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	06/09/2026

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 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. Based on observation, record review, and interview, the facility failed to ensure wound treatments were in place as ordered and neurological checks were completed following a fall for 1 of 3 residents reviewed for non-pressure skin conditions and 1 of 3 residents reviewed for falls. (Resident B)Finding includes: On 6/8/26 At 1:10 p.m., Resident B was observed in her room with CNA 1. CNA 1 lifted the resident's pant leg and removed her sock so the resident's wounds could be observed on the right lower leg and left heel. Neither wound had a dressing in place, both were open to air. During an interview at the time, CNA 1 indicated she was unaware if the resident required any dressings to the wounds.Resident B's record was reviewed on 6/8/26 at 11:00 a.m. The diagnoses included, but were not limited to, dementia, heart failure, COPD, kidney disease stage 3, panic disorder, history of falling, anemia (low iron), depression, and macular degeneration (vision loss).The Annual Minimum Data Set (MDS) assessment, dated 3/26/26, indicated the resident was severely impaired for daily decision making. Upper/lower body dressing required partial to moderate assistance. Toileting and shower/bathing required substantial to maximum assistance.A Care Plan, revised on 4/20/26, indicated the resident had an unwitnessed fall on 4/20/26. Interventions were to monitor/document/report for 72 hours any change in pain or mental status to the physician.A Neurological Check flowsheet, dated 4/20/26, indicated there was no documentation of neurological checks after 4/21/26 at 2:00 p.m. The documentation was incomplete for shifts five through nine of the 72 hour post fall period.A Nurse's Post Fall Evaluation Note, dated 4/21/26 at 10:26 a.m., indicated the resident had an unwitnessed fall in her room on 4/20/26 at 5:06 p.m. There was no incident note or assessment documented at the time of the fall. A Physician's Order, dated 5/27/26, indicated to cover the blister to the left heel with a dry dressing and wrap it with Kerlix every day at bedtime.A Physician's Order, dated 5/27/26, indicated to cleanse the right lower leg with wound wash, pat dry, apply ointment, and cover with a bordered gauze every night shift and as needed.A Care Plan, revised on 6/5/26, indicated the resident had blisters on the right shin, left heel, and left plantar foot. Interventions included to administer treatments as ordered and encourage repositioning every two hours and as needed. During an interview on 6/9/26 at 11:00 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) indicated the night nurse had completed the dressing changes and the resident must have removed them. The ADON agreed nursing staff should have replaced the dressings or documented the resident's removal. The neurological check flowsheet was not completed, but they continued to record vital signs. The DON indicated the computer system was less than a year old and the staff were having difficulty navigating some of the assessments. They understood the concern regarding vital signs with no neurological assessment post fall.This citation relates to Intake 3017146. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(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