STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Pointe Health and Rehab	3800 Eli Place Newburgh, IN 47630

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35733 Based on observation, interview, and record review, the facility failed to ensure adequate safety measures were in place to prevent accidents for 2 of 3 residents reviewed. This deficient practice resulted in Resident C requiring hospitalization , sutures, and a subarachnoid hemorrhage. (Resident B, Resident C) Findings include: 1. On 4/8/25 at 1:28 p.m., Resident C's clinical record was reviewed. Resident C was admitted on [DATE] and discharged to the hospital on 2/26/25. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, visuospatial deficit and spatial neglect following cerebral infarction, cerebral infarction due to thrombosis of right middle cerebral artery, muscle weakness (generalized), unsteadiness on feet, other abnormalities of gait and mobility, need for assistance with personal care. An admission Minimum Data Set (MDS) assessment, dated 1/27/25, indicated Resident C's cognition was intact, range of motion impairment upper and lower one side, toileting dependent substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort), toilet transfer substantial/maximal assistance, lying to sitting on side of bed (the ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support) substantial/maximal, no falls 2-6 months prior to admission. The Care Plans included but were not limited to: Resided needed assistance with activities of daily living (ADL's) related to cerebrovascular accident (CVA) with left hemiplegia. The interventions included but were not limited to: - Resident required assist of two when toileting with transfers, on/off the commode, do not leave unattended on commode, initiated 1/24/25. - Resident required assist of two with transfers to the right side. Use bilateral platform walker and gait belt pivot transfer only. Resident to only ambulate with therapy at this time, initiated 1/24/25 and revised 2/25/25. (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 0689 Level of Harm - Actual harm Residents Affected - Few	- Resident required assist of one with transfers to the right side. Use bilateral platform walker and gait belt, initiated 1/24/25 and revised 1/27/25. Resident was at risk for falls related to decreased mobility, new CVA with flaccid left sided hemiplegia, unsteady gait, initiated 1/24/25. The interventions included, but were not limited to: - Do not leave unattended when sitting on the commode, initiated 2/27/25. - Increased assistance with transfers to two person assist including transfers on/off commode, initiated 2/27/25. A Physical Therapy communication to nursing note with a therapist signature, dated 1/24/25, and nurses signature, dated 1/27/25, indicated the resident was a one assist with transfers, set up, to right side, use bilateral platform rolling walker and gait belt. Progress notes were reviewed and included but were not limited to: On 2/24/25 at 11:51 a.m., a physician progress note indicated the patient's plan of progress was discussed with nursing staff and therapy. Patient was seen up in her recliner. She was alert and oriented. She reported she did not feel well today. She reported she had been having dry heaving due to phlegm and was coughing frequently. She also reports increased congestion. No complaints of chest pain, shortness of breath, nausea, vomiting, fever or chills. Patient's pain is controlled. On 2/24/25 at 9:43 p.m., indicated . 1700, [5:00 p.m.] residents room. BP [blood pressure] 111/78 P [pulse] 93 R [respirations] 16 T [temperature] 100.6, oxygen 93% on RA [room air] Description of fall: CNA notified this nurse that resident was lowered to the floor. CNA was assisting resident with ambulating from recliner to bed, gait belt in place. As resident was turning around to sit on edge her bed her legs gave out and CNA assisted resident to the floor on her side. When this nurse entered resident's room, resident was noted lying face down on floor. Resident began to dry heave and had small amount of emesis on floor. Resident was assisted onto her back, assisted to seated position. No complaintsof [sic] pain. ROM WNL [range of motion within normal limits] to bilateral extremities. Resident assist to standing position with 2 staff assist Range of motion; mental status, neurochecks if unwitnessed or hit head; ROM WNL, witnessed fall as CNA assisted resident to the floor Immediate intervention: Resident's transfer status changed to assist x [of] 2 due to increased weakness from not feeling well. Physician notification; family (responsible party notification: MD [medical doctor] and Spouse made aware of fall. On 2/25/25 at 9:49 a.m., Fall IDT (Interdisciplinary Team) Note, Late Entry: Attendees present: MDS, CM (case manager), Therapy. On 2/24/25 at 7:00 p.m., CNA was assisting resident with ambulating from recliner to bed and just as resident was turning around to sit on edge her bed her legs gave out and CNA assisted resident to the floor on her side. When this nurse entered resident's room, resident was noted lying face down on floor. Resident began to dry heave and had small amount of emesis on floor. Resident was assisted onto her back, assisted to seated position. No complaints of pain. ROM WNL to bilateral extremities. Resident assisted to standing position with two staff assist. Root cause of fall: Resident not feeling well and legs became weak. Intervention and care plan updated. Updated transfers status for two staff due to increased weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/25/25 at 12:23 p.m., Followed up with NP (Nurse Practitioner) regarding resident's increased weakness, temperature noted on 2/25/25 and vomiting. New order received for Tamiflu prophylactic due to suspected Influenza A. Family aware. On 2/28/25 at 9:46 a.m., Notice of Transfer & Discharge and (name of facility) Bed Hold Authorization mailed via United States Postal Service Certified Mail to resident address for transfer on 2/26/25. On 2/28/25 at 9:52 a.m., Fall IDT Note, Attendees present: HFA (Health Facility Administrator), DON (Director Of Nursing), Therapy, CM, MDS. On 2/26/25 at 10:00 a.m., resident was being assisted by staff to toilet. Staff briefly exited room to get linens to assist resident with bathing needs and returned to find resident on floor in front of commode. Root cause of fall: impaired sitting balance. Intervention and care plan updated: will re-evaluate upon hospital return. An NP progress note, dated 2/26/25 indicated after initial visit and prior to leaving facility patient experienced a fall in the bathroom of SNF (skilled nursing facility). She apparently struck her head, causing a laceration to outer left eyebrow that appears to need sutures. Patient recently had CVA and was on ASA (aspirin) and plavix (blood thinner), putting her at risk for bleed. Neurological deficits noted to baseline and appeared relatively unchanged with limited exam. Staff also stated that she did have a LOC (loss of consciousness) with the fall. Advised nursing to send urgently to ER (emergency room) for evaluation and treat. A hospital document, dated 2/26/25 at 11:45 a.m., included but was not limited to: Alert and non-toxic, lying flat with cervical collar in place speaking in full sentences, obvious laceration to the left temporal. Radiology/procedures: Computed Tomography (CT) Head WO (without) contrast comparison CT head 12/30/24. Scattered areas of subarachnoid hemorrhage. On 4/10/25 at 10:00 a.m., Therapy 1 indicated the therapy notes from 2/24/25 indicated Resident B was feeling ill and was a minimum assist of one on the commode during the therapy session. At 12:08 p.m., Therapy 1 indicated from a therapy note, dated 2/20/25, Resident C was able to sit without assist before she became ill. Her assist was changed to two assist because she had become ill and was requiring assist to sit upright during the therapy session on 2/24/25, therapy normally put a communication note in the Kardex and MDS updated the care plan. At 12:24 p.m., Therapy 1 indicated Resident C's care plan indicated she was a two assist when toileting and was not supposed to be left on the commode alone. Therapy 1 indicated Resident C had been changed to assist of one prior to the falls for transfers, set up to right side, but therapy had not changed her assist of two and to not be left alone on the commode. An interview on 4/10/25 at 11:00 a.m., with Assistant Director Of Nursing (ADON) indicated CNA 2 put Resident C on the commode by herself, CNA 2 had told her she was unaware the resident had been made a two assist again. Normally if a resident fell , in the morning meeting IDT reviewed interventions, the care plan was updated, the Kardex was updated, it was on the computer and the CNA's had access to review it. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 4/10/25 at 11:03 a.m., with the Case Manager indicated when Resident C had the fall on 2/24/25 she was changed back to a two assist while under an acute episode. An interview on 4/10/25 at 12:18 p.m., with Therapy 2 indicated therapy notes on 2/20/25 indicated Resident C was able to sit unsupported without assist, notes on 2/24/25 indicated she was a minimum assist of one during the therapy session and needed help to sit upright due to leaning to the side and feeling ill. Therapist 2 indicated Resident C's care plan, dated 1/24/25 for two assist to toilet and to not leave alone on the commode had not been changed by therapy. Resident C had always been a 2 assist to toilet and not be left alone on commode. 2. On 4/8/25 at 1:00 p.m., a State reportable incident for Resident B was reviewed. The incident indicated on 3/30/25 at 1:30 p.m. staff were transferring resident in a mechanical lift and the resident experienced a fall. Trauma work up was negative. A written statement, dated 3/30/25, by CNA 3 indicated, after lunch at approximately 1:10 p.m., CNA 3 was laying Resident B in her bed with the mechanical lift. When they were almost to her bed, the left foot of the mechanical lift hit the bottom wheel of bed. At that time, resident fell out side of mechanical lift sling, to floor. All straps were secured in place before the transfer. A written statement, dated 3/30/25, by LPN 2 indicated LPN 2 called to resident number. CNA stated Resident B had just fell out of the mechanical lift. LPN 2 entered resident room and noted mechanical lift between the beds in in the room, legs together. Resident was lying on her back, her head was at the opening of the mechanical lift and her feet were on top of the mechanical lift legs. CNA stated when she placed the mechanical lift close to the bed, she hit the wheel of the bed frame, resident began rocking and then fell out of the lift. On 4/8/25 at 11:20 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, mild cognitive impairment, history of falling, other reduced mobility, need for personal assistance, and vascular dementia. A quarterly MDS assessment, dated 3/5/25, indicated Resident B's cognition was moderately impaired, chair to bed transfer dependent (helper does all of effort resident does none of the effort to complete activity). Care plans included but were not limited to: Resident needed assistance with ADL's revised 6/13/23. Interventions included, but were not limited to, resident required a mechanical lift and two person assist for all transfers, revised 4/1/25. A progress note, dated 3/30/25 at 1:40 p.m., indicated at 1:10 p.m., CNA called nurse to resident room stating resident was on the floor. Upon entering resident room, noted resident lying on floor on her back. Mechanical lift in room. On 4/8/25 at 1:09 p.m., the DON indicated one staff member was transferring Resident B when she fell out of the mechanical lift. On 4/8/25 at 1:13 p.m., Resident B indicated she thought she fell at her brother's house and not at the facility. Resident B was observed to be confused. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/9/25 at 8:39 a.m., CNA 4 and CNA 5 indicated when using a mechanical lift two staff were required. On 4/8/25 at 2:04 p.m., the ADON provided the current policy on safe handling/transfers with a implemented date of 2/28/24. The policy included, but was not limited to, it was the policy of the facility to ensure that residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The resident's mobility needs would be addressed on admission and reviewed quarterly, after a significant change in condition, or based on direct care staff observations or recommendations. Two staff members must be utilized when transferring residents with a full body mechanical lift. On 4/8/25 at 2:04 p.m., the ADON provided the current manual for the mechanical lift used for the transfer of Resident B. The manual included, but was not limited to: .Warning : [name of mechanical lift manufacturer] strongly recommends that two caregivers take part in the lifting process . On 4/10/25 at 12:57 p.m., the ADON provided the current policy on fall investigation and risk evaluation, revised date of 8/2024. The policy indicated it was the policy of the facility to provide an environment that was free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goal, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risks of an accident. This citation relates to Complaints IN00456718 and IN00456869. 3.1-45(a)(2)