

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-039

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 06/25/2024	
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COD 3800 ELI PLACE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/25/24</p> <p>Facility Number: 012966 Provider Number: 155803 AIM Number: 201110390</p> <p>At this Emergency Preparedness survey, Hamilton Pointe Health and Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 115 certified beds. At the time of the survey, the census was 90.</p> <p>Quality Review completed on 06/27/24</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:</p>			E 0000	<p>The completion of this Plan of Correctio 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.</p> <p>The facility is requesting a desk review for compliance.</p>		
E 0006 SS=F Bldg. --	<p>403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)</p> <p>Plan Based on All Hazards Risk Assessment</p> <p>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2),</p>						

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

TITLE

(X6) DATE

Shawn Cates

Administrator

07/05/2024

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 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 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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	<p>§484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency</p>						

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	<p>preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of Emergency Preparedness Manual on 06/25/24 between 9:45 a.m. and 12:45</p>			E 0006	<p>No residents were identified related to this deficiency. All residents on the campus have the potential to be affected. The Emergency Preparedness Manual was reviewed and updated to include additional all-hazard approach. Facility Regional Plant Operations consultant will review and amend as necessary.</p> <p>Facility Administrator will ensure the Emergency Preparedness Plan is reviewed and updated as appropriate annually.</p>		07/09/2024

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K 0000 Bldg. 01	<p>p.m. with the Director of Plant Operations present, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. The most recent date reviewed was 01/2022 according to the date on the risk assessment form. Based on interview at the time of record review, the Director of Plant Operations said 01/2022 was the date of the most recent review of the risk assessment as far as he knew.</p> <p>This finding were reviewed with the Administrator and Director of Plant Operations during the exit conference.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 06/25/24</p> <p>Facility Number: 012966 Provider Number: 155803 AIM Number: 201110390</p> <p>At this Life Safety Code survey, Hamilton Pointe Health and Rehab was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of</p>			K 0000	<p>The completion of this Plan of Correctio 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.</p> <p>The facility is requesting a desk review for compliance.</p>		

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K 0711 SS=F Bldg. 01	<p>Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 115 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 06/27/24</p> <p>NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms</p>			K 0711	<p>It is the policy of Hamilton Pointe to provide a complete a facility specific written fire safety plan for the protection of all residents.</p> <p>No residents were identified or affected by the practice. The facility fire plan was reviewed and updated to reflect where the smoke barriers are located. Plant</p>		07/09/2024

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	<p>(2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:</p> <p>i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the facility's Fire Plan on 06/25/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant Operations present, the plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. Based on interview at the time of record review, the Director of Plant Operations acknowledged and agreed that the Fire Plan did not identify where the smoke barriers were located in the facility.</p> <p>This finding was reviewed with the Administrator and Director of Plant Operations during the exit</p>				<p>of Operations manager will ensure all Emergency Disaster binders and available Emergency preparedness binders are updated to reflect these changes.</p>		

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