| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155736 | A. Building<br>B. Wing | 08/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mill Pond Health Campus | 1014 Mill Pond Lane<br>Greencastle, IN 46135 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review and interview, the facility failed to develop a care plan for the resident's respiratory durable medical equipment, a cough assist device and a suctioning device, for 1 of 3 residents reviewed for quality of care. (Resident B)Findings include:A clinical record review for Resident B was completed on 8/19/25 at 10:26 a.m. Diagnoses included amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease), dysphagia (difficulty swallowing), rheumatoid arthritis, depression, and anxiety. The resident was admitted to the facility from her home on 7/15/25 and was receiving hospice services. An admission Minimum Data Set (MDS) assessment, dated 7/21/25, indicated the resident was cognitively intact, was unable to speak, understood others and was able to be understood. The resident required substantial to maximal assistance for dressing, bed mobility, and personal hygiene. She was dependent on staff for assistance with transfer, wheelchair mobility, showering, toileting, A nursing progress note, dated 7/15/25 at 9:17 p.m., included the resident was alert and oriented and communicated by using a whiteboard. She utilized a ventilator machine at night and had an airway clearance device at bedside.The resident's care plan lacked a problem, goal, or approach regarding the resident's ventilator machine, airway clearance device (suctioning), and cough assist device.During an interview on 8/19/25 at 2:18 p.m., the Director of Nursing (DON) indicated the resident had been using the respiratory equipment at home and had used them in the facility on her own. The staff had not been in-serviced regarding the cough assist device or the ventilator machine that she used at night. There was a staff member that worked most days on her hall that was familiar with the ventilator machine. The resident's care plan lacked an entry regarding her respiratory devices. During an interview on 8/19/25 at 5:05 p.m., the Corporate Nurse Consultant indicated the equipment was her preference to use. She had brought them from home and used them as needed. The hospice care plan indicated that hospice was responsible for medical supplies. The facility had not entered a care plan for the cough assist device or the suctioning device.A current facility policy, revised 8/21/24, titled, 48 Hour Baseline Care Plan Guidelines, provided by the Corporate Nurse Consultant on 8/19/25 at 5:11 p.m. , included the following: Procedure .5. Any changes to the residents care will be care planned accordingly until the comprehensive care plan is developed and then will be included on the comprehensive care plan. This citation relates to Intake 2584408.3.1-35(a) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155736 | A. Building<br>B. Wing | 08/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mill Pond Health Campus | 1014 Mill Pond Lane<br>Greencastle, IN 46135 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>Based on record review and interview, the facility failed to obtain physician's orders or the assessment for the use of a cough assist device and an airway clearance device (suctioning) for 1 of 4 residents reviewed for quality of care. (Resident B)Findings include:A clinical record review for Resident B was completed on 8/19/25 at 10:26 a.m. Diagnoses included amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease), dysphagia (difficulty swallowing), rheumatoid arthritis, depression, and anxiety. The resident was admitted to the facility from her home on 7/15/25 and was receiving hospice services. An admission minimum data set (MDS) assessment, dated 7/21/25, indicated the resident was cognitively intact, was unable to speak, understood others and was able to be understood. The resident required substantial to maximal assistance for dressing, bed mobility, and personal hygiene. She was dependent on staff for assistance with transfer, wheelchair mobility, showering, and toileting. A nursing progress note, dated 7/15/25 at 3:23 p.m. included the resident was alert and oriented and used a whiteboard for communication. The resident had a gastric tube and received supplement five times a day. Resident orders had been entered. A nursing progress note, dated 7/15/25 at 9:17 p.m., included the resident was alert and oriented and communicated by using a whiteboard. She utilized a ventilator machine at night and had an airway clearance device at bedside.The physician's orders lacked an order for an airway clearance device or a cough assist device. During an interview on 8/19/25 at 2:18 p.m., the Director of Nursing (DON) indicated there should have been physician orders regarding the resident's cough assist device and airway clearance device (suctioning). The resident had used the devices as needed. The resident had been using the respiratory equipment at home and had used them in the facility on her own. The resident's care plan lacked an entry regarding her respiratory devices. During an interview on 8/19/25 at 5:05 p.m., the Corporate Nurse Consultant indicated the equipment was her preference to use. She had brought them from home and used them as needed. The hospice care plan indicated that hospice was responsible for medical supplies. The facility had not entered a care plan or physician orders for the cough assist device or the suctioning device. No policy was provided prior to the exit conference. The Corporate Nurse Consultant indicated there was no specific policy regarding physician orders. This citation relates to Intake 2584408.3.1-37(a) |