STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155459	A. BUILDING -- B. WING	05/21/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/21/25 Facility Number: 000341 Provider Number: 155459 AIM Number: 100286550 At this Emergency Preparedness survey, Hickory Creek at New Castle was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 36. Quality Review completed on 05/28/25	E 0000		
K 0000 Bldg. 01	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). Survey Date: 05/21/25 Facility Number: 000341 Provider Number: 155459 AIM Number: 100286550 At this Life Safety Code survey, Hickory Creek at New Castle was found not in compliance with	K 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. The plan of correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this plan of correction to be considered the facility's allegation of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Young	Executive Director	06/06/2025

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.

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	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. This one-story facility was determined to be of Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 36 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one outside shed used for storage which was not sprinklered. Quality Review completed on 05/28/25		compliance is effective 6-12-25 Hickory Creek New Castle respectfully requests paper compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors. Findings include: Based on the facility tour and interview with the Maintenance Director (MD) on 05/21/25 at 11:30 a.m., the Housekeeping Supply Closet, equipped with a self-closing device, failed self-close and	K 0321	1. What corrective action will be accomplished for residents found to have been affected by deficient practice? Housekeeping supply closet door self-closure was immediately adjusted so as to self-close when opened. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	06/12/2025

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	latch into the door frame. The MD stated that the door worked properly just a few days ago. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		No residents, staff or visitors were affected by this deficiency. Potential to affect 5 residents as well as staff and visitors. Maintenance Director checked all other self closing doors with not other concerns noted. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director will check doors to ensure self closure is functioning properly. 4. How corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? Maintenance Director/Designee will complete the POC QAPI tool weekly times 4 weeks and monthly times 6 months. If 100% compliance is not achieved an action plan will be developed. 5. Date of completion 6-12-25	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 2 residents.	K 0351	1. What corrective action will be accomplished for residents found to have been affected by deficient practice? Hole in ceiling of residents room 1 was immediately repaired. Walk around facility brought no further concerns. 2. How other residents having the	06/12/2025

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	Findings include: Based on the facility tour and interview with the Maintenance Director (MD) on 05/21/25 at 12:15 p.m., in RR # 1 there was a hole in the ceiling where an outlet had been removed and was not covered. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned area had a hole that needed attention. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents were affected by this deficiency. With potential to affect staff and up to 2 residents. Walk around facility by maintenance director to check for holes in ceiling brought no further concerns. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director in-serviced on fire barrier precautions 6-6-25 4. How corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? Maintenance Director/Designee will complete the POC QAPI tool weekly times 4 weeks and monthly times 6 months. If 100% compliance is not achieved an action plan will be developed. 5. Date of completion 6-12-25	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility.	K 0712	1. What corrective action will be accomplished for residents found to have been affected by deficient practice All completed fire drill forms have been audited by Administrator and	06/12/2025

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	Findings include: Based on records review and interview with the Maintenance Director (MD) and Executive Director on 05/21/25 at 10:10 a.m., 5 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. The MD agreed the days needed to be spread out during the month. These conditions do not allow fire drills to be conducted on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		director of maintenance. Fire drill schedule has been established to monitor that drills are completed for each shift rotating on a 3 month period and at different times of the month. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing in facility have potential to be affected. All completed fire drill forms have been audited by administrator and director of maintenance to review schedule of drills for each shift to ensure no further shift is missed. Shift time frames have been reviewed with maintenance director to ensure all times for drills are accurate for fire drills. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Director of maintenance in-serviced on monitoring fire drills to ensure each shift is completed for each quarter. Director of maintenance will monitor all completed fire drill forms and the fire drill schedule to ensure all shifts are completed timely each quarter and are completed during different times of the month. 4. How corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be	

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			put into place? Director of maintenance will bring all fire drill forms to be reviewed during monthly quality assurance meeting for 6 months unless additional monitoring is required. QA team will review that each fire drill is complete once quarterly for compliance. 5. Date of completion 6-12-25	