STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 30 - May 8, 2025. Facility number: 000427 Provider number: 155672 AIM number: 100275150 Census Bed Type: SNF/NF: 49 Residential: 24 Total: 73 Census Payor Type: Medicare: 3 Medicaid: 40 Other: 6 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 5/15/2025	F 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hamilton Grove does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify a Physician of a resident's change in condition related to blood pressures and missed doses of medication for 2 of 5 residents who were reviewed. (Resident 3 and 30 Findings include:	F 0580	The facility failed to notify a Physician of a resident's change in condition related to blood pressures and missed doses of medication for 2 of 5 residents who were reviewed. (Resident 3 and 30) A) Notified MD of change of	06/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cherry Smith	Corp Director of Clinical Services	05/30/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	1. Resident 3's record review was completed on 5/6/2025 at 8:53 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, generalized anxiety disorder, hypercholesterolemia, supravalvular aortic stenosis, peripheral vascular disease, atrial fibrillation, nonrheumatic mitral valve disease and hypertension. Current Physician's orders indicated Resident 3 was to receive 2.5 milligrams (mg) of olanzapine (treats symptoms of mental health disorders), 10 mg of melatonin (sleep aid) and 40 mg of pravastatin (treats high cholesterol) at bedtime. A review of the April 2025 Medication Administration Record (MAR) indicated Resident 3 had refused her bedtime medications of olanzapine, melatonin and pravastatin on 4/8/2025. In addition, Resident 3 had not received her bedtime doses of olanzapine, melatonin or pravastatin on 4/23/2025. The record lacked the documentation indicating why the medications were not administered on 4/23/2025 or that the Physician had been notified the resident had refused any medications on either date. A review of the May 2025 MAR indicated Resident 3 had refused to take her scheduled doses of olanzapine, melatonin and pravastatin at bedtime on 5/2/2025. The record lacked the documentation a Physician had been notified. During an interview with the Assistant Director of Nursing (ADON) on 5/8/2025 at 10:20 A.M., she indicated Resident 3 did not receive her prescribed medications on 4/23/2025 and she was not able to identify why the medications were not given, or if the Physician was notified Resident 3 had refused or missed her bedtime medications on		condition of resident 3 and 30 B) Residents were assessed for changes in condition and missed medication. C) Nursing staff were educated on change of condition and medication administration. D) An audit will be completed by the designee for changes of condition and medication administration. Three charts per week for 4 weeks. Two charts per week for 4 weeks. One chart per week for4 weeks. One chart monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results will be reviewed in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	4/8, 4/23, or 5/2/2025.2. The clinical record of Resident 30 was reviewed on 5/2/2025 at 9:58 A.M. The resident's diagnoses included, but were no limited to: vascular dementia, chronic kidney disease, depression, morbid obesity, obstructive sleep apnea, personal history of transient ischemic attack and cerebrovascular accident, dementia, encephalopathy, visual hallucinations and lymphedema. An Annual Minimum Data Set (MDS) assessment, dated 2/10/2025, indicated Resident 30 was moderately cognitively impaired. A current Care Plan, initiated 2/23/2025, indicated Resident 30 had a potential for an alteration in cardiac circulation. Interventions included, but were not limited to: vital signs as ordered, facility policy and as needed and update physician and family as needed. A Nursing Progress Note, dated 2/6/2025, indicated Resident 30 had the following vital signs: blood pressure 80/56 mmHg (millimeters of mercury). Resident 30's record lacked documentation the medical provider and/or the family was notfied of the low blood pressure assessment. During an interview, on 5/05/2025 at 9:39 A.M., RN 3 indicated if a resident's vital signs were out of a normal range, she would have looked to see if the physician had left vital sign parameters guidelines in the chart. RN 3 indicated if the physician had not left call parameters for vital signs, depending on the time and day, she would notify the physician either in person, if he was in the building rounding, by email message or by calling the on-call provider. RN 3 indicated for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	any blood pressure below a systolic of 80 mmHg she would have held the blood pressure medications and contacted the medical provider. During an interview, on 5/06/2025 at 11:24 A.M., the Director of Nursing (DON) indicated at the time of the low blood pressure assessment, on 2/6/2025 at 6:41 P.M. an agency nurse was caring for Resident 30. The DON indicated the nurse should have re-checked the blood pressure and notified the physician. On 5/8/2025 at 10:20 A.M. the ADON provided a policy, dated 2/28/2024, and titled, "Medication Administration". The ADON indicated the policy was the one currently used by the facility. The policy indicated, "...8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters...14. Administer medication as ordered in accordance with manufacturer specifications...19. Report and document any adverse side effects or refusals...." On 5/6/2025 at 3:10 P.M., the DON provided a policy titled, "Acute Condition Changes," dated 1/23/2024 and indicated the policy was the one currently used by the facility. The policy indicated "...Licensed nursing team member(s) will assess residents for acute condition changes from the resident's baseline and will notify both the physician and family of such changes...." 3.1-5(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility	F 0757	The facility failed to ensure	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	failed to ensure adequate monitoring of antipsychotic medications occurred medications timely for 2 of 3 residents who were reviewed for antipsychotic medications . (Resident 3 and 18) Findings include: 1. Resident 3's record review was completed on 5/6/2025 at 8:53 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, generalized anxiety disorder, hypercholesterolemia, supravalvular aortic stenosis, peripheral vascular disease, atrial fibrillation, nonrheumatic mitral valve disease and hypertension. A current Physician's order indicated Resident 3 received 2.5 mg of olanzapine (antipsychotic medication that treats symptoms of mental disorders) once a day at bedtime. Resident 3 had an AIMS (Abnormal Involuntary Movement Scale) assessment on 12/2/2024. There was no documentation to indicate another AIMS assessment had been completed after 12/2/2024 and before 5/6/2025. During an interview on 5/5/2025 at 2:20 P.M., the Director of Nursing indicated the facility's policy was to perform an AIMS assessment quarterly for residents receiving antipsychotic medications and Resident 3 had not received a quarterly AIMS assessment. 2. A record review was completed on 5/5/2025 at 8:58 A.M. for Resident 18. Diagnoses included, but were not limited to, psychotic disorder with delusions and major depressive disorder. A Quarterly Minimum Data Set assessment, dated		adequate monitoring of antipsychotic medications occurred timely for 2 of 3 residents who were reviewed for antipsychotic medications. (Residents 3 and 1 8). A) AIMs scale for residents 3 & 18 were updated. B) AIMS scales were reviewed for all residents on psychotropics. C) Nursing staff were educated on the psychotropic medication policy. D) An audit will be completed by designee for residents on psychotropic meds for AIMS scale completion. Three residents a week for 4 weeks. Two residents a week for 4 weeks. One resident a week for 4 weeks. One resident a month thereafter until found in substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	1/19/2025, indicated Resident 18's cognition was severely impaired and she received antipsychotic medication daily. Physician Orders included, but were not limited to - Abilify 2.5 milligrams by mouth daily for a psychotic disorder with delusions, on 6/27/2022 she may have a psychiatric evaluation with follow ups and on 5/10/2022 to monitor for antipsychotic side effects. A Care Plan, dated 5/10/2022, indicated Resident 18 was at risk for adverse side effects related to the use of an antipsychotic and included an intervention for an Abnormal Involuntary Movement Scale (AIMS) assessment to be completed per facility policy. Documentation of AIMS assessments completed for Resident 18 for the past 12 months was requested on 5/5/2025 at 2:15 P.M. There had only been one AIMS assessment completed, on 1/13/2025, for the past year. During an interview on 5/6/2025 at 10:50 A.M., the DON indicated the facility policy was for AIMS assessments to be completed quarterly but Resident 18 had not had any completed in 2024. A current policy titled, "Psychotropic Medication Policy" and dated 10/31/2022, was provided by the DON on 5/6/2025 at 12:18 P.M. The policy indicated, "...Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a change in condition, change in antipsychotic medication, PRN (as needed) or as per campus policy...." 3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to store food in a sanitary manner related to labeling and dating opened food and disposing of expired food in 1 of 1 kitchen that was reviewed. This deficient practice had the potential to affect 49 of the 49 residents who received their meals from the kitchen. Finding includes: During an observation of the kitchen on 4/30/2025 at 8:15 A.M. with the Certified Dietary Manager (CDM), the following foods were in the walk-in cooler, but were expired or had no opened on or use by date: - 1 package of smoked turkey dated 4/14/2025 - 1 container with cut up purple onion dated 4/20/2025 - 1 container of premade chicken salad dated 4/22/2025 - 1 package of Virginia ham dated 4/21/2025 - A container with cut up white onion dated 4/21/2025 During an observation of the kitchen with the CDM on 4/30/2025 at 8:20 A.M., the following was observed: - Leaf tarragon was open but did not have an opened on or use by date. - Ranch powder was open but did not have an opened on or use by date. - Red food coloring was open but did not have an opened on or use by date. - Chopped chives was opened and had expired on 1/30/2024.	F 0812	The facility failed to provide a sanitary environment related to disposing of expired food in a resident's personal refrigerator for 1 of 3 personal refrigerators observed. (Resident #3) A) Refrigerator for resident 3 was checked, cleaned, and emptied of expired food. B) Refrigerators for all other residents were checked for cleanliness and expired food. C) Nursing staff and housekeeping staff were educated on the resident refrigerator policy. D) An audit will be completed by designee for residents with a refrigerator. Three refrigerators will be audited a week for 4 weeks. Two a week for 4 weeks. One a week for 4 weeks. One monthly thereafter until found in substantial compliance.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	During an interview on 4/30/2025 at 8:21 A.M., the CDM indicated any food that was opened should have been dated with the day it was opened. All opened food should have been used in three days or thrown away. On 5/6/2025 at 2:05 P.M. the Administrator provide an undated policy titled, "Labeling and Dating Foods) and indicated it was the policy currently used by the facility. The policy indicated, "...All foods stored will be properly labeled according to the following guidelines...2...Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date...4. Prepared food or opened food items should be discard when:...The food item is leftover for more than 72 hours. 3.1-19 (i)(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to provide a sanitary environment related to disposing of expired food in a resident's personal refrigerator for 1 of 3 personal refrigerators observed. Finding includes: During an observation on 4/30/2024 at 9:51 A.M. of Resident 3's personal refrigerator, the following was observed: - A container of parmesan cheese with an expiration date of 11/2023 - A single serve cup of chocolate pudding with an expiration date of 7/3/2024.	F 0921	The facility failed to provide a sanitary environment related to disposing of expired food in a resident's personal refrigerator for 1 of 3 personal refrigerators observed. (Resident #3) A) Refrigerator for resident 3 was checked, cleaned, and emptied of expired food. B) Refrigerators for all other residents were checked for cleanliness and expired food. C) Nursing staff and housekeeping staff were educated on the resident refrigerator policy.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	- A single serve cup of vanilla pudding with an expiration date of 11/24/2024. - Two cups of juice were covered with no date. The juice in both cups had separated and a large buildup of a thick white substance covered the top third of the juice glasses. - One bowel with a lid that contained no made on or use by date. The food in the bowel had mold and was unidentifiable. During an interview on 4/30/2024 at 9:55 A.M., RN 2 indicated she was not sure whose responsibility it was to clean out resident's personal refrigerators. She indicated expired food should not be in the resident's personal refrigerator. During an interview on 5/7/2025 at 3:15 P.M., the Director of Nursing (DON) indicated it was the Nurse's responsibility to check the resident's personal refrigerators for expired food. On 5/7/2025 at 3:15 P.M., the DON provided an undated policy titled, Food from Family, Visitors, Community" and indicated it was the policy currently used by the facility. The policy indicated, "...Food stored for residents should be labeled and dated appropriately and discarded per safe food storage guidelines...." 3.1-19(e)		D) An audit will be completed by designee for residents with a refrigerator. Three refrigerators will be audited a week for 4 weeks. Two a week for 4 weeks. One a week for 4 weeks. One monthly thereafter until found in substantial compliance.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 7 - 8, 2025. Facility number: 000427	R 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hamilton Grove does not admit that the deficiencies listed on this report exist, nor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility failed to store food in a sanitary manner related to labeling and dating opened food and disposing of expired food in 1 of 1 kitchen that was reviewed. This deficient practice had the potential to affect 49 of the 49 residents who received their meals from the kitchen. Finding includes: During an observation of the kitchen on 4/30/2025 at 8:15 A.M. with the Certified Dietary Manager (CDM), the following foods were in the walk-in cooler, but were expired or had no opened on or use by date: - 1 package of smoked turkey dated 4/14/2025 - 1 container with cut up purple onion dated 4/20/2025 - 1 container of premade chicken salad dated 4/22/2025 - 1 package of Virginia ham dated 4/21/2025 - A container with cut up white onion dated 4/21/2025 During an observation of the kitchen with the	R 0273	The facility is alleged to be out of compliance by failing to discard expired food from inventory. All residents could have been affected. A) Expired food was thrown away. B) All food area surveyed to discard of any additional food. No additional food identified. C) Dietary staff on Safe Food Handling and Labeling and Storage. D) An audit will be completed by the Dietary Manager/designee 3 times per week for 3 months and 2 days a week for 3 months until substantial compliance is found. Results will be reviewed in QAPI	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	CDM on 4/30/2025 at 8:20 A.M., the following was observed: - Leaf tarragon was open but did not have an opened on or use by date. - Ranch powder was open but did not have an opened on or use by date. - Red food coloring was open but did not have an opened on or use by date. - Chopped chives was opened and had expired on 1/30/2024. During an interview on 4/30/2025 at 8:21 A.M., the CDM indicated any food that was opened should have been dated with the day it was opened. All opened food should have been used in three days or thrown away. On 5/6/2025 at 2:05 P.M. the Administrator provide an undated policy titled, "Labeling and Dating Foods) and indicated it was the policy currently used by the facility. The policy indicated, "...All foods stored will be properly labeled according to the following guidelines...2...Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date...4. Prepared food or opened food items should be discard when:...The food item is leftover for more than 72 hours.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 3 of 5 residents whose Emergency information was reviewed. (Residents 3, 4 and 5)	R 0356	R 356 The facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 3 of 5 residents whose emergency	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/08/2025

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

(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
	Finding includes: 1. On 5/8/2025 at 11:40 A.M., the Emergency binder for the facility was reviewed. The following residents did not have a Face sheet (paper with resident's emergency contact and clinical information) in the Emergency binder: -Residents 3, 4 and 5. On 5/8/2025 at 11:50 A.M., the Administrator indicated Resident 3, 4 and 5's Face sheet was missing from the Emergency binder. A policy for maintaining the Emergency binder was requested, but one was not received before the survey exit on 5/8/2025.		information was reviewed. (Residents 3, 4, and 5) A) Emergency evacuation binder updated with complete information for residents 3, 4, and 5. B) Emergency evacuation binder was updated with all resident information. C) Nursing staff were educated on Emergency evacuation binder contents and use. D) An audit will be completed by a designee for up-to-date emergency binder information on AL residents. Three residents will be audited per week for 4 weeks. Two a week for 4 weeks. One a week for 4 weeks. One monthly thereafter until found in substantial compliance.	