STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING **01** B. WING _____	R **08/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	**31869 CHICAGO TRAIL** **NEW CARLISLE, IN 46552**

(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
{K 000}	INITIAL COMMENTS A 2nd Post Survey Revisit (PSR) for the 1st PSR survey that exited on 07/24/23 for the Life Safety Code survey that exited on 04/26/23 was conducted by the Indiana Department of Health in accordance to 42 CFR 483.90(a) Survey Date: 08/11/23 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Life Safety Code PSR, Hamilton Grove was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in corridors, areas open to the corridor, and hardwired smoke detectors in all resident rooms. A 2-hour occupancy barrier separates the assisted living portion and a business occupancy section from the healthcare part of the building. A bathing area and physical/occupational therapy rooms for healthcare residents both are located outside of the 2-hour wall located within the business area of the building which was then surveyed as part of healthcare. The facility has a capacity of 85 and had a census of 67 at the time of this survey.	{K 000}		

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
	155672	A. BUILDING **01** B. WING _____	R **08/11/2023**

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{K 000}	Continued From page 1 All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 08/11/23	{K 000}		