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	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Pond Health Campus	1014 Mill Pond Lane 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on observation, interview, and record review, the facility failed to ensure a physician order was obtained for a Tubigrip (a tubular bandage that provides support for sprains, strains, swelling, and more) for 1 of 1 resident reviewed for limited range of motion (Resident 32). Findings include: During the initial pool observation, on 2/28/25 at 10:46 a.m., Resident 32 was sitting up in bed eating breakfast and a dressing was noted on the resident's left arm from her hand to up past her elbow. The resident indicated the wrap had been on her left arm for a while because she banged it on the side rail of her bed, and she was unable to use her left arm normally. Resident 32's record was reviewed on 3/3/25 at 10:18 a.m. The profile indicated the resident's diagnosis included, but were not limited to, brain mass (a cancerous or noncancerous mass or growth of abnormal cells in the brain), Alzheimer's disease with early onset (when Alzheimer's is diagnosed before the age of [AGE] years old), and edema, unspecified (swelling caused by excess fluid in tissues or body cavities). A quarterly Minimum Data Set (MDS) assessment, dated 1/12/25, indicated the resident had moderate cognitive impairment and had functional impairment on one side. A care plan, dated 7/8/24, indicated the resident was at risk for skin breakdown; requires assistance with bed mobility, transfers, and toileting. Interventions included, but were not limited to, left arm geri sleeve (long sleeve to help prevent skin shear) and avoid shearing skin during positioning, transferring, and turning. The care plan lacked an intervention indicating the resident had a Tubigrip on left arm. During an interview with a family member, on 3/3/25 at 1:30 p.m., the family member indicated the dressing had been on the resident's left arm for awhile and she thought it was because of the swelling in her left arm and skin tears. A late entry progress note, dated 12/26/24, indicated Resident 32 had a new skin tear to her left arm and had increased swelling in her arm. Steri strips (thin adhesive bandages that help close wounds) applied to the skin tear. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 1/26/35, indicated Resident 32 had received another skin tear to left forearm during care while turning in bed. Left arm was very edematous and the resident had little movement in the arm. A progress note, dated 2/1/25, indicated Resident 32 had a skin tear to her left upper posterior arm. Resident's arm noted to be very edematous, skin was very frail, and thin due to swelling. Hospice notified and would assess the resident tomorrow. A hospice progress note, dated 2/2/25, indicated Resident 32 had a skin tear to the back of left arm. The resident's record lacked documentation of a physician order for any kind of wrap or dressing/sleeve to resident's left arm. During an interview, on 3/3/25 at 2:21 p.m., the Certified Resident Medication Aide (CRMA) 5 indicated the resident had on a dressing/sleeve due to the skin tears on her left arm. During an interview, on 3/3/25 at 2:22 p.m., Registered Nurse (RN) 6 indicated Resident 32 had skin tears to her left arm and it was swollen, so the dressing/sleeve was used as a preventive measure. During an interview, on 3/4/25 at 9:04 a.m., the Clinical Support Nurse indicated Resident 32 had a Tubigrip on her left arm but was unable to find a physician order for its use. On 3/4/25 at 1:55 p.m., the Clinical Support Nurse provided a document with a revised date of 9/21/17, titled, Physician - Provider Notification Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .To ensure the resident's physician or practitioner is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provisions of appropriate interventions for care .1. Resident assessments for change in condition suspected injury, event of unknown origin or ordered lab and or other diagnostic tests should be completed in a timely manner 3.1-37

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34525 Based on observation, record review, and interview, the facility failed to ensure that a nebulizer (a small machine that turns liquid medicine into a mist that can be inhaled into the lungs) mask was bagged when not in use for 1 of 2 residents reviewed for respiratory care (Resident 19). Findings include: During the initial observation of Resident 19, on 2/28/25 at 9:41 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. During a random observation, on 3/4/25 at 9:41 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. During a random observation, on 3/5/25 at 9:18 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. At the same time the Clinical Support observed the un-bagged mask. Resident 19's record was reviewed on 3/4/25 at 9:47 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease of native coronary artery (a buildup of fats, cholesterol and other substances in and on the walls of the heart arteries that reduces blood flow) and stage 4 chronic kidney disease (a condition where the kidneys are severely damaged and are not filtering waste well). A quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident had no cognitive deficit. The assessment lacked documentation of any shortness of breath (SOB). Review of the resident's care plans lacked documentation of any respiratory concerns, or the use of medications related to respiratory concerns. A physician's order, dated 2/19/25, indicated to administer one 0.5 milligram (mg)-3 mg (2.5 mg base)/3 milliliter (ml) vial of ipratropium-albuterol solution (a medication which works by opening the airways and reducing inflammation in the lungs to help the patient breathe) for nebulization every 4 hours as needed. Review of the February 2025 medication administration record (MAR) indicated the resident had been administered one nebulizer treatment on, 2/20/25 at 2:36 p.m., for congestion. A Nurse Practitioner (a registered nurse with advanced training to diagnose and treat patients) note, dated 2/19/25 at 10:15 a.m., indicated the resident had been seen for increased weakness and fatigue. She had the flu the other week. No SOB was documented, but she had a productive cough (a cough that brings up mucous or phlegm [thick substance secreted by the mucous membranes of the respiratory passages]). Interventions included, but were not limited to, Duonebs (medication that combines ipratropium and albuterol to treat chronic obstructive pulmonary disease) every 4 hours as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/5/25 at 9:18 a.m., the Clinical Support indicated the resident's nebulizer mask should have been bagged and dated for storage when not in use. On 3/5/25 at 9:40 a.m., the Clinical Support provided a document, with a review date of 12/16/24, titled, Respiratory Equipment, and indicated it was the policy currently being used by the facility. The policy indicated, .SOP Details .3. Medication Nebulizers .f. Store .in plastic bag, marked with date and resident's name, between uses 3.1-47(a)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 34525 Based on record review and interview, the facility failed to ensure a recommendation made by the Pharmacists was addressed in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 22). Findings include: Resident 22's record was reviewed on 2/28/25 at 2:10 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure (conditions that can lead to heart failure that linked to high blood pressure) and stage 5 chronic kidney disease (a condition when the kidneys are severely damaged and have stopped doing their job of filtering waste from the blood). The profile lacked documentation of a diagnosis of hypotension (low blood pressure). A quarterly Minimum Data Set (MDS) assessment, dated 1/26/25, indicated the resident had no cognitive deficit and received dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are not functioning properly). A care plan, dated 4/17/24, indicated the resident was non-compliant with physician orders, which included, but were not limited to, not taking medications. The care plan lacked documentation of the resident having hypotension. A pharmacy recommendation, dated 4/29/24, indicated to consider adjusting the dose times and hold parameters for the resident's Midodrine (anti-hypotensive medication) 5 milligrams (mg) three times a day (TID). The statement, Leave alone, had been written on the bottom of the document with the date of 5/2/24. The recommendation lacked any physician documentation to justify the statement. During an interview, on 3/3/25 at 1:58 p.m., the Clinical Support indicated she could not find documentation for a rationale for the statement leave alone. A pharmacy recommendation, dated 6/24/24, indicated to avoid giving the evening dose of Midodrine 5 mg TID after evening meal or within 4 hours of bedtime to prevent supine hypertension (HTN-high blood pressure when lying down). The document indicated the task had been completed. Review of the June 24 medication administration record (MAR) indicated the medication had been given between 6:00 p.m., and 10:00 p.m. The MAR lacked documentation of the specific time the medication had been administered. A pharmacy recommendation, dated 7/22/24, indicated to avoid giving evening dose of Midodrine 5 mg TID after evening meal or within 4 hours of bedtime to prevent supine HTN. The document indicated the task had been completed. Review of the July 2024 MAR indicated the evening dosage times had been changed to 4:00 p.m., to 6:00 p.m. During an interview, on 3/3/25 at 2:26 p.m., the Executive Director (ED) indicated the expectation was that pharmacy recommendations would be addressed within the time prior to the next pharmacy medication regimen review date. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/3/25 at 2:28 p.m., the Clinical Support indicated she was not able to locate a specific policy related to the physician addressing the pharmacy recommendations. The facility would follow the State and Federal regulations. It was expected that all pharmacy recommendations would be addressed timely by the physician and the facility. 3.1-48(a)(4) 3.1-48(a)(6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on observation, interview, and record review, the facility failed to ensure proper labeling of prepared food, and the facility failed to dispose of expired food for 1 of 2 kitchen observations. This had the potential to affect 50 of 50 residents who received food from the kitchen. Findings include: 1. During an initial kitchen tour with the Business Office Manager (the Dietary Manager was unavailable), on [DATE] at 10:27 a.m., a plastic container of prepared chicken salad was observed on a shelf in the walk-in refrigerator. There was no label or use by date on the container of chicken salad. The business office manager was not aware of when the chicken salad was prepared and how long it had been in the walk-in refrigerator. She indicated the chicken salad would have to be discarded since it did not contain a label with a use by date on it. During an interview, on [DATE] at 10:30 a.m., Dietary Services Assistant 8 indicated prepared food was good for 4 days and then should be discarded. 2. In the refrigerator, on [DATE] at 10:32 a.m., there was a plastic container of prepared poppy seed dressing with a use by date of [DATE], container of prepared lemonade with a use by date of [DATE], container of prepared apple raspberry juice with a use by date of [DATE], container of prepared blue Gatorade with a use by date of [DATE], and an opened container of thickened liquid with a use by date of [DATE]. The business office manager indicated the juices and salad dressing should have been discarded. During an interview, on [DATE] at 9:26 a.m., the Dietary Manager indicated prepared food items were good for 3 days and then should be discarded. The food items should contain a label with a use by date and then should be discarded after that date. On [DATE] at 12:30 p.m., the Clinical Support Nurse, provided a document with a review date of [DATE], titled, Leftover Food Storage, and indicated it was the policy currently being used by the facility. The policy indicated, .To enforce proper storage and usage of leftover food and ultimately avoid microbial foodborne illness .2. Date all food and use or discard within three days 3XXX,d+[DATE](i)(3)