STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Grove	31869 Chicago Trail New Carlisle, IN 46552

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the responsible party for 1 of 3 residents reviewed for discharge from the facility, received in writing, a Notice of Medicare Non-Coverage including the date of discharge. (Resident B) Finding Includes:On 12/1/25 at 1:14 P.M., Resident B's clinical record was reviewed. Resident B was admitted to the facility on [DATE] and discharged home with family on 11/8/25. The residents' diagnoses included but were not limited to a fractured sacrum, chronic bronchitis, chronic obstructive pulmonary disease, repeated falls, altered mental status, depression, anxiety, and liver cancer.A facility admission Agreement form, dated 9/3/22 and signed by the facility Area Marketing Liaison and Resident B's family member on 10/3/25, indicated the family member was Resident B's Resident Representative. The admission Agreement indicated the Resident Representative was an individual the Resident had chosen to act on his or her behalf to support decision making; access medical.information; manage financial matters and receive notification. The Resident Representative was a person authorized to act on behalf of the Resident.Resident B's MDS (Minimum Data Set) assessment, dated 10/9/25 for a Discharge Assessment, indicated Resident B's diagnoses included altered mental state,the resident was cognitively intact, utilized a walker and wheelchair for locomotion and required supervision for toileting hygiene, transferring to chair and toilet, and required moderate assistance for dressing, personal hygiene, and tub or shower transfers. Resident B had participated in Physical and Occupational Therapies while at the facility. The MDS indicated Resident B had participated in goal setting in her Care Plan meeting and her goal was to be discharged back into the community or home. Neither the residents' family nor the responsible had participated in the Care Plan meeting.A Nursing Progress Note, dated 11/5/25 at 12:11 P.M., indicated the resident's last day of Medicare Part A for skilled nursing coverage was 11/7/25 and the resident had been notified of the right to appeal and had signed the Notification of Medicate Non-Coverage (NOMNC) form. The form had been placed at the bedside as requested by the resident.son, rehab and admission/discharge distro list. was documented in the progress note.Review of Resident B's Notification of Medicate Non-Coverage form, signed by the resident on 11/5/25, indicated skilled nursing facility services were to end on 11/7/25.The Nurse Practitioner's Discharge Note, dated 11/7/25, indicated Resident B's reason for admission to the facility included a desired nursing home placement due to memory issues.On 12/2/25 at 2:25 P.M., during an interview, the Director of Nursing indicated Resident B had been given a NOMNC but her responsible party, whom she was discharged to, had not given the NOMNC form/notice.On 12/3/25 at 1:00 P.M., during an interview with the Administrator, she indicated Resident B's Responsible Party had not been aent a NOMNC letter nor any bed hold information per the facility's policy.On 12/2/25 at 2:30 P.M., and on 12/3/25 at 9:30 A. M., a policy for Admission, Transfer, and Discharge was requested from the Director of Nursing and the Administrator, respectively, but was not provided.This Citation relates to Intake 2664672.3.1-12(a)(6)(ii)(iii)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a discharge care plan was created for 1 of 3 residents reviewed for discharge planning. The facility also failed to ensure the Resident's Responsible Party was invited to participate in the care planning process for their family member for 1 of 3 resident reviewed for discharge planning. (Resident B).Finding Includes:On 12/1/25 at 1:14 P.M., Resident B's clinical record was reviewed. Resident B was admitted to the facility on [DATE] and discharged home with family on 11/8/25. The residents' diagnoses included but were not limited to a fractured sacrum, chronic bronchitis, chronic obstructive pulmonary disease, repeated falls, altered mental status, depression, anxiety, and liver cancer.A facility admission Agreement form, dated 9/3/22 and signed by the facility Area Marketing Liaison and Resident B's family member on 10/3/25, indicated the family member was Resident B's Resident Representative. The admission Agreement indicated the Resident Representative was an individual the Resident had chosen to act on his or her behalf to support decision making; access medical.information; manage financial matters and receive notification. The Resident Representative was a person authorized to act on behalf of the Resident.Resident B's MDS (Minimum Data Set) Assessment, dated 10/9/25 for an admission Assessment, indicated the resident's diagnoses included altered mental state. The assessment indicated the resident was cognitively intact, utilized a walker and wheelchair for locomotion, required supervision for toileting hygiene, transferring to chair and toilet and required moderate assistance for dressing, personal hygiene, and tub or shower transfers. Resident B had participated in Physical and Occupational Therapies while at the facility. The MDS assessment indicated Resident B had participated in goal setting in her Care Plan meeting and her goal was to be discharged back into the community or her home. Neither the residents' family nor responsible party had participated in the Care Plan meeting.An MDS (Minimum Data Set) Assessment, dated 11/8/25 for a Discharge Assessment, offered no indication that Resident B or Resident B's Responsible Party had been involved in the discharge planning for the resident. A Nursing Progress Note, dated 11/5/25 at 12:11 P.M., indicated the resident's last day of Medicare Part A for skilled nursing coverage was to be on 11/7/25 and the resident had been notified of the right to appeal and had signed the Notification of Medicate Non-Coverage (NOMNC) form.On 12/2/25 at 2:25 P.M. during an interview, the Director of Nursing indicated there was not a discharge plan included in the residents' comprehensive care plans and that neither Resident B's family nor responsible were provided invitations or notification of care plan meetings.On 12/3/25 at 1:00 P.M. during an interview with the Administrator, she indicated Resident B's family had not been appropriately invited to care plan meetings though they should have been invited to the care plan meetings.On 12/3/25 at 12:38 P.M., the Administrator provided the policy titled, Comprehensive Care Plans, dated 1/29/25. The policy indicated, .The comprehensive care plan will describe, at a minimum, the following.The resident's goals for.desired outcomes, and preferences for future discharge.The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:.The resident and the resident's representative.This Citation relates to Intake 2664672. 3. 1-35(a)(1)(c)(2)(C)