

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00145071 and Complaint IN00145580.</p> <p>Complaint IN00145071 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00145580 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: March 13 and 14, 2014</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 35 SNF/NF: 55 Residential: 50 Total: 140</p> <p>Census payor type: Medicare: 25 Medicaid: 26 Other: 89</p>	F000000	<p>This Plan of Correction is prepared and executed because it is required by the Provisions of State and Federal regulations. The Village at Hamilton Pointe maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such a nature as to limit our capability to provide adequate care.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Total: 140</p> <p>Sample: 7</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 17, 2014, by Jodi Meyer, RN</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to use a gait belt during the transfer of a resident, or the assistance of two staff as care planned, resulting in a skin tear which developed into a skin laceration requiring sutures, for 1 of 3 residents reviewed who required assistance with transfers, in a sample of 7. (Resident D)</p> <p>Findings include:</p> <p>1. On 3/13/14 at 10:00 A.M., the Administrator provided an Indiana State Department of Health (ISDH) Incident Report Form. The form included: "...Resident hit right arm on wheelchair and opened area measuring 17 cm x 3 cm x 3 cm...Follow up added 2/27/14 Investigation reveals that resident obtained laceration to right arm during transfer. Resident stated she bumped her arm on her</p>	F000323	<p>1. Resident #D has been discharged. Unable to correct. 2. The Director of Nursing observed resident transfers on March 24, 2014, and no issues were noted. 3. Licensed staff and C.N.A.'s will be reeducated regarding the Resident Handling Policy. This reeducation will be completed by March 24, 2014. 4. The Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe resident transfers on day, evening and night shifts at various times five (5) times per week for two weeks (2), then two (2) times per week for eight (8) weeks and weekly for fourteen (14) weeks to verify that the appropriate equipment and number of staff was used per the care plan to transfer the resident. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of six (6) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as</p>	03/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wheelchair..." The Administrator indicated at that time that she reported the incident to the ISDH due to the size of the laceration.</p> <p>The closed clinical record of Resident D was reviewed on 3/13/14 at 10:15 A.M. The resident was admitted to the facility on 1/21/14 with diagnoses including, but not limited to, muscle weakness and peripheral neuropathy.</p> <p>A Minimum Data Set (MDS) assessment, dated 1/28/14, indicated the resident required extensive assistance of two+ staff for transfer ("how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position").</p> <p>A care plan, dated 2/3/14, indicated: "Focus: [Resident D] has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] weakness, incontinence at times, requires assistance with her ADL's." The Interventions included: "Transfer: [Resident D] required 2 staff participation."</p> <p>A computerized listing of "Activities of Daily Living" transfers indicated the resident required extensive</p>		<p>needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>assist of two staff from 1/28/14 until 2/18/14.</p> <p>Progress Notes included the following notations:</p> <p>2/18/14 at 8:30 P.M.: "...Needs extensive assistance of two staff for transfers. Needs extensive assist of two for ambulation. Needs extensive assistance of two staff for bed mobility...Has edema lower extremity...Resident complains of weakness...."</p> <p>A Physical Therapy Recertification & Updated Plan of Treatment, dated 2/18/14, indicated: "...LTG [long term goal], Patient will transfer sit<>stand and stand pivot with min A [minimal assistance] with AD and cues for safe technique in order to facilitate increased independence with ADLs and prepare for gait Baseline (2/18/2014) mod A x 2 with 100% v/c's [verbal cues]."</p> <p>Progress Notes continued:</p> <p>2/19/14 at 8:30 P.M.: "...Needs extensive assistance of one staff for transfers...."</p> <p>An Occupational Therapy Treatment Encounter note, dated 2/20/14,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>included: "Mod A transfers to and from toilet with use of grab bars...."</p> <p>Progress Notes continued:</p> <p>2/22/14 at 8:08 A.M.: "Called to resident's room by CNA stating resident had bumped arm on wheelchair and obtained a skin tear. Upon exam found a laceration measuring 17 cm x 3 cm x 3 cm. Wrapped arm in towel and called physician [name]. Orders received to send to emergency room for evaluation. Family and on call nurse notified."</p> <p>A hospital emergency room note, dated 2/22/14 at 8:33 A.M., indicated: "...presents to the Emergency Department by EMS [emergency medical services] from a nursing home with complains [sic] of skin tear to right arm...the nursing home reported to EMS that patient hit her arm on the wheel of a wheelchair and cut it open. Patient states that she fell but is unable to tell us information about the fall...Patient has dressings on bilateral legs for old ulcers. Patient had edema in bilateral legs...Physical Exam: Laceration to right forearm that extends 18 cm...Procedures: Repair nylon, Skin</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p># (Nylon) 15...actively bleeding...."</p> <p>A hospital history and physical, dated 2/22/14, indicated: "The patient sustained a right forearm laceration in a nursing home...apparently sustained a large right arm laceration as it got caught in a wheelchair and was brought into the ER. Her laceration was sutured up...."</p> <p>On 3/13/14 at 11:00 A.M., during interview with CNA # 1, she indicated she had transferred Resident D from the bed to the wheelchair. She indicated the resident was a "1 person assist." CNA # 1 indicated she did not use a gait belt during the transfer, and demonstrated how she wrapped her arms around the resident's waist. CNA # 1 indicated she noted a small skin tear on the resident's arm, and went and told the nurse. CNA # 1 indicated when she returned with the nurse, the skin tear was "all the way up her arm."</p> <p>On 3/14/14 at 9:25 A.M., during interview with LPN # 1, she indicated CNA # 1 came and got her and told her Resident D had a skin tear. LPN # 1 indicated when she saw the resident, "it looked like her arm had</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>just split open." LPN # 1 indicated the resident's skin was "real fragile." LPN # 1 indicated the resident was confused at times, but was usually alert. LPN # 1 indicated the resident was able to stand and pivot with one assist sometimes.</p> <p>On 3/14/14 at 1:40 P.M., during interview with PTA # 1, she indicated the staff was "always supposed to use a gait belt during transfers."</p> <p>2. On 3/14/14 at 2:10 P.M., the Director of Nursing provided the current facility policy on "Resident Handling Policy," undated. The policy included: "Gait belt usage is mandatory for all resident handling with the exception of bed mobility & medical contraindications. The gait belt will be readily available for use...."</p> <p>This Federal tag relates to Complaint IN00145071.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE