STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. BUILDING 00 B. WING	06/05/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00435563. This visit was in conjunction with the Recertification and State Licensure Survey and State Residential Licensure Survey. Complaint IN00435563 - Federal deficiencies related to the allegations are cited at F684 and F9999 . Survey dates: May 28, 29, 30, 31, June 3, 4, 5, 2024. Facility number: 012966 Provider number: 155803 AIM number: 201110390 Census Bed Type: SNF/NF: 71 SNF: 17 Residential: 53 Total: 141 Census Payor Type: Medicare: 9 Medicaid: 59 Other: 21 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2024.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Cates	Administrator	07/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to provide care by thorough assessment of a resident prior to narcotic medication administration and implementation of a person centered care plan for the use of narcotics, and a care plan that reflected accurate resuscitative measures for 1 of 2 residents reviewed for expiration in the facility. (Resident P) Findings include: On 6/3/24 at 9:15 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and atrial fibrillation. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated Resident P was cognitively intact and was receiving opioid pain medication during the seven day lookback period. Physician orders included, but were not limited to: Do not resuscitate, dated 2/9/24. Observe for side effects (Narcotic pain medication), dated 2/15/24. Ipratropium-albuterol (medication to improve breathing) inhalation solution 0.5-2.5(3) mg/mL (milligram per milliter) one inhalation inhale orally every eight hours as needed, dated 2/27/24. Norco (opioid pain medication) oral tablet 5-325 mg (Hydrocodone-Acetaminophen) Give one tablet by mouth three times a day for pain hold for sedation, dated 4/15/24. Norco oral tablet 5-325 mg	F 0684	The facility will ensure this requirement is met through the following corrective measures: 1. Resident P no longer resides at the facility. 2. All residents have the potential to be affected. Code status care plans have been removed and the code status has been incorporated into the Choices care plan. Those residents receiving opioid narcotics were reviewed to ensure a care plan to address the potential for adverse effects was in place. A pain medication order audit was completed to ensure that staff are prompted to assess pain level prior to administration. 3. The policies on Care Planning & Pain Management were reviewed and no changes were indicated. Licensed nursing staff will be educated on those policies. The DON or his designee will review 5 random residents twice weekly to ensure assessment is completed prior to administration and that potential side effects are being monitored at least once per shift for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until	07/09/2024

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	(Hydrocodone-Acetaminophen) Give one tablet by mouth every four hours as needed for pain, dated 4/15/24. Resident P's clinical record included a signed document Titled Indiana Physician Orders for Scope of Treatment (POST), dated 2/9/24, and indicated Medical Interventions Comfort Measures (Allow Natural Death). Care plans included, but were not limited to: I have elected to be a full code, dated 2/9/24. I have chronic breathing problems related to asthma; observe for increased shortness of breath, difficulty breathing, change in mental status.., dated 3/21/24. The clinical record lacked a care plan relating to narcotic pain medications and potential adverse side effects to monitor. On 6/3/24 at 9:15 A.M., Resident P's medication administration record was reviewed. Resident P narcotic sheet indicated on 4/23/24 Norco 5-325 mg was given at 6:35 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 8:00 P.M. A progress note dated 4/23/24 at 5:16 P.M., indicated Resident was given a breathing treatment and oxygen saturation level had come back to 89% on 2L (liters). A progress note dated 4/23/24 at 6 P.M., indicated Resident P's family member had notified staff of the resident's symptoms. Vitals checked and oxygen saturation dropped to 68%. Resident was placed on 2L oxygen by nasal cannula. Resident declined going to the hospital. Staff set an acute visit for the following day.		100% compliance is maintained. The DON or his designee will review 5 random residents twice weekly to ensure potential side effect care plans are in place for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. The Social Services Manager or his designee will review 6 random resident's care plans weekly to ensure accurate code status is addressed in the Choices care plan for 6 weeks and until 100% compliance is achieved, the 10 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	A progress note dated 4/23/24 at 7:17 P.M., indicated LPN 45 took bedtime medications to Resident P, and resident was unable to rouse or swallow medications. EMS and family were called, the Physician was notified through Telemedic. Ambulance arrived followed by the Fire Department. Blood glucose level had dropped, and an intravenous line was started by EMS in Resident P's left shin bone. At 8:08 P.M., Resident P stopped breathing. CPR (cardio-pulmonary resuscitation) was not started. On 6/5/24 at 8:43 A.M., LPN 45 stated Resident P's oxygen level was at 68% prior to the breathing treatment of albuterol administered on 4/23/24 at 5:16 P.M. The Norco 5-325 tablet was signed out at 8:00 P.M., but should have been signed out at 7:17 P.M. with the other bedtime medications; Resident did not take any of the bedtime medications due to inability to swallow, the medications rolled out when a spoonful was placed in Resident P's mouth. Prior to 7:17 P.M., Resident P was completely alert and oriented, and having a full conversation. Resident P had no adverse signs, symptoms, or side effects other than nausea and respiratory changes. EMS (emergency medical services) and fire department arrived at the facility quickly; LPN 45 indicated she was not sure what Resident P's blood sugar was when EMS checked it, Resident was not a regular blood sugar check and did not receive insulin. Nurse indicated she probably should have revised charting and struck out the medications out for the eMAR (electronic medication administration record) to reflect the resident not taking the medications, but it was a chaotic night and staff were doing their best to get everyone caught up and the rest of the resident's taken care of.			

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	During an interview on 6/5/24 at 10:22 A.M., Regional Clinical Nurse 9 indicated in order for a nurse to recognize respiratory distress, it would have to be more than just low oxygen levels, and the resident did not have an order for oxygen but staff can administer oxygen in emergent situations without an order. During an interview on 6/5/24 at 11:38 A.M., Regional Clinical Nurse 9 indicated the care plan that indicated Resident P was a full code was inaccurate and should have indicated do not resuscitate, there was not a care plan related to pain medication side effects, and the facility did not have a policy relating to monitoring adverse side effects of narcotic pain medications. This citation relates to complaint IN00435563. 3.1-37(a)			
F 9999 Bldg. 00	3.1-28 STAFF TREATMENT OF RESIDENT (c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. This State Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an injury of unknown source to the Indiana Department of Health (IDOH) for 1 of 1	F 9999	The facility will ensure this requirement is met through the following corrective measures 1. No residents were affected by the lack of reporting. 2. All residents have the potential to be affected. 3. The policy IDOH-LTC Abuse & Incident Reporting Policy was reviewed and has not been revised. Facility leadership was provided education regarding the reporting of injuries of unknown origin. The DON or his designee will review all noted injuries to ensure an investigation has been	07/09/2024

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	resident reviewed for injuries of unknown source. (Resident D) Finding includes: On 5/30/24 at 1:21 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, displaced fracture of the medial condyle of left tibia, wedge compression fracture of fourth thoracic vertebra, and dementia. The current Quarterly MDS (Minimum Data Set) Assessment dated 5/10/24 indicated Resident D was mildly cognitively impaired and had a history of falls. Resident D is dependent for assistance with mobility and transfer. During record review, an X-Ray of the resident's left femur and lower leg was conducted on 5/9/24 at (Name of Hospital) indicated there was an acute fracture of the proximal tibia. A second X-Ray of left knee on 5/23/24 conducted at (Office) indicated there was no change in the displacement and had some healing. The record lacked notification of an injury of unknown source. During an interview on 6/3/24 at 2:10 P.M., the Administrator indicated that everything from the hospital says the age of fracture was age undetermined, was not acute so it was not reported. On 6/3/24 at 2:00 P.M., the Regional Nurse Consultant provided a current policy "Administrative-Accidents and Incidents Investigating and Reporting" revised in 7/21. The policy indicated "to ensure the reportable occurrences are recorded and monitored to		conducted and the incident reported, if indicated, 5 times weekly on-going. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	facilitate compliance with the state and federal laws. Unusual occurrences reported to the Indiana State Department of Health will be recorded, tracked, and monitored to ensure residents are receiving appropriate care and services....Injury of an unknown source should be classified and as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed, and the injury is suspicious because of the extent of the injury or the location..." This citation relates to complaint IN00435563.			