PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		155736	B. WING _			C 07/24/2024	
NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, Z 1014 MILL POND LANE GREENCASTLE, IN 46135	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	INITIAL COMMENTS	3	F	000			
	This visit was for the IN00437687.	Investigation of Complaint					
		87 - Federal/state deficiency ions are cited at F600.					
	Survey dates: July 2	4, 2024					
	Facility number: 004 Provider number: 15 AIM number: 200526	5736					
	Census Bed Type: SNF/NF: 51 Residential: 27 Total: 78						
	Census Payor Type: Medicare: 8 Medicaid: 29 Other: 41 Total: 78						
	This deficiency reflect accordance with 410	ets State Finding cited in IAC 16.2-3.1.					
F 600 SS=D	Quality review complete from Abuse and CFR(s): 483.12(a)(1)		F6	600			
	Exploitation The resident has the neglect, misappropriand exploitation as dincludes but is not lin corporal punishment	om Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and		TITLE		(VS) DATE	

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

TLE (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.

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sical or cher resident's r (a) The facil (a)(1) Not us abuse, corpary seclusion QUIREMEN on record realled to ensurable facility acts for 1 of 3 and 8). The dod on 7/5/24, and was the includes: (24 at 9:45 and was the includes: (25 at 9:45 and was the includes: (26 at 9:45 and was the includes: (27 at 9:45 and was the includes: (28 at 9:45 and was the includes: (29 at 9:45 and was the includes: (20 at 9:45 and was the includes: (21 at 9:45 and was the includes: (22 at 9:45 and was the includes: (24 at 9:45 and was the includes: (25 at 9:45 and was the includes: (26 at 9:45 and was the includes: (27 at 9:45 and was the includes: (28 at 9:45 and was the includes: (29 at 9:45 and was the includes: (29 at 9:45 and was the includes: (20 at 9:45 and was the includes: (21 at 9:45 and was the includes: (22 at 9:45 and was the includes: (24 at 9:45 and was the includes: (25 at 9:45 and was the includes: (26 at 9:45 and was the includes: (27 at 9:45 and was the includes: (28 at 9:45 and was the includes: (29 at 9:45 and was the includes: (40 at 9:45 and was the includes: (41 at 9:45 and was the includes: (42 at 9:45 and was the includes: (43 at 9:45 and was the includes: (44 at 9:45 and was the includes: (45 at 9:45 and was the includes: (45 at 9:45 and was the includes: (46 at 9:45 and was the includes: (47 at 9:45 and was the includes: (48 at 9:45 and was the incl	mical restraint not required to nedical symptoms. ity must- se verbal, mental, sexual, or coral punishment, or n; T is not met as evidenced view and interviews, the great that a staff member abuse policy and cell phone residents reviewed for abuse efficient practice was prior to the start of the refore past noncompliance. a.m., a review of an Indiana and (IDOH) Reportable Incident (29/24 at 9:30 p.m., indicated fare Assistant (CRCA) 9 social media platform with an and in the restroom. The video indicating, "this woman will and the employee was face while holding up her can and the social media gation began. ion summary, dated 6/29/24 at the data a social media video was income and a video was incom	F 6		of		
The second of th	R SUPPLIER H CAMPUS SUMMARY SEACH DEFICIEN EGULATORY OF ed From pagesical or chere e resident's re- electron pagesical or chere expected and the facility acceptance of the facility	IDENTIFICATION NUMBER: 155736 R SUPPLIER H CAMPUS SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) ed From page 1 rsical or chemical restraint not required to e resident's medical symptoms. P(a) The facility must- P(a) (1) Not use verbal, mental, sexual, or a labuse, corporal punishment, or ary seclusion; EQUIREMENT is not met as evidenced on record review and interviews, the ailed to ensure that a staff member of the facility abuse policy and cell phone cy for 1 of 3 residents reviewed for abuse and on 7/5/24, prior to the start of the and was therefore past noncompliance.	IDENTIFICATION NUMBER: A. BUILDIN B. WING_ SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) Ed From page 1 Sical or chemical restraint not required to be resident's medical symptoms. E(a) The facility must- E(a)(1) Not use verbal, mental, sexual, or labuse, corporal punishment, or arry seclusion; EQUIREMENT is not met as evidenced on record review and interviews, the ailed to ensure that a staff member of the facility abuse policy and cell phone cy for 1 of 3 residents reviewed for abuse and on 7/5/24, prior to the start of the and was therefore past noncompliance. includes: E/24 at 9:45 a.m., a review of an Indiana nent of Health (IDOH) Reportable Incident ent, dated 6/29/24 at 9:30 p.m., indicated do a resident in the restroom. The video and a caption indicating, "this woman will leath of me," and the employee was a grimacing face while holding up her finger. The CRCA was immediately ded upon the report of the social media and an investigation began. of investigation summary, dated 6/29/24 to m.m., indicated that a social media video was of a resident in the background and CRCA naking hand gestures in the background.	TIDENTIFICATION NUMBER: 155736 R SUPPLIER H CAMPUS SIMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SACH DEFICIENCY MUST BE PRECEDED BY FUILL EGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) F 600 F 600 F 600 F 600 F 600 F 600 Page ENCASTLE, IN 46135 PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) F 600 F 600 F 600 F 600 F 600 F 600 Page ENCASTLE, IN 46135 F 600 F 600	The facility must- (a) (1) Not use verbal, mental, sexual, or labuse corporal punishment, or any seclusion; QUIREMENT is not met as evidenced on record review and interviews, the ailed to ensure that a staff member of 10 if 3 residents reviewed for abuse and was therefore past noncompliance. includes: (2/24 at 9-45 a.m., a review of an Indiana ment of Health (IDOH) Reportable Incident mit, dated 6/29/24 at 9-30 p.m., indicated 14 as a sident on a social media platform with an flable resident in the restroom. The video ad a caption indicating, "this woman will leath of me," and the employee was a grimacing face while holding up her inger. The CRCA was immediately ded upon the report of the social media and investigation summary, dated 6/29/24 tp.m., indicated that a staff member of the ED that a social media platform with an flable resident in the rescription. (a) the facility and the employee was a grimacing face while holding up her inger. The CRCA was immediately ded upon the report of the social media and continued and an investigation summary, dated 6/29/24 tp.m., indicated that a staff member of the ED that a social media platform with an flable resident in the background.	

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F 600	initiated with active was identified through suspended employer as the one in the viot the resident had been and medical doctor interviewed CRCA sivilating the facility's was terminated from residents had a hear completed and residents. Resident B's record 1:23 p.m. The profiled diagnosis included, depression (a mental person's thoughts, for well-being), genen (severe, ongoing an activities), and Alzhethat destroys memor functions). A Brief Interview for assessment complete resident had severe During an interview, Dementia Care Directof the incident that devening shift, but she evening. The Demenshe did not see the seen to other co-we hear that it had occurred.	ge 2 6/30/24 abuse education was staff. On 7/1/24 the resident gh an interview with the lee. Resident B was identified leo. Once an identification of en made the responsible party was informed. The facility of and she admitted to a sabuse policy. The CRCA in her position at the facility. All deto-toe skin assessment lents with a BIMS above 8 ducation was provided to all was reviewed on 7/24/24 at le indicated the resident's but were not limited to, al state that can affect leelings, behaviors, and sense ralized anxiety disorder exiety that interferes with daily leimer's (a progressive disease ry and other important mental left on 5/28/24, indicated the cognitive impairment. On 7/24/24 at 11:10 a.m., the coor indicated she was aware leccurred on 6/29/24 on the left was not working that intia Care Director indicated social media post that CRCA orkers and was surprised to larred. The Dementia Care lare of the employee having	F 600			

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F 600	Director indicated al hired on cell phone media. During an interview, Certified Residentia indicated she was media video after the her the video and so personally. CRMA 4 to hear that it had on the staff member every before. Staff were en onboarding training what not to post on the video on a socoworkers which was Director (ED) on 6/2 in the video was not a poor choice and we be poor to be poor choice and we poor choice and w	y issues. The Dementia Care I staff were educated when usage and posting on social on 7/24/24 at 11:15 a.m., the I Medication Aide (CRMA) 4 hade aware of the social e fact. CRCA 9 had not sent of therefore she had not seen it indicated she was shocked occurred and was not aware of er doing anything like that ducated during their about cell phone use and social media. on 7/24/24 at 11:31 a.m., the insultant indicated CRCA 9 had platform to her is reported to the Executive 19/24. The resident who was identifiable. The CRCA made was terminated for her actions.	F 60			
	the post. The social	with this staff member prior to media video was sent to describe to the ED.				

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F 600	Continued From paç	ge 4	F 600			
	Social Service Direct aware of the social representally. Resident days after the instart any psychological of resident was not cool resident was initiated CRCA 9 when was initiated with current continue ongoing. To compliance by intervention weekly times 4	dic Event form, dated 7/1/24 ras having a bad day and making a video and posting it atform. Immediate education rrent staff members and will				
	6/30/24 and 7/1/24,	vice sign-up sheet, dated indicated staff were educated hone usage. The sign-up staff signatures.				
	_	on 7/24/24 at 2:15 p.m., the A 9 was terminated from her				
	Consultant provided 2023, titled, "Cell Pr Electronic Devices," policy currently bein policy indicated, " phones and other el prohibited in work al	a.m., the Regional Nurse a document, dated June nones, Cameras, and and indicated it was the g used by the facility. The b. Use of personal cell ectronic devices are strictly reasc. The unauthorized camera or other electronic				

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F 600	device to photograph and/or his/her person accommodations and resident's or designar consent is prohibited On 7/24/24 at 11:35 a Consultant provided a date of 8/29/29, titled Procedural Guideline policy currently being policy indicated, "l. include keeping and/humiliating photograp social media or multing the deficient practice after the facility imples included the following assessment of all resigns-servicing education	or record any resident hal space, including dispersonal care, without the ted representative's written" a.m., the Regional Nurse a document, with a revised pused by the facility. The social Media - This would be or distributing demeaning or one and recordings through media messaging" a.w. was corrected by 7/5/24 amented a systemic plan that gractions: head to toe skin sidents, interviews were dents with a BIMS over 8, and ongoing monitoring by and Performance	F	500			