STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. BUILDING _____ B. WING _____	C 02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON POINTE HEALTH AND REHAB	**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
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00428371. This visit included a Covid 19 Focused Infection Control Survey.

Complaint IN00428371- No deficiencies related to the allegations are cited.

Survey dates: February 19, 2024.

Facility number: 012966
Provider number: 155803
AIM number: 201110390

Census Bed Type:
SNF/NF: 78
SNF: 26
Residential: 51
Total: 155

Census Payor Type:
Medicare: 14
Medicaid: 65
Other: 25
Total: 104

Hamilton Pointe Health And Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00428371 and Covid 19 Focused Infection Control Survey.

Quality review completed on February 20, 2024.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE