STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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. Survey dates: May 4, 5, 6, 7, and 8, 2025 Facility number: 000341 Provider number: 155459 AIM number: 100286550 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 2 Medicaid: 29 Other: 4 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 15, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to promote dignity by ensuring residents were changed in a timely manner after episodes of incontinence for 2 of 2 residents reviewed for dignity. (Residents 7 & 11) Findings include:	F 0550		

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
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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. The clinical record for Resident 11 was reviewed on 5/6/25 at 10:02 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, epilepsy, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 2/4/25, indicated Resident 11 was cognitively intact, was always incontinent of bowel and bladder, and was dependent with toileting. An incontinence due to impaired mobility and overactive bladder care plan, dated 4/5/24, indicated to assist with incontinent care as needed and to check and change every two hours for incontinence. During an interview with Resident 11 on 5/5/25 at 10:44 a.m., they indicated they have to wait long periods at night to be changed when calling out that they have been incontinent. Resident 11 indicated night shift will not check her during the night, so by the time morning comes she was completely soaked in urine and required a complete bed change due to her linens being soaked in urine. Resident 11 indicated it made her frustrated, angry, and humiliated from having to lay in her urine. During an interview with Resident 11 on 5/6/25 at 11:08 a.m., she indicated staff had already been "on her" today for needing to be changed so much. She indicated it upset her, and she was crying, saying she can't help it. She indicated the staff does this to her every day when she was wet and waiting to be changed. During an observation with Licensed Practical Nurse (LPN) 2 on 5/6/25 at 11:29 a.m., LPN 2 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	performing incontinent care to Resident 11. LPN 2 indicated her brief was wet when she removed it. During an interview with Resident 3 (Resident 11's roommate) on 5/7/25 at 12:40 p.m., she indicated she had seen Resident 11 wait several times for her call light to be answered when she calls out "wet". Resident 3 indicated staff will come into the room, turn off the call light, and say they will be back, but then not return for a long time. Resident 3 had a Quarterly Minimum Data Set (MDS) assessment, on 2/11/25, indicating they were cognitively intact. During an interview with the Director of Nursing (DON) on 5/7/25 at 12:18 p.m. she indicated staff conduct every two hour checks with residents who are incontinent. The DON indicated Resident 11's bed was soaked a lot of times due to medications she was on and that could occur even an hour after being toileted. 2. The clinical record for Resident 7 was reviewed on 5/6/2025 at 1:22 p.m. The medical diagnoses included bilateral lower limb amputations and major depression. An Annual MDS assessment, dated 3/18/2025, indicated Resident 7 needed assistance with transferring and toileting, was cognitively intact, and incontinent of bowel and bladder. An activities of daily living (ADL) care plan, revised 3/18/2025, indicated Resident 7 needed assistance with activities of daily living with an intervention to provide Resident 7 with toileting routinely. During an interview and observation on 5/5/2025 at 1:10 p.m., Resident 7 indicated she had to wait a long time, up to two hours, to get assistance after			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	putting on her call light. The last time this happened was during the last week, and it was worse in the evening after supper. Due to the waiting times, she stated she had to "sit in urine for a long time and it makes me [Resident 7] feel disgusting and humiliated." Resident 7's room was noted to smell of urine. Resident 7 stated she had "accidents", and they do not clean her room on the weekends so it sometimes "smells". A policy entitled "Resident Rights" was provided by the Executive Director on 5/7/2025 at 12:40 p.m. The policy indicated that residents have the right to be treated with consideration, respect, and full recognition of their dignity. 3.1-3(a) 3.1-3(t)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record review, the facility failed to provide showers as preferred for Resident 4 and failed to ensure Resident 21 had a pressure-reducing cushion in place as care planned for 2 of 2 residents reviewed for accommodation of needs (Resident 4 and Resident 21). Findings include: 1. During an interview with Resident 4 on 5/5/25 at 11:09 a.m., she indicated she was supposed to get a shower three times a week and the facility staff were not assisting her with showers. The resident indicated there was one CNA (Certified Nurse Aide) who would give her a shower, the other CNAs gave her bed baths because she had to use	F 0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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 mechanical lift to transfer. The resident indicated she preferred to have a shower instead of a bed bath. Review of the shower book, on 5/6/25 at 1:42 p.m., indicated Resident 4 was scheduled to have a shower three times a week on Tuesday, Wednesday, and Saturday. Review of the record of Resident 4, on 5/8/25 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, cerebral palsy, diabetes, cerebral infarction with hemiplegia and hemiparesis affecting unspecified side, anxiety, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/25, indicated the resident was moderately impaired for daily decision making. The resident was dependent on the staff for showering. The plan of care for Resident 4, dated 4/14/25, indicated the resident required assistance with activities of daily living (ADLs) related to cerebral palsy and hemiplegia. The interventions included, but were not limited to, transfer resident with two staff with a mechanical lift and assist with bathing per residents' preference of showers. The preference for customary routine and activities for Resident 4, dated 5/7/24, indicated the resident preferred to have a shower. The shower report for Resident 4, dated March 2025, indicated the resident received a bed bath instead of a shower on 3/6/25, 3/8/25, 3/11/25, 3/13/25, 3/15/25, 3/25/25, 3/27/25, and 3/29/25. The shower report for Resident 4, dated April			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	2025, indicated the resident received a bed bath instead of a shower on 4/1/25, 4/2/25, 4/5/25, 4/19/25, 4/27/25 and 4/30/25. The preference for daily routine policy was provided by the Executive Director (ED) on 5/7/25 at 12:50 p.m. The policy indicated the purpose was to identify and develop a plan of care that reflects a resident's past and current daily customary routines. 2. The clinical record for Resident 21 was reviewed on 5/6/2025 at 11:45 a.m. The medical diagnoses included schizophrenia and chronic kidney disease. A Quarterly MDS assessment, dated 3/11/2025, indicated Resident 21 was cognitively intact. A nursing assessment, dated 3/11/2025, indicated Resident 21 was not at risk for developing a pressure area. A skin care plan, revised 3/21/2025, indicated Resident 21 was at risk for skin breakdown and to utilize a pressure-reducing cushion while in the wheelchair. During an interview and observation, on 5/5/2025 at 12:53 p.m., Resident 21 was noted to be sitting in his wheelchair. Midway through the interview, Resident 21 stood up and transferred to bed. Resident 21's wheelchair was noted to have a cushion in place. Resident 21 indicated he had never used a cushion in his wheelchair. During an interview and observation, on 5/6/2025 at 1:09 p.m., Resident 21's wheelchair was noted to be without a cushion. During an interview with the Director of Nursing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	(DON) on 5/7/2025 at 12:32 p.m., she indicated Resident 21's cushion was in the second bathroom and drying after it was washed. The DON verified they have spare cushions that staff could utilize, but she was unsure why the staff did not utilize one. A policy entitled "Resident Rights" was provided by the ED on 5/4/2025 at 12:05 p.m. The policy indicated residents have the right to " ...receive services in the facility with reasonable accommodation of resident needs and preferences ..." 3.1-3(v)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide incontinent care in a timely manner for a resident dependent on staff for toileting needs for 1 of 4 residents reviewed for activities of daily living (ADLs). (Resident 22) Findings include: During an interview with Resident 22 on 5/5/25 at 12:48 p.m., she indicated last week or last weekend, she had to wait four hours in an incontinent brief that was wet with urine and had a bowel movement in it. The resident turned her call light on at 10:00 a.m., and they did not change her until 2:00 p.m. The roommate (Resident 17) indicated she was present when this happened and witnessed it. Resident 22 indicated she reported it to Licensed Practical Nurse (LPN) 6 and Certified Nurse Aide (CNA) 7 and various	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	other nursing staff. The resident had a clock in her room with the correct time and indicated she had timed it the day it happened. The resident indicated her bottom was "raw" from laying in a dirty incontinent brief that long. During an observation on 5/7/25 at 11:45 a.m., CNA 3 and CNA 4 provided incontinent care for Resident 22. The resident's incontinent brief was soaked with urine and had also leaked through her jean shorts. LPN 5 applied magic butt paste to the resident's buttocks. The resident's buttocks were pink, shiny, and raw. Review of the record of Resident 22, on 5/7/25 at 1:08 p.m., indicated the resident's diagnoses included, but were not limited to, urinary tract infection, multiple sclerosis, chronic kidney disease, morbid obesity, neuromuscular dysfunction of bladder, and need for assistance with personal care. The Admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated the resident was cognitively intact for daily decision making. The resident was always incontinent of her bowels and bladder. The resident was dependent for toileting needs. The plan of care for Resident 22, dated 3/31/25, indicated the resident required assistance with ADLs related to multiple sclerosis, morbid obesity, and incontinence. The interventions included, but were not limited to, assistance with toileting and/or incontinent care as needed. The skin assessment for Resident 22, dated 5/3/25, indicated the resident was observed to have moisture associated dermatitis on her buttocks.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	The physician order for Resident 22, dated 5/5/25, indicated the resident was ordered magic butt paste to buttocks every shift for redness. The nursing skills competency provided by the Executive Director, on 5/8/25 at 11:45 a.m., indicated the procedure included, but were not limited to, assistance with toileting or perineal care as needed. 3.1-38(a)(3)(A)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to follow policy for a resident who utilized an electronic cigarette and was on oxygen for 1 of 1 resident reviewed for accidents. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed on 5/6/25 at 10:02 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, epilepsy, and schizoaffective disorder. The Annual Minimum Data Set (MDS) assessment indicated Resident 11 was cognitively intact for daily decision making and was dependent on laying to sitting up in bed. During an observation and interview with Resident 11 on 5/5/25 at 10:46 a.m., Resident 11 was sitting up in bed with oxygen on and using an electronic cigarette.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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 with Resident 11 on 5/6/25 at 11:10 a.m., she indicated she did use their electronic cigarette while on oxygen. Resident 11 indicated she had been told by some staff it was okay to use the electronic cigarette while on oxygen, and then some staff have said it was not okay. Resident 11 indicated that the Executive Director (ED) came into her room yesterday and told her she had to turn her oxygen off when she used her electronic cigarette. Resident 11 indicated she was unable to turn the oxygen off herself because it was out of her reach while lying in bed. During an observation and interview on 5/7/25 at 10:45 a.m., Resident 11 was lying in bed with her oxygen concentrator behind her bed. She indicated she continues to use her electronic cigarette while on oxygen. Resident 11 indicated she cannot reach the oxygen to turn it off, so it stays on while she uses her electronic cigarette. She indicated she has used her electronic cigarette for over two years while wearing oxygen, and no one had said anything about it until "the State" came in. A use of electronic cigarette care plan, dated 4/1/24, indicated the electronic cigarette policy would be reviewed with the resident upon using and as needed During an interview with the Director of Nursing (DON) on 5/7/25 at 12:13 p.m., they indicated they were aware that Resident 11 uses an electronic cigarette in her room while on oxygen. The DON indicated Resident 11 does not have an order to self-administer her oxygen and has not been educated to manage her oxygen. The DON indicated Resident 11 could use her call light to have staff turn her oxygen on and off for her when			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	she wanted to use her electronic cigarette. An "Electronic Cigarettes" policy was provided by the ED on 5/6/25 at 1:00 p.m. It indicated "....9. Residents using oxygen are restricted from using electronic cigarettes when oxygen is in use. Oxygen must be shut off and removed prior to the resident using electronic cigarettes..." 3.1-45(a)(1)			
F 0727 SS=F Bldg. 00	1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4 RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to provide eight consecutive hours of registered nurse (RN) coverage daily for 2 of 30 days reviewed. This deficient practice had the protentional to affect all 35 residents. Findings include: Preliminary review of the survey, completed on 5/4/2025 at 8:35 a.m., indicated the facility had a nurse-staffing waiver for RN coverage of eight consecutive hours every day. Review of the nursing schedule from April 4, 2025, through May 5, 2025, indicated the facility did not have RN coverage for the following days: April 20, 2025, and May 3, 2025. During an interview on 5/6/2025 at 12:45 p.m., the Executive Director (ED) indicated the facility will continue to utilize the RN waiver at that time. Overall, their staffing of RNs had improved, but not completely stabilized at that time. They are currently using as needed (PRN) RNs as well as their DON as the RN coverage, but it was mainly PRN RNs, and it was not consistent enough to get	F 0727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

(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
	rid of the waiver currently. During an interview on 5/8/2025 at 11:35 a.m., the ED indicated there were no residents that needed RN specific care. The facility had a mitigation strategy to not admit any residents who would need RN specific care, to have an RN on-call, and an understanding with a local facility within the same corporation to have an RN come on-site in the case of need. During an interview on 5/8/2025 at 11:52 a.m., the ED indicated there was no policy regarding RN coverage, but the facility's expectation was to utilize the federal regulations. 3.1-17(b)(3)			