerations to both wrists and was				team to ensure discharged	y	
	not responsive but still breathing. Staff applied				residents have follow up for re	turn	
	pressure to the lacerations, called 911/EMS				as warranted. As a measure o		
	(emergency medical services), first responders				ongoing compliance, director of		
	arrived and presumed care. The resident was				health services (DHS) or design		
	transported via EMS to the hospital for treatment.				will audit 5 residents weekly for	•	
	The resident was currently stable. A follow-up				1		
		d on 4/2/24 and indicated the			weeks, then every other week		
					months, and then monthly for 3 months to ensure discharged		
		treatment in an in-patient			_	£	
	nospital setting with	n psychiatric treatment.			residents have been reviewed		
	0 4/10/04 (2.10	1 D: (CN :			potential return to the campus		
		p.m., the Director of Nursing			4. As a quality measure, the D	HS	
	1 '	esident C was a danger to self			or designee will review any		
		itted to the facility for that			findings and corrective action		
		t had told the hospital to not			least quarterly and ongoing un		
		mentation from the hospital			campus achieves one hundred		
	1 -	The resident's son had			percent compliance in the cam	-	
	· ·	n that day, that his father and			Quality Assurance Performand		
		finances and the resident was			Improvement meetings. The p		
		or was running low, due to			will be reviewed and updated a	as	
	the facility fees, hos	spitalizations, doctor bills, and			warranted.		
	medications.						
	I	p.m., the DON indicated the					
		the hospital for the 72-hour					
	1 * *	hen the hospital started asking					
		to the AL (assisted living)					
		did not feel confident that the					
	resident was truly n	ot a danger to self. Corporate					
	policy, per corporat	te leadership, the AL did not					
	provide enough sup	pervision for the resident to be					
	safe at the facility.	The rationale for the financial					
	I -	ent for the resident. The					

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 2 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155736	A. BUILDING B. WING	00	COMPL 04/22/	ETED
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	facility believed the rationale for the self harm had to be cons and staff if the reside to the AL facility. To documentation nor a to confirm the reside. On 4/19/24 at 3:50 p Consultant (RN) 3 i when Resident C has observed the resider shower bench, with There was paperwood handwritten note on resident's room, whele of the consultant that the resident and the son would tell RN 3 what the resident and resident on the had and resident and back dated to 3/25/2 contacted by the host facility would not be needs, then later, in safety concern for stacility indicated the and residents. The finance calls when the facility, and the residents to have access to his kept coming up with could not be allower facility. The resident	financial situation was the financial situation was the financial situation was the financial for the other residents ent was allowed to come back the DON did not provide an interview from Resident C ent had financial concerns. D.m., Registered Nurse indicated she was at the facility did attempted suicide and at in his shower, seated on a the wounds on his wrists. The fix, medical bills, and a a bedside table in the fix indicated, "Too much [s-the left indicated, "Too much [s-the left indicated, "Too much [s-the left indicated, "Too much fix son took the note from RN inot give the note back nor remainder of the note stated. All interview, on 4/22/24 at 10:10 Resident C was transferred cospital medical unit until he in the hospital. The facility had reviction notice on 4/8/24 and the fixed the resident was a staff and other residents. The resident was a taff and other resident was a taff and other residents. The resident was a taff and other residents. The resident was a taff and other residents. The resident was a taff and other residents and taff and other residents. The resident was a taff and other residents and taff and ot				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 3 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	CON	TE SURVEY MPLETED 22/2024
	PROVIDER OR SUPPLIED		1014 M	ADDRESS, CITY, STATE, ZIP CO IILL POND LANE NCASTLE, IN 46135	DD I	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	suicide. The resider medical floor and to on his discharge fro facility. The resider admission into an A	the had attempted to commit that was currently in the hospital the hospital staff were working to me the hospital to an AL and the was safe and appropriate for AL facility at this time.				
	Manager (BOM) in morning meeting fithat the ADM had a home office that Recome back to the A sent out 30-day evibut she had never s documentation. The timely, and she had notices. A hospital	5 a.m., the Business Office dicated she had heard in from the Administrator (ADM) discussed with the corporate esident C was not allowed to L facility. BOM indicated she ction notices to the residents, ent the resident any e resident had paid his bills I not sent the resident any psychiatrist had called the oken to the DON about the				
	indicated the DON the facility was not back to the facility member come to ga from the facility. T facility the next we Resident C's belong to go back to the fa him that they were back to the facility. received any docum the resident's bed h transfer/discharge f During a telephone 12:40 p.m., Resider were looking into a	8 p.m., Resident C's family had called him and indicated going to accept Resident C and when would the family ather the resident's belongings he family member went to the ekend and retrieved all of gings. The resident had wanted cility, but the DON had told not able to accept the resident. The family member had not mentation or correspondence of old nor a notice of from the AL facility. conversation, on 4/22/24 at at C indicated the hospital staff another AL facility for the errom the hospital. He would				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 4 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 22/2024
	PROVIDER OR SUPPLIER		1014 M	ADDRESS, CITY, STATE, ZIP (IILL POND LANE NCASTLE, IN 46135	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	would not let him b was unsure why the to the facility. He w facility, but with all facility, he would ra had not received any about the bed hold in discharge. The hospite resident, on Friday today what he was gresident was going a hospital. The reside concerns about being RN 3, on 4/22/24 at required paperwork document), code state Notice of Transfer of Hold policy should discharge to the host when a resident was facility did not have procedure for the transfer to the hospithe State guidelines. Resident C's medica 4/19/24 at 11:32 a.m. not limited to, depre respiratory failure w (congestive obstruct disease that block as breathe), and CHF (chronic condition in pump blood as well.	al record was reviewed on n. Diagnoses included, but was ession, pain, acute and chronic with hypoxia, COPD tive pulmonary disease) (lung irflow and make it difficult to (congestive heart failure) n which the heart doesn't				
l			1	1		1

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 5 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE COMPI 04/22	LETED
	ROVIDER OR SUPPLIER		1014 M	ADDRESS, CITY, STATE, ZIP COD IILL POND LANE NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
	supervision as need					
	p.m., indicated Cert (CRMA) 7 on AL (nurse and stated she bathroom. Upon enshe observed staff whis wrists and a knin on the bar of soap. asked her to call 91 assistance, while Clwrists. Staff moved onto a blanket on the where we continued above his heart until The resident was the The medical record documentation of and depression, suicidal that would place Rein the facility at risk On 4/22/24 at 11:26 the Notice of Trans.	a.m., RN 3 provided a copy of fer or Discharge document for				
	spoken to the ADM Discharge documen the case manager at resident a copy. The ADM about the tran	/1/24, and indicated she had and the Notice of Transfer or it was emailed, on 4/8/24, to the hospital to give the chospital had contacted the asfer from the hospital back to ADM had indicated to the				
	hospital that the res other residents and days to appeal the d not respond to the a With the commotion	ident was a danger to self, staff, and the resident had 10 ischarge, but the resident did ppeal within the 10 days. In at the time of the suicide, staff had not provided the				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 6 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155736	B. W	ING		04/22/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				IILL POND LANE		
MILL POI	ND HEALTH CAMP	PUS			NCASTLE, IN 46135		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
		nentation of the notice of					
	_	e and had provided a copy for					
		give to him. The facility did					
	not have a policy for the transfer or discharge of a						
		have provided the Notice of					
		ge document and the Bed Hold					
		ident at the time of the					
	transfer to the hospi	tal.					
	This citation relates	to Complaint IN00431685.					
R 0045	410 IAC 16.2-5-1.2(r)(6-9)						
	Residents' Rights - Deficiency						
Bldg. 00							
	Based on record rev	riew and interview, the facility	R 0	045	1. Residents C, B, D suffered	no ill	05/22/2024
	failed to ensure bed	hold documentation and			effects from the alleged deficie	ent	
	notice of transfer or	discharge policies were			practice.		
	provided to the resid	dents and/or responsible			2. Residents who have been		
	parties at the time o	f the hospital transfers for 3 of			discharged to the hospital hav	е	
	3 residents reviewed	d for hospitalization (Residents			the potential to be affected by	the	
	C, B, and D).				alleged deficient practice. Like	;	
	Findings include:				residents have been audited to ensure required paperwork is		
					to the hospital with		
		Department of Health Survey			resident/family.		
		d 3/25/24 at 4:35 p.m.,			3 Nursing staff have been		
	•	cility indicated Resident C was			educated on sending required		
	observed by staff se	eated on a shower chair in the			paperwork per policy, including	g the	
		ions to both wrists and was			transfer/discharge/bed hold po		
	not responsive but s	still breathing. Staff applied			is sent with the residents upor	í	
	pressure to the lacer	rations, called 911/EMS			going to the hospital. As a		
	(emergency medica	l services), first responders			measure of ongoing compliand	ce,	
	arrived and presume	ed care. The resident was			the director of health services		
	transported via EMS	S to the hospital for treatment.			(DHS) or designee will audit 5		
	The resident was cu	rrently stable. A follow-up			residents weekly for 4 weeks,	then	
	statement was added	d on 4/2/24 and indicated the			every other week for 2 months	; ,	
	resident continued t	reatment in an in-patient			and then monthly for 3 months	s to	
	hospital setting with	n psychiatric treatment.			ensure the transfer/discharge/	bed	
					hold policy is sent with the		
	On 4/22/24 at 12:18	p.m., Resident C's family			residents upon going to the		

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 7 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 04/22	LETED
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CO	DD	
MILL PO	ND HEALTH CAME	PUS		NCASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ECTION DULD BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		tor of Nursing (DON) had cated the facility was not going		hospital. 4. As a quality measure	the DHS	
		C back to the facility and when		or designee will review		
		nember come to gather the		findings and corrective a		
		gs from the facility. The family e facility the next weekend and		least quarterly and ongo campus achieves one h	-	
		ident C's belongings. The		percent compliance in the		
		d to go back to the facility, but		Quality Assurance Perfo	•	
		nim that they were not able to		Improvement meetings.	•	
	•	back to the facility. The family		will be reviewed and up	dated as	
		ceived any documentation or the resident's bed hold nor a		warranted.		
	*	ischarge from the AL facility.				
	notice of transfer a	isonarge from the 712 facility.				
	During a telephone conversation, on 4/22/24 at					
	-	nt C indicated the hospital staff				
	-	nother AL facility for the				
	_	from the hospital. He would				
	-	ne facility, but the facility				
		eack to the facility. The resident ey would not let him come back				
	-	would like to come back to the				
	-	I that has gone on with the				
	-	ather go to another facility now.				
	-	d any paperwork from the				
		ed hold nor a notice of transfer				
	or discharge.					
	Registered Nurse C	Consultant (RN) 3, on 4/22/24 at				
	_	I the required paperwork of the				
	-	Care document), code status,				
	,	Notice of Transfer or				
		d the Bed Hold policy should				
	_	ent prior to discharge to the				
	•	the hospital, when a resident				
		pital. The facility did not have				
	a written policy and	-				
		of an AL resident to the				
	-	cility followed the State				
	guidelines.					

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 8 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

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	PROVIDER OR SUPPLIEF		1014 M	ADDRESS, CITY, STATE, ZIP COE ILL POND LANE ICASTLE, IN 46135)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLETION
	4/19/24 at 11:32 a.r not limited to, depre respiratory failure v (congestive obstruct disease that block a breathe), and CHF (chronic condition in pump blood as well Resident C's semiar 1/24/24, indicated t intact, was independent activities of daily lisupervision as need A nurse's progress in p.m., indicated Cert (CRMA) 7 on AL (nurse and stated she bathroom. Upon enshe observed staff v his wrists and a knii on the bar of soap. asked her to call 91 assistance, while Cl wrists. Staff moved onto a blanket on the where we continued above his heart until The resident was the The medical record hold policy or other documentation was time of the transfer.	nnual service plan, dated he resident was cognitively dent with mobility and most ving with escort and/or ed. note, dated 3/25/24 at 7:12 cified Resident Medication Aide assisted living) had called the e needed help in Resident C's tering the resident's bathroom, with Resident C bleeding from fe laying open with blood on it The nurse called the DON and 1/EMS, got additional staff RMA 7 held pressure on both the resident from the shower the bathroom floor on his back it to hold pressure and elevated 1 EMS arrived to take over. en transferred to the hospital. lacked documentation the bed transfer or discharge provided to the resident at the			
i	I are rouse of frails	ioi oi Discharge accument for	I	I	

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 9 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY LETED 2/2024
	PROVIDER OR SUPPLIEF		1014 M	ADDRESS, CITY, STATE, ZIP CO IILL POND LANE NCASTLE, IN 46135	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Resident C, dated 4 spoken to the ADM Discharge documer the case manager at resident a copy. The ADM about the traithe AL facility. The hospital that the resother residents and days to appeal the donot respond to the a With the commotion attempt, on 3/25/24 resident with document ansfer or discharge the case manager to not have a policy for resident but should Transfer or Dischard document to the restransfer to the hospital. During a confidentian, they indicated and resided on the laward discharged from sent the resident and back dated it to 3/2: 14 days before the chospital. 2. An Indiana State System report, date by the facility indicassisted living (AL) in the activity room Resident B was their toward the floor. No large amount of brigaries.	All/24, and indicated she had and the Notice of Transfer or at was emailed, on 4/8/24, to the hospital to give the chospital had contacted the asfer from the hospital back to ADM had indicated to the ident was a danger to self, staff, and the resident had 10 discharge, but the resident did ppeal within the 10 days. In at the time of the suicide and had provided the mentation of the notice of e and had provided a copy for give to him. The facility did or the transfer or discharge of a have provided the Notice of ge document and the Bed Hold ident at the time of the				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 10 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY TPLETED 22/2024
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	party and medical d Medical Services (F	ded to the fall. The responsible octor notified. Emergency EMS) called and transported ospital for evaluation and				
	9:04 a.m. Diagnose to, essential (primar pressure), edema, v.	was reviewed on 4/22/24 at s included, but were not limited by) hypertension (high blood ascular dementia with anxiety.				
	12/15/23, indicated severely impaired a	nnual service plan, dated the resident was cognitively nd was dependent on staff for vities of daily living.				
	indicated Resident I in the activity room per the other resider and fell straight bac the fall and immedi	with another resident, when he walker with another resident, when he, Resident B got very pale k onto the floor. Staff heard he ately came to the room. The stroom Resident				
	B was agonal breatl verbal or physical s reactive. Do not res time. Vital signs ob pressure noted. Res amount of bright re-	ning and not responding to timulation and pupils were not uscitate status verified at this tained with elevated blood ident B began to vomit a large d blood and was turned on to esident B's emergency contact				
	was notified and asl hospital for evaluati medical service) wa bright red blood 2 n ambulance to arrive the resident's nose a noted to the back of ice pack applied to	seed to send the resident to the son. 911/EMS (emergency is called. Resident B vomited more times while waiting on the self-blood was also coming from and a large hematoma was of the resident's head with an the hematoma. Resident B did some questions and stated she				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 11 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SI COMPLE 04/22/2	TED
	PROVIDER OR SUPPLIER		1014 M	ADDRESS, CITY, STATE, ZIP CO IILL POND LANE NCASTLE, IN 46135	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	p.m. and placed a c her onto the stretch at this time for the department. A copy	of the resident's CCD document) and DNR (do not				
	hold policy or other	lacked documentation the bed transfer or discharge provided to the resident at the to the hospital.				
	Consultant (RN) 3 paperwork of the C document), code standard results and to discharge to the hospital, when a result of the facility did not procedure for the tresident to the hospithe State guidelines unable to find the N	p.m., Registered Nurse indicated, the required CD (continuity of care atus, advanced directive, or Discharge form, and the Bed be given to the resident prior hospital and sent to the sident was sent to the hospital. have a written policy and ansfer/discharge of an AL ital, but the facility followed a RN 3 indicated, she was lotice of Transfer or Discharge				
	3. An Indiana State System report, date submitted by the fa (AL) Resident D st lost footing, and fel the fall, Resident D hip/leg. Resident D emergency room to Verbal report of co AL facility on 4/17 hospital indicated F	Department of Health Survey d 4/17/24 at 3:10 p.m., cility indicated, assisted living bod up from the wheelchair, l in the AL common area. After complained of pain to the right was sent to the hospital x-ray for possible fracture. Infirmed fracture provided to the desident D was not a candidate intion. The facility will address				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 12 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/22/2024
	PROVIDER OR SUPPLIER		1014 M	ADDRESS, CITY, STATE, ZIP COD IILL POND LANE NCASTLE, IN 46135	•
	ı			, T	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO	PRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DETCIENCT	DATE
	status upon return to	o the campus.			
	4/22/24 at 9:25 a.m	al record was reviewed on . Diagnoses included, but were na, dementia, low back pain, blood pressure).			
	Resident D's semiar	nnual service plan, dated			
		he resident was cognitively			
		was dependent on staff for			
		vities of daily living, and			
		d memory care unit in the			
	assisted living (AL)) facility.			
	p.m., indicated the memory care unit d Resident D was obs her bottom, leaning side. The resident w common area, lost h	note, dated 4/16/24 at 6:30 nurse was called to the secured ue to Resident D having a fall. served on the floor, sitting on against the desk on her right was up walking around in the her footing and fell. Initially Slow to allow the nurse to do			
		no shortening of extremities			
		fter assessment and the			
		d up and back into her			
		n complained of pain to right			
	hip/leg. A call was	placed to the resident's spouse			
		. Informed him that the resident			
	_	ng of pain and asked if spouse			
		be sent to hospital emergency			
	` ′	uation and x-rays. Resident D's			
	_	e preferred the x-rays be done			
		bile unit versus going to the			
	•	eed to the medical doctor (MD)			
		ident and the family wishes.			
	_	ray right hip/leg and pelvis. A			
	_	he x-ray team and ordered			
		. A return call was received			
		approximately an hour later hey could be at the facility			
I	i stating the earnest t	ncy could be at the facility	1	i e	

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 13 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155736	A. BUILDING B. WING	00 00	COMP	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIER		1014 M	ADDRESS, CITY, STATE, ZIP COD ILL POND LANE ICASTLE, IN 46135		
(X4) ID	ı		ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	COMPLETION DATE
	would be in the mor	rning. The family was given an				
	EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION would be in the morning. The family was given an update about x-rays. A nurse's progress note, dated 4/16/24 at 11:26 p.m., indicated the nurse was called to the secured memory unit, family wanted to speak to a nurse. Upon entering the unit, the staff advised the nurse of the resident's fall. The family voiced concerns of the resident's low blood pressure and low oxygen saturation. Resident D was very anxious at the present time with a pale pallor and complaints of extreme pain to the right lower extremity and right foot and noted swelling to right knee. Received orders to do an in-house right hip x-ray. The family was okay with sending the resident out to hospital emergency department (ED) due to the amount of pain the resident was experiencing and for complaints of chest pain. A nurse's progress note, dated 4/16/24 at 11:38 p.m., indicated 911/EMS (emergency medical services) was call for ambulance to transport Resident D to the ED. A nurse's progress note, dated 4/16/24 at 11:42 p.m., indicated Resident D observed exiting the facility on a stretcher via assistance by two EMT and a nurse to the hospital ED. A nurse's progress note, dated 4/17/24 at 2:28 a.m., indicated the nurse had received an update on Resident D from the hospital. Resident D would be admitted to the hospital. Resident D would be admitted to the hospital with pneumonia, low oxygen saturation, and suspicious right knee fracture. The medical record lacked documentation the bed hold policy or other transfer or discharge documentation was provided to the resident at the time of the transfer to the hospital.					

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 14 of 20

09/27/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/22/2024 155736 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1014 MILL POND LANE MILL POND HEALTH CAMPUS GREENCASTLE. IN 46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE On 4/22/24 at 2:56 p.m., Registered Nurse Consultant (RN) 3 indicated, the required paperwork of the CCD (continuity of care document), code status, advanced directive, Notice of Transfer or Discharge form, and the Bed Hold policy should be given to the resident prior to discharge to the hospital and sent to the hospital, when a resident was sent to the hospital. The facility did not have a written policy and procedure for the transfer/discharge of an AL resident to the hospital, but the facility followed the State guidelines. RN 3 indicated, she was unable to find the Notice of Transfer or Discharge and Bed Hold documentation for Resident D. This citation relates to Complaint IN00431685. R 0048 410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency Bldg. 00 Based on record review and interview, the facility R 0048 1. Residents C did not return to 05/22/2024 failed to ensure a relocation plan was prepared for the facility. the relocation and to provide continuity of care 2. Discharged residents have the for a resident for 1 of 3 residents reviewed for potential to be affected by the discharges (Resident C). alleged deficient practice and through alterations in processes Finding includes: and in servicing the campus will ensure follow up with discharged An Indiana State Department of Health Survey residents are completed timely for System report, dated 3/25/24 at 4:35 p.m., potential return to campus. submitted by the facility indicated Resident C was 3. An in-service has been observed by staff seated on a shower chair in the completed with Interdisciplinary shower with lacerations to both wrists and was team to ensure discharged not responsive but still breathing. Staff applied residents have follow up for return pressure to the lacerations, called 911/EMS as warranted. As a measure of (emergency medical services), first responders ongoing compliance, director of

6DKZ11 Event ID: Facility ID: 004550 If continuation sheet Page 15 of 20 State Form

health services (DHS) or designee

weeks, then every other week for 2

will audit 5 residents weekly for 4

arrived and presumed care. The resident was

transported via EMS to the hospital for treatment.

The resident was currently stable. A follow-up

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155736		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/22/2024
	PROVIDER OR SUPPLIER ND HEALTH CAMPUS	1014 M	ADDRESS, CITY, STATE, ZIP COD ILL POND LANE ICASTLE, 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
140	statement was added on 4/2/24 and indicated the resident continued treatment in in-patient hospital setting with psychiatric treatment. On 4/19/24 at 2:10 p.m., the Director of Nursing (DON) indicated, Resident C was a danger to self and was not re-admitted to the facility for that reason. The resident had told the hospital to not to provide the documentation from the hospital stay to the facility. The resident's son had indicated to staff, on that day, that his father and him had discussed finances and the resident was almost out of funds or was running low, due to the facility fees, hospitalizations, doctor bills, and medications. On 4/19/24 at 2:57 p.m., the DON indicated, the resident was not at the hospital for the 72-hour psychiatric hold, when the hospital started asking for the readmission to the AL (assisted living) facility. The facility did not feel confident that the resident was truly not a danger to self. Corporate policy, per corporate leadership, the AL did not provide enough supervision for the resident to be safe at the facility. The rationale for the financial stress was still present for the resident. The facility believed the financial situation was the rationale for the self-harm attempt. Psychological harm had to be considered for the other residents and staff if the resident was allowed to come back to the AL facility. On 4/19/24 at 3:50 p.m., Registered Nurse Consultant (RN) 3 indicated, she was at the facility when Resident C had attempted suicide and observed the resident in his shower, seated on a shower bench, with the wounds on his wrists. There was paperwork, medical bills, and a handwritten note on a bedside table in the resident's room, which indicated, "Too much [s		months, and then monthly for months to ensure discharged residents have been reviewed potential return to the campus 4. As a quality measure, the D or designee will review any findings and corrective action least quarterly and ongoing uncampus achieves one hundred percent compliance in the cam Quality Assurance Performance Improvement meetings. The p will be reviewed and updated a warranted.	for . HS at til d npus ce

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 16 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	- I	SURVEY LETED 2/2024		
	PROVIDER OR SUPPLIEF		1014 M	STREET ADDRESS, CITY, STATE, ZIP COD 1014 MILL POND LANE GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE		
	note but the residen 3 and the son would	dle" with more written on the t's son took the note from RN d not give the note back nor remainder of the note stated.						
	a.m., they indicated and resided on the I was discharged from sent the resident and back dated to 3/25/2 contacted by the hod facility would not be needs, then later, in safety concern for sefacility indicated the and residents. The facility indicated the and residents. The facility, and the resident to have access to his kept coming up with could not be allowed facility. The resident at the facility on time another facility on time another facility indicated. The resident medical floor and the on his discharge from facility. The resident admission into an ACON 4/22/24 at 10:55 Manager (BOM) in morning meeting from that the ADM had come office that Recome back to the Acone back and never see the see that Recome back to the Acone back to the	-						
	sent out 30-day evid	ction notices to the residents,						

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 17 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	E SURVEY PLETED 2/2024	
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS		1014 M	STREET ADDRESS, CITY, STATE, ZIP COD 1014 MILL POND LANE GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	notices. A hospital facility and had sporesident.	not sent the resident any psychiatrist had called the ken to the DON about the					
	indicated, the DON the facility was not back to the facility member come to ga from the facility. The	had called him and indicated going to accept Resident C and when would the family ther the resident's belongings are family member went to the ekend and retrieved all of					
	Resident C's belong to go back to the fac him that they were back to the facility. received any docum	rings. The resident had wanted cility, but the DON had told not able to accept the resident The family member had not nentation or correspondence of					
	_	rom the AL facility. The family icate the facility provided a					
	12:40 p.m., Resider were looking into a resident's discharge like to go back to th would not let him b was unsure why the	conversation, on 4/22/24 at at at C indicated, the hospital staff mother AL facility for the from the hospital. He would be facility, but the facility ack to the facility. The resident by would not let him come back would have liked to go back to					
	the facility, but with facility, he would ra The resident had no regards to a dischar He had not received facility about the be or discharge. The he	a all that has gone on with the other go to another facility now. It heard from the facility in ge plan for continuity of care. If any paperwork from the other deal hold nor a notice of transfer pospital doctor had told the					
	today what he was	4/19/24, that he should know going to do and where the after the discharge from the					

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 18 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE GREENCASTLE, IN 48135 GREENCASTLE, IN 48135 CAMPETIC GREEN ON MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION hospital. Resident C's medical record was reviewed on 41/92/4 at 11:32 am. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPP (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathy, and CHT (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on Al. (assisted living) had called the nurse and stated she needed help in Resident C's bathroom. Upon entering the resident's halmroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bar of soap. The nurse called the DON and asked her to call 91 IzMS, got additional staff assistance, white (RMA 7 held pressure on both wrists. Staff moved the resident from the shower onto as blanket on the bathroom (Bore on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over, The resident was then transferred to the hospital. The medical record lacked documentation of a discharge or relocation plan for the resident. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of the Notice of Transfer or Discharge document for		IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 04/22			
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION Resident C's medical record was reviewed on 4/19/24 at 11:32 a.m. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPP (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathe), and CHF (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on Al. (assisted living) had called the muse and stated she needed help in Resident C's bathroom. Upon entering the resident's bathroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bur of soap. The nurse called the DON and asked her to call 91/14/58, go additional staff assistance, while CRMA 7 held pressure on both wrists. Staff moved the resident from the shower onto a blanket on the bathroom floor on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over. The resident was then transferred to the hospital. The medical record lacked documentation of a discharge or relocation plan for the resident. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of				1014 M	1014 MILL POND LANE				
4/19/24 at 11:32 a.m. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPD (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathe), and CHF (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on AL (assisted living) had called the nurse and stated she needed help in Resident C's bathroom. Upon entering the resident's bathroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bar of soap. The nurse called the DON and asked her to call 911/EMS, got additional staff assistance, while CRMA 7 held pressure on both wrists. Staff moved the resident from the shower onto a blanket on the bathroom floor on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over. The resident was then transferred to the hospital. The medical record lacked documentation of a discharge or relocation plan for the resident. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of	PREFIX	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL	LD BE	COMPLETION		
Resident C, dated 4/1/24, and indicated she had		4/19/24 at 11:32 a.mot limited to, depressive obstruction disease that block a breathe), and CHF (chronic condition in pump blood as well Resident C's semian 1/24/24, indicated to intact, was independent of the condition of the	m. Diagnoses included, but was ession, pain, acute and chronic with hypoxia, COPD tive pulmonary disease) (lung irflow and make it difficult to (congestive heart failure) in which the heart doesn't as it should). mual service plan, dated he resident was cognitively dent with mobility and most ving with escort and/or ed. mote, dated 3/25/24 at 7:12 tiffed Resident Medication Aide assisted living) had called the eneeded help in Resident C's tering the resident's bathroom, with Resident C bleeding from fe laying open with blood on it The nurse called the DON and 1/EMS, got additional staff RMA 7 held pressure on both the resident from the shower he bathroom floor on his back it to hold pressure and elevated al EMS arrived to take over. en transferred to the hospital. lacked documentation of a tion plan for the resident for Discharge document for						

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 19 of 20

PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155736	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS			1014 M	ADDRESS, CITY, STATE, ZIP COD IILL POND LANE NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	spoken to the ADM and the Notice of Transfer or Discharge document was emailed, on 4/8/24, to the case manager at the hospital to give the resident a copy. The hospital had contacted the ADM about the transfer from the hospital back to the AL facility. The ADM had indicated to the hospital that the resident was a danger to self, other residents and staff, and the resident had 10 days to appeal the discharge, but the resident did not respond to the appeal within the 10 days. With the commotion at the time of the suicide attempt, on 3/25/24, staff had not provided the resident with documentation of the notice of transfer or discharge and had provided a copy for the case manager to give to him. The document lacked a discharge plan for continuity of care for the resident.				

State Form Event ID: 6DKZ11 Facility ID: 004550 If continuation sheet Page 20 of 20