| 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 | 05/14/2026 |

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| Mill Pond Health Campus | 1014 Mill Pond Lane<br>Greencastle, IN 46135 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure proper food handling for 2 of 2 hall tray meal service observations. This had the potential to affect residents receiving hall trays during the lunch meal service. Findings include:During a lunch meal service observation (healthcare lunch trays), on 5/7/26 at 12:40 p.m., Dietary Services Assistant 18 was preparing the hall trays at her hot cart (cart used to transport food and keep it warm) and removed ice from the ice bucket with the use of an ice scoop, she placed the ice in a cup and placed the ice scoop back into the ice bucket with the ice. She placed the drink cup on a tray to be served. At 12:44 p.m. she prepared another drink for a hall tray and placed the ice scoop back into the ice bucket after she prepared the drink. At 12:45 p.m. she prepared another drink for a hall tray and placed the ice scoop back into the ice bucket after she prepared the drink. At 12:46 p.m. and 12:47 p.m., the dietary services assistant prepared more drinks for the hall trays and returned the ice scoop back into the ice bucket. At 12:48 p.m., the dietary services assistant left the common area and proceeded down the 300 hallway with the ice bucket uncovered down the hallway and the ice scoop still in the bucket. During a breakfast meal service observation (healthcare breakfast trays), on 5/8/26 at 9:09 a.m., Dietary Services Assistant 18 was standing at the hot cart and the ice scoop was noted to be inside the ice bucket with the ice. She left the common area with the cart and proceeded down the 300 hallway with ice bucket uncovered. During an interview, on 5/11/26 at 9:00 a.m., Dietary Services Assistant 6 indicated the ice bucket should be covered with plastic when being transported down the hallway, she further indicated they had always kept the ice scoop in the ice bucket when not in use. During an interview, on 5/11/26 at 12:51 p.m., Dietary Services Assistant 9 indicated she was educated today (5/11/26) by the dietary manager to make sure to place the ice scoop in a separate container when not in use. She further indicated in the past they would just place the ice scoop in the ice bucket when not in use. On 5/11/26 at 11:03 a.m., the Regional Nurse Consultant provided an undated document, titled, In-Use Utensils; Between Use Storage, and indicated it was the current policy being used by the facility. The policy indicated, . (2) In food that is not potentially hazardous with their handles above the top of the food within containers or equipment that can be closed, such as bins of ice.(5) In a clean, protected location if the utensils, such as ice scoops. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3) |

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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>Based on interview and record review, the facility failed to ensure a resident's preferences were met, for 1 of 2 residents reviewed for choices (Resident 18). Findings include:During an interview, on 5/7/26 at 10:47 a.m., Resident 18 indicated she used to receive 3 showers a week until she developed the need to use a shower chair. Now she was lucky if she got 2 per week. Resident 18's record was reviewed on 5/8/26 at 2:25 p.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis unspecified (a chronic neurological disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain) and diabetes mellitus with hyperglycemia (too much sugar in the blood). An annual Minimum Data Set (MDS) assessment, dated 1/27/26, indicated the resident had no cognitive deficit, had no documented behaviors of refusal of care, and was dependent with her personal hygiene and bathing. An annual Life Enrichment assessment, dated 1/29/26, indicated the resident preferred showers. The assessment lacked documentation as to how many showers per week the resident preferred. A profile care guide care plan, dated 3/15/22, indicated the resident preferred showers. Interventions included, but were not limited to, shower per schedule. The resident's care plans lacked documentation of refusals with assistance of her ADL (activities of daily living- the basic skills necessary for individuals to independently care for themselves, such as eating and bathing). Review of the April 2026 Point of Care (POC) document (the recording and documenting of patient information directly at the bedside or point of care) indicated the resident had received showers on 4/8/26, 4/19/26, 4/22/26, and 4/25/26. The POC lacked documentation of any resident refusal of care. Review of the May 2026 POC document indicated the resident had received showers on 5/3/26 and 5/10/26. The POC lacked documentation of any resident refusal of care. During an interview, on 5/11/26 at 12:20 p.m., the Assistant Director of Nursing Services (ADNS) indicated the facility staff did not complete shower sheets. The POC was where the staff would document showers and baths given along with any refusal of care by a resident. During an interview, on 5/11/26 at 12:44 p.m., the Life Enrichment Director indicated she completed the preferences for the residents but only asked the preference of shower versus bath. She had just started to ask the residents about their preference of the day for the bath or shower but had never asked the numbers they preferred. It was her understanding that the facility expectation was that each resident would get 2 per week. She did not believe this was a policy, but just the expectation. During an interview, on 5/11/26 at 2:35 p.m., the Regional Clinical Support indicated there was not a specific policy for the number of showers residents would receive, but the staff would attempt to make sure every resident received 2 showers a week. She was unable to find any documentation of the Resident 18's refusals for her showers. On 5/11/26 at 2:51 p.m., the Regional Clinical Support provided a document, with a revised date of 5/11/16, titled, Guidelines for Bathing Preference, and indicated it was the policy currently in use by the facility. The policy indicated, .Procedure.2, The resident shall determine their preference for bathing upon admission.c. Type of bathing-tub bath, bed bath or shower.4. Bathing shall occur at least twice a week unless resident's preference states otherwise. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(u)(1) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure the privacy of the residents was maintained for 2 of 8 observations for privacy (Residents 29 and 32). Findings include:<br><br>1. On 5/8/26 at 10:47 a.m., during an interview Resident 29 indicated the staff had come into the bathroom while she was sitting on the toilet and checked her blood pressure. She indicated she had asked them to wait, but they came in anyway and checked her blood pressure. She indicated this was embarrassing and she should have time alone to use the bathroom facilities. She indicated there were times she was getting dressed and the staff walked in without asking permission to come in and failed to knock on the door.<br><br>During the resident interview, three staff members came in without knocking on the door or waiting for permission to enter. Activities Assistant 4 came in and asked about activities, Certified Nursing Aide (CNA) 3 came in and delivered water, and a third unidentified employee came in and walked to the other side of the room and then left.<br><br>On 5/11/26 at 10:00 a.m., reviewed the medical record of Resident 29. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to Unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body), and hemiparesis (a relatively mild loss of strength) following cerebral infarction affecting right dominant side).<br><br>A Minimum Data Set (MDS) assessment, dated 4/20/26, indicated the resident was cognitively intact and required assistance from the staff for daily care needs.<br><br>A care plan, dated 4/24/25, indicated the resident had impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, impaired or reduced safety awareness related to dementia. Interventions included, but were not limited to, greet with verbal and non-verbal gestures, using resident's preferred name.<br><br>On 5/11/26 at 11:32 a.m., during an interview, Licensed Practical Nurse (LPN) 7 indicated the expectation was all employees should knock and wait for permission to enter a resident's room.<br><br>On 5/11/26 at 11:38 a.m., during an interview, Housekeeper 8 indicated when entering a resident's room, she would knock on the door and wait for permission prior to entering the resident's room.<br><br>2. During the lunch meal service observation (healthcare hall trays), on 5/11/26 at 12:38 p.m., Resident 32 was sitting in his Broda chair (specialized highly adjustable medical wheelchair or reclining chair designed for long term care) in the common area across from the nurse's station. There was also a female resident sitting in her wheelchair in front of the television. A few minutes later a CNA pushed another female resident in her wheelchair into the common area from the dining room to watch the television. A contracted Hospice Nurse entered the common area and sat next to Resident 32. The nurse did not address the resident when she sat down next to him. The contracted Hospice Nurse 12 obtained vital signs on Resident 32. The nurse obtained his blood pressure using a wrist cuff, temporal (forehead) temperature, pulse oximeter reading, heart rate, and palpated his abdomen (continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | with her bare hands. There were several other residents and staff in the hallway at that time along with dietary staff preparing and serving the lunch hall trays. The Hospice Nurse also took a phone call while charting and completing her assessment on Resident 32. The Hospice Nurse never addressed or communicated with Resident 32 during the assessment.<br><br>Resident 32's record was reviewed on 5/11/26 at 2:36 p.m. The profile indicated the resident diagnoses included, but were not limited to, unspecified dementia (group of conditions characterized by impairment of at least two brain functions such as memory and judgment), and dysphagia (difficulty swallowing food, liquids, or salvia).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 3/26/26, indicated the resident was rarely understood and was on hospice services.<br><br>During an interview, on 5/11/26 at 2:18 9.m., the Registered Nurse (RN) 10 indicated that staff should not be performing assessments and/or vital signs in a common area on any resident. The assessment should be completed behind closed doors for privacy.<br><br>On 5/11/26 at 11:00 a.m., the Regional Nurse Consultant provided a document, with a revised date of 5/11/17, titled, Resident Rights Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Our residents have a right to: a. Be treated with dignity and respect .d. Privacy<br><br>410 IAC (Indiana Administrative Code) 16.2-3.1-3(o)(5) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure discharge reporting information was communicated to the receiving healthcare facility for 1 of 4 residents reviewed for hospitalization (Resident 2). Findings include:On 5/12/26 at 2:30 p.m., the medical record of Resident 2 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but was not limited to, encephalopathy (any disease, damage, or malfunction of the brain), hypertension (high blood pressure), and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high). An admission Minimum Data (MDS) assessment, dated 4/7/26, indicated the resident had severe cognitive impairment and required maximum assistance from the staff for all care needs. The medical record indicated on 4/26/26 the resident experienced a sudden change and decline in condition. The resident was assessed and physician notified. The resident was sent to the hospital and admitted to Intensive Care Unit (ICU). The record lacked documentation of resident condition report being called to the hospital emergency room (ER) or the Emergency Response Service (EMS) at the time of the discharge. The record lacked documentation of written condition report including most recent vital signs, list of medications and allergies or a physician order to transfer the resident to the hospital. On 5/13/26 at 10:25 a.m., during an interview Registered Nurse (RN) 2 indicated if she were sending a resident to the hospital she would call the physician and obtain an order to send the resident to the hospital. She would then call the family then call report to the hospital emergency room nurse, if she knew where the resident was being sent. She indicated she would give her number to EMS and ask them to call her and notify her of where they sent the resident. She acknowledged she could give report to the attending EMS and ask them to report the information to the ER nurse. She indicated she would document how the report was communicated in the medical record. On 5/13/26 at 11:25 a.m., during an interview the regional Nurse Consultant acknowledged the record lacked evidence of a physician order to send the resident to the hospital and the record lacked evidence of written report being given to the hospital. On 5/13/26 at 11:00 a.m., the Regional Clinical Nurse provided a document, titled, Guidelines for Transfer and Discharge, dated 5/3/17, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Emergency Transfers/Discharges.a. Nursing should obtain physician's orders for emergency transfer or discharge and may include stating the reason the transfer or discharge is necessary on an emergency basis .c. Nursing should print and send the resident's CCD (continuum of care document) which includes current diagnosis, most recent vital signs, allergies, attending physician, current medications, treatments, and advanced directives. 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(B) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for 2 of 29 MDS assessments reviewed for accuracy (Residents 26 and 15). Findings include:<br><br>1. Resident 26's closed record was reviewed on [DATE] at 10:08 a.m. A significant change MDS, dated [DATE], indicated the resident had severe cognitive deficit, had a documented terminal illness, and received hospice (end of life) services.<br><br>The census indicated the resident expired on [DATE].<br><br>The record lacked documentation of a death in facility MDS. The last documented MDS was the significant change MDS on [DATE].<br><br>During an interview, on [DATE] at 10:15 a.m., the MDS Coordinator indicated the death in facility MDS had been overlooked and had not been completed.<br><br>The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated [DATE], indicated, .A0301: Type of Assessment.F.12. Death in Facility.Coding Tips and Special Populations.A0310E=0 for: Entry of Death in Facility.<br><br>2. On [DATE] the medical record of Resident 15 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, unspecified cirrhosis of liver (severe, permanent scarring of the liver caused by long-term liver damage or disease), encounter for palliative care (end of life comfort care), and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).<br><br>A physician order, dated [DATE], indicated resident admitted under hospice services related to terminal diagnosis of unspecified cirrhosis of liver disease, if disease runs normal course life expectancy of 6 months or less.<br><br>A Minimum Data Set (MDS) assessment, dated [DATE], indicated hospice services were provided during the assessment period, and the resident was severely cognitively impaired requiring maximum assistance for all care needs.<br><br>An MDS, dated [DATE], indicated hospice services had not been provided during the assessment period.<br><br>A care plan dated [DATE] indicated Resident 15 had elected for comfort care and had chosen hospice services. Interventions included, but were not limited to, provide basic comfort measures.<br><br>On [DATE] at 10:14 p.m., during an interview the MDS nurse indicated she did not catch the entry when completing the MDS. She acknowledged the resident was on hospice services during the look back period.<br><br>On [DATE] at 1:36 p.m., the Regional Nurse Consultant indicated the facility follows the RAI assessment manual. The Resident Assessment Instrument (RA)I manual indicated, . section O0110K1, (continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Hospice care. Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medication was labeled with a date opened during 1 of 3 medication cart observations.Findings include:On 5/11/26 at 2:40 p.m., during observation of medication cart with Licensed Practical Nurse (LPN) 7 observed an insulin pen containing Lantus insulin, identified as being prescribed to Resident 18 with no date opened recorded on the label.On 5/11/26 at 2:42 p.m., during an interview LPN 7 acknowledged insulin pens must have a date opened on the pen.On 5/11/26 at 2:49 p.m., the medical record of Resident 18 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, diabetes mellitus type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (high blood pressure), and major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks).A physician order, dated 8/8/25, indicated to administer 60 units subcutaneous (under the skin) Lantus Solostar U-100 Insulin (insulin glargine) insulin 100 unit/mL (3 mL) twice a day.On 5/11/26 at 2:52 p.m., the Regional Nurse Consultant provided a document, titled, Medication Storage In The Facility, dated 11/18, and indicated it was the policy currently being used by the facility. The policy indicated, .D. When the original seal of a manufacturers container or vial is initially broken, the container or vial will be dated.1. A date opened sticker shall be placed on the medication (NOTE: the best stickers to affix contain both a date opened and expiration notation line) .410 Indiana Administrative Code (IAC) 3.1-25(j)410 Indiana Administrative Code (IAC) 3.1-25 (m)410 Indiana Administrative Code (IAC) 3.1-25 (n) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate documentation of medication administration for 1 of 3 residents reviewed for medication administration (Residents 3), and the facility failed to ensure a written physician order was obtained to send resident to the hospital for 1 of 4 residents reviewed for hospitalizations (Resident 2).Findings include:1. During an interview, on 5/7/26 at 1:24 p.m., Resident 3 indicated the nursing staff were late administering her insulin a lot of the time and there were some days that she didn't get her insulin injections at all.<br><br>During an interview, on 5/12/26 at 10:44 a.m., Resident 3 indicated it was usually the same nurse on nightshift that was late administering her medications (pills and insulin) and sometimes she didn't get her medications at all.<br><br>Resident 3's record was reviewed on 5/11/26 at 11:31 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), end stage renal disease (the final, permanent stage of chronic kidney disease), and encephalopathy (any disease, damage, or malfunction that alters brain function or structure).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 3/15/26, indicated the resident was cognitively intact and was on insulin injections and received anti-depressant, anti-coagulant (blood thinner), and diuretic (water pill) medications.<br><br>A care plan, dated 12/23/22, indicated the resident had potential for cardiovascular distress related to diagnosis of HTN (hypertension -elevated blood pressure) and CHF (congestive heart failure-the heart muscles become weakened or stiff, meaning it cannot pump blood efficiently to meet the body's needs). Interventions included, but were not limited to, medications as ordered, observe for and report side effects as needed.<br><br>A care plan, dated 12/23/22, indicated the resident was at risk for hypo/hyperglycemia (low or elevated blood sugar) related to diabetes mellitus. Interventions included, but were not limited to, medication per order and monitor blood sugars per md (medical doctor) order.<br><br>A physician order, dated 3/11/26, indicated to administer amlodipine (treats high blood pressure) 5 mg (milligrams) by mouth once daily from 6 to (-) 10:00 p.m.<br><br>Review of April 2026 MAR (Medication Administration Record) indicated the following administration times for the 6 - 10:00 p.m. dose of amlodipine medication:<br><br>a. On 4/1/26 the medication was documented as late administration: Charted late due to patient care at 11:07 p.m. by Licensed Practical Nurse (LPN) 17.<br><br>b. On 4/3/26 the medication was documented as late administration: Charted late due to patient care at 10:27 p.m. by LPN 17.<br><br>c. On 4/8/26 the medication was documented as late administration: Charted late due to patient care at 11:51 p.m. by LPN 17.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | d. On 4/9/26 the medication was documented as late administration: Charted late due to patient care at 11:59 p.m. by LPN 17.<br><br>e. On 4/15/26 the medication was documented as late administration: Charted late due to patient care at 10:43 p.m. by LPN 17.<br><br>f. On 4/16/26 the medication was documented as late administration: Charted late due to patient care at 10:27 p.m. by LPN 17.<br><br>g. On 4/17/26 the medication was documented as late administration: Charted late due to patient care at 11:13 p.m. by LPN 17.<br><br>h. On 4/23/26 the medication was documented as late administration: Charted late due to patient care at 11:40 p.m. by LPN 17.<br><br>i. On 4/28/26 the medication was documented as late administration: Charted late due to patient care at 11:11 p.m. by LPN 17.<br><br>j. On 4/30/26 the medication was documented as late administration: Charted late due to patient care at 11:10 p.m. by LPN 17.<br><br>Review of May 2026 MAR indicated the following administration times for the 6 - 10:00 p.m. dose of amlodipine medication:<br><br>a. On 5/5/26 the medication was documented as late administration: Charted late due to patient care at 11:36 p.m. by LPN 17.<br><br>b. On 5/6/26 the medication was documented as late administration: Charted late due to patient care at 10:43 p.m. by LPN 17.<br><br>c. On 5/7/26 the medication was documented as late administration: Charted late administered on time 11:43 p.m. by LPN 17.<br><br>A physician order, dated 2/10/26, indicated to administer Eliquis (blood thinner) 5 mg by mouth twice daily at 6 - 10:00 a.m. and 6 - 10:00 p.m.<br><br>Review of April 2026 indicated the following administration times for the 6 - 10:00 p.m. dose of Eliquis mediation:<br><br>a. On 4/1/26 the medication was documented as late administration: Charted late due to patient care at 11:07 p.m. by LPN 17.<br><br>b. On 4/15/26 the medication was documented as late administration: Charted late due to patient care at 10:43 p.m. by LPN 17.<br><br>c. On 4/21/26 the medication was documented as late administration: Charted late due to patient care at 11:18 p.m. by LPN 17.<br><br>d. On 4/28/26 the medication was documented as late administration: Charted late due to patient care<br>(continued on next page) |

| 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 | 05/14/2026 |

| 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.

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | at 11:11 p.m. by LPN 17.<br><br>Review of May 2026 indicated the following administration times for the 6 - 10:00 p.m. dose of Eliquis mediation:<br><br>a. On 5/5/26 the medication was documented as late administration: Charted late due to patient care at 11:36 p.m. by LPN 17.<br><br>b. On 5/6/26 the medication was documented as late administration: Charted late due to patient care at 10:43 p.m. by LPN 17.<br><br>c. On 5/7/26 the medication was documented as late administration: Charted late administered on time 11:43 p.m. by LPN 17.<br><br>A physician order, dated 2/10/26, indicated to administer isosorbide dinitrate (treat chest pain and manage heart failure) 20 mg by mouth twice a day on Mon, Wed, and Fri. at 6-10:00 a.m. and 6 - 10:00 p.m.<br><br>Review of April 2026 indicated the following administration times for the 6 - 10:00 p.m. dose of isosorbide dinitrate mediation:<br><br>a. On 4/1/26 the medication was documented as late administration: Charted late due to patient care at 11:07 p.m. by LPN 17.<br><br>b. On 4/3/26 the medication was documented as late administration: Charted late due to patient care at 10:27 p.m. by LPN 17.<br><br>c. On 4/8/26 the medication was documented as late administration: Charted late due to patient care at 11:51 p.m. by LPN 17.<br><br>d. On 4/15/26 the medication was documented as late administration: Charted late due to patient care at 10:43 p.m. by LPN 17.<br><br>e. On 4/17/26 the medication was documented as late administration: Charted late due to patient care at 11:13 p.m. by LPN 17.<br><br>Review of May 2026 indicated the following administration times for the 6 - 10:00 p.m. dose of isosorbide dinitrate mediation:<br><br>a. On 5/6/26 the medication was documented on 5/7/26 as late administration: Charted late due to patient care at 1:02 a.m. by LPN 17.<br><br>b. On 5/11/26 the medication was documented on 5/12/26 as late administration: Charted late due to patient care at 12:03 a.m. by LPN 17.<br><br>A physician order, dated 2/10/26, indicated to administer isosorbide dinitrate (treat chest pain and manage heart failure) 20 mg by mouth three times a day on Sun, Tuesday, Thursday, and Saturday. at 6 - 10:00 a.m. 11:00 a.m. - 1:30 p.m., and 6 - 10:00 p.m.<br>(continued on next page) |

| 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 | 05/14/2026 |

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

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of April 2026 MAR indicated the following administration times for the 6 - 10:00 p.m. dose of isosorbide dinitrate mediation:<br><br>a. On 4/9/26 the medication was documented as late administration: Charted late due to patient care at 11:59 p.m. by LPN 17.<br><br>b. On 4/14/26 the medication was documented as late administration: Charted late administered on time at 11:11 p.m. by LPN 17.<br><br>c. On 4/16/26 the medication was documented as late administration: Charted late due to patient care at 10:27 p.m. by LPN 17.<br><br>d. On 4/21/26 the medication was documented on 4/22/26 as late administration: Charted late due to patient care at 12:28 a.m. by LPN 17.<br><br>e. On 4/23/26 the medication was documented as late administration: Charted late due to patient care at 11:40 p.m. by LPN 17.<br><br>f. On 4/28/26 the medication was documented as late administration: Charted late due to patient care at 11:11 p.m. by LPN 17.<br><br>g. On 4/30/26 the medication was documented as late administration: Charted late due to patient care at 11:10 p.m. by LPN 17.<br><br>Review of May 2026 indicated the following administration times for the 6 - 10:00 p.m. dose of isosorbide dinitrate mediation:<br><br>a. On 5/5/26 the mediation was documented on 5/6/26 as late administration: Charted late due to patient care at 1:03 am. by LPN 17.<br><br>A physician order, dated 3/18/26, indicated to administer Basaglar Kwik-Pen (insulin medication) 100 unit/ml (milliliters), give 5 units subcutaneously (under the skin) at bedtime from 7 - 11:30 p.m.<br><br>Review of April 2026 MAR indicated the following administration times for the 7 - 11:30 p.m. dose of Basaglar mediation:<br><br>a. On 4/10/26 the record lacked documentation of the insulin being administered.<br><br>Review of May 2026 MAR indicated the following administration times for the 7-11:30 p.m. dose of Basaglar mediation:<br><br>a. On 5/5/26 the medication was documented as late administration: Charted late due to patient care at 11:36 p.m. by LPN 17.<br><br>b. On 5/7/26 the medication was documented as late administration: Charted late administered on time 11:43 p.m. by LPN 17.<br><br>During an interview, on 5/12/26 at 9:16 a.m., LPN 16 indicated she would administer the resident's medication to them and immediately return to the computer to document them as given.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155736 | A. Building<br>B. Wing | 05/14/2026 |

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

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 5/12/26 at 11:51 a.m., LPN 11 indicated she would document she gave the residents' their medications as soon as she left their room and returned to the computer.<br><br>During an interview, on 5/13/26 at 10:19 a.m., the Regional Nurse Consultant indicated she was not aware of why a nurse would document patient care on the medication administration record. It was the expectation that nursing staff would document as soon as the medication was administered.<br><br>During a phone interview, on 5/13/26 at 10:29 a.m., LPN 17 indicated she was busy on the nightshift and had to assist other staff with their duties and therefore she was late documenting her medication administration pass. She indicated Resident 3 would often get her medication on time, but the documentation did not reflect that. She could not recall why some of the medications that were a part of the bedtime medication pass had different times of administration on the MAR. She indicated she gave all the bedtime medications to Resident 3 at the same time, but the documentation did not reflect that at times.<br><br>During an interview, on 5/13/26 at 11:54 a.m., the Regional Nurse Consultant indicated medication administration should be documented as soon as administered by nursing.<br><br>On 5/13/26 at 11:52 a.m., the Regional Nurse Consultant provided a document with a revised date of 11/18, titled, Preparation and General Guidelines, and indicated it was the current policy being used by the facility. The policy indicated, .1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.<br><br>2. On 5/12/26 at 2:30 p.m., the medical record of Resident 2 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to encephalopathy (any disease, damage, or malfunction of the brain), hypertension (high blood pressure), and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high).<br><br>The medical record indicated on 4/26/26 the resident experienced a sudden change and decline in condition. The record indicated the resident was assessed and the on call physician was notified and a telephone order was obtained to send the resident to the hospital. The record lacked documentation of a physician order to transfer the resident to the hospital.<br><br>On 5/13/26 at 10:25 a.m., during an interview Registered Nurse (RN) 2 indicated if she were sending a resident to the hospital she would call the physician and obtain an order to send the resident to the hospital and she would document the information in the medical record.<br><br>On 5/13/26 at 11:00 a.m., the Regional Clinical Nurse provided a document, titled, Guidelines for Transfer and Discharge, dated5/3/17, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Emergency Transfers/Discharges.a. Nursing should obtain physician's orders for emergency transfer or discharge and may include stating the reason the transfer or discharge is necessary on an emergency basis.<br><br>410 Indiana Administrative Code (IAC) 3.1-50(f) |