STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 This visit was for the Investigation of Complaints IN00451961 and IN00451216. Complaint IN00451961 - No deficiencies related to the allegations are cited. Complaint IN00451216 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: February 4 and 5, 2025 Facility number: 000418 Provider number: 155565 AIM number: 100274870 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 4 Medicaid: 36 Other: 11 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 13, 2025.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure a resident was safely transported in her wheelchair resulting in a fall and nasal fracture for 1 of 3 residents reviewed for accidents (Resident B). The deficient practice was corrected on 1/22/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an interview, on 2/4/25 at 10:23 a.m., Resident B indicated she was admitted to the facility in December 2024 with a right shoulder and right hip fracture following a fall at home. On the morning of 1/10/25, the facility's bus driver was going to take her out to an appointment in Indianapolis to have her sutures removed from her previous fracture repair. The bus driver pushed her in her wheelchair, from her room towards the exit door, and she was moving pretty fast. There was a "dip" in the floor near the dining room, and when the bus driver pushed the wheelchair over the dip the resident's foot got caught on the floor. She was wearing sneakers, and the bottom of them caught on the floor. The resident went face first out of the wheelchair and sprained her right foot, fractured her nose, and sustained a black eye. The resident did not remember if she had foot pedals for her wheelchair available, but they were not in place at the time the incident occurred. The resident indicated after the fall, the staff assisted her back to the wheelchair, and they proceeded to her	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 2	F 689		

appointment in Indianapolis. The physician's office, in Indianapolis, sent her to the emergency room (ER) from her appointment. At the ER, they diagnosed the resident with a nasal fracture. The facility's bus driver took the resident back to the facility, the same day, after the ER visit. The resident indicated she had pain related to the fall. At the same time, the resident was observed with a small purple bruise under her right eye, surrounded by yellowish/greenish bruising.

On 2/4/25 at 11:58 a.m., a change in the floor grade was observed when walking to the dining room from the 100 hall. The floor went up slightly when walking in that direction.

Resident B's record was reviewed on 2/5/25 at 9:40 a.m. Diagnoses on the continuity of care document (CCD) included, but were not limited to, fracture of unspecified part of the neck of the right femur (large bone in thigh) and unspecified fracture of the lower end of the right humerus (bone in the upper arm).

An admission Minimum Data Set (MDS) assessment, dated 12/29/24, indicated the resident was cognitively intact and had not refused care. The resident had an impairment in mobility of one side of the upper and lower extremities. The resident used a manual wheelchair, was dependent for wheeling 50 feet and making 2 turns, and was dependent for wheeling 150 feet. The resident was dependent with lower body dressing and for putting on and taking off footwear.

A fall event, dated 1/10/25, indicated the resident had a witnessed fall, hit her head, and experienced pain. There was bruising and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 3	F 689		

swelling noted. The resident was being pushed in the dining room by staff, and went down a slope, while going to the facility's bus. The resident was lying on her stomach and had shoes on. Environmental factors observed in the area of the fall indicated, "foot pedals off." The intervention put in place to prevent another fall was to ensure foot pedals were in place when the resident used the wheelchair.

An Interdisciplinary Team (IDT) note, dated 1/10/25, indicated the resident fell when a staff member propelled the resident and her feet caught on the floor when exiting the dining room. The resident fell forward out of the wheelchair. There was bruising to the resident's ankle and face and bleeding from her nose. The immediate, short term intervention indicated the resident was assisted into the wheelchair and went to the appointment. Foot pedals were applied to the wheelchair. The intervention put in place to address the root cause of the fall was to put foot pedals on the resident's wheelchair when the staff propelled her.

A care plan, initiated on 12/24/24, indicated the resident was at risk for falls and had a history of falls prior to admission. An intervention, dated 1/10/25, indicated, "foot pedals on wheelchair when staff propelling her."

ER discharge instructions, dated 1/10/25, indicated diagnoses from the ER visit included fall, periorbital (around the eye) hematoma (localized collection of blood caused by an injury) of the right eye, and nasal bone fracture. The discharge instructions indicated the resident needed to maintain sinus precautions (measures taken to prevent further irritation or injury to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 4	F 689		

sinuses).

During an interview, on 2/4/25 at 12:05 p.m., Certified Nurse Aide (CNA) 4 indicated when the resident fell her shoe caught just right on the dip in the floor, and she fell forward out of the wheelchair. It was an easy area to trip over. He was not sure if the resident should have had foot pedals in place at the time of the fall, but she did have foot pedals afterwards.

During an interview, on 2/4/25 at 2:56 p.m., Licensed Practical Nurse (LPN) 3 indicated he was not sure which residents were required to have foot pedals for their wheelchair. He did not remember if the resident should have had foot pedals at the time of her fall.

During an interview, on 2/4/25 at 3:04 p.m., CNA 5 indicated she was the bus driver the day the resident's fall occurred. She told the resident to keep her feet up, but when they hit the dip in the floor, near the dining room, the resident's sneakers hit the ground and got stuck. CNA 5 indicated she stopped, grabbed the resident's shoulders, and tried to pull her back, but the resident fell. She did not think the fall would have occurred if the resident had not been wearing the sneakers with a bottom that was easy to get stuck to the floor. CNA 5 did not indicate, however, any extra precautions taken when propelling the resident while she was wearing the sneakers. Staff assisted the resident back into the wheelchair, and she took the resident to her appointment. Foot pedals were not on the resident's wheelchair when the incident occurred, and she was not able to remember if they were put on after the fall or not. Since the incident, it was made a requirement to put foot pedals on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 5	F 689		

wheelchairs when the residents used the facility's bus for transportation. They received training on using foot pedals when residents went to appointments. When residents were propelled down ramps they were trained to put their hands on the resident's shoulder.

During an interview, on 2/5/25 at 8:45 a.m., the Executive Director (ED) indicated they did not have a facility policy regarding wheelchairs or a requirement for foot pedals. After the incident, they made it their policy to use foot pedals for all residents going out for appointments unless they refused.

On 2/5/25 at 9:45 a.m., the ED provided a document titled, "Fall Management Policy," last revised in August 2022 and indicated it was the policy currently being used by the facility. The policy indicated, "...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...."

The deficient practice was corrected by 1/22/25 after the facility implemented a systemic plan that included the following actions: immediate assessment by the charge nurse of the effected resident and the provision of first aide and follow-up care, staff members who provided assistance to residents with wheelchair transport received education on proper wheelchair transport activities, staff members educated that residents who required assistance with wheelchair mobilization for appointments outside of the facility should use foot pedals while being transported to and from the appointment, and a Quality Assurance and Performance Improvement (QAPI) plan implemented with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 689	Continued From page 6 completion of an audit tool for scaled ongoing monitoring. The first audit tool was completed on 1/22/25. This citation relates to Complaint IN00451216. 3.1-45(a)(2)	F 689		