

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Hamilton Pointe Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the residents' families for 2 of 3 residents reviewed for notification of changes. A resident's family was not notified of a change in the resident's physical condition and a resident's fall. (Resident F, Resident M)Findings include:</p> <p>1. On 7/30/25 at 2:37 P.M., Resident F's clinical record was reviewed. Diagnoses included but were not limited to hypertension and acute respiratory failure. The Current admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. Resident F needs supervision for transferring, setting up for eating, partial assistance with hygiene, and substantial/maximum assistance of 2 for toileting and dressing. Current physician orders included, but were not limited to, Tylenol Extra Strength Oral Tablet (pain relief) 500 Milligrams (MG). Give 1 tablet by mouth three times a day for Shoulder pain dated 7/24/25.</p> <p>The Current Fall Risk Care Plan dated 7/1/25 indicated the resident was at risk for falls due to a history of falls and impaired balance. Current interventions included but were not limited to, call bell within reach, call don't fall sign to bathroom door, and wear proper footwear or non-slip footwear when up.</p> <p>A nursing progress dated 7/20/25 at 10:00 A.M., composed by RN 7, indicated the daughter came to visit and was informed at that time that the resident had a fall. The daughter noticed that the resident had a mental status change and wanted the resident sent to the hospital.</p> <p>During a phone interview on 7/30/25 at 8:38 A.M., the Power of Attorney indicated she was not notified about the fall until the family came to visit and found Resident F confused. She also indicated that the nurse who was assigned to the resident did not start the paperwork until after the family was made aware. During an interview on 7/31/25 at 10:15 A.M., RN 7 indicated she probably should have called the family at the time the resident had fallen instead of doing her medications and several other things at this time.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 8/01/25 at 1:40 P.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnosis included, but was not limited to, epilepsy. The most recent Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident M was moderately cognitively impaired and was dependent on staff (staff do all the work) for toileting and transfers. Physician orders included, but were not limited to: Onfi oral tablet 20 MG (milligrams), give 20 mg by mouth at bedtime for seizures; Start date 4/1/25Levetiracetam Oral Tablet 750 MG, give 750 mg by mouth two times a day for seizures; Start date 4/1/25Lamictal Tablet 200 MG, give one tablet by mouth two times a day for seizures; Start date 4/1/25 Resident M's special instructions for plan of care indicated: Please contact Palliative service with all changes in conditions, to receive orders. Current care plan included, but was not limited to: I am currently prescribed an anticonvulsant for seizure disorder; Date Initiated: 11/26/24 I have a seizure disorder and convulsions; Date Initiated: 8/10/20 A nursing progress note dated 7/3/2025 7:08 P.M., indicated Resident began having seizure activity in the hallway. Tremors of all extremities, particularly arms. Hands grasping and eyes blinking. Lasted no more than 3 minutes. She was then taken to her room. She had seizure activity twice more. Complain of headache. The clinical record, including progress notes, assessments, and documentation, lacked notification to family, physician, or palliative care post-seizure activity. During an interview on 8/5/25 at 10:20 A.M., the Director of Nursing indicated that after a resident experienced a seizure, staff should monitor the resident and notify the family and physician.</p> <p>On 7/31/25 at 10:31 A.M., the Administrator provided a current policy Notification of Change dated August 2024. The policy indicated .The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification .</p> <p>This citation relates to complaint 2567193 3.1-59(a)(1)3.1-5(a)(2)</p>