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	04/05/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 1, 2, 3, 4, and 5, 2024. Facility number: 000341 Provider number: 155459 AIM number: 100286550 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 1 Medicaid: 21 Other: 5 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 15, 2024	F 0000	Hickory Creek at New Castle survey exit date 4-5-23 plan of correction due 4-28-24. This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the 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 facilities allegation of compliance is effective 4-30-24. We respectfully request paper compliance. We respectfully ask for paper IDR review of F727 as we disagree with scope assigned.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
		F 0656	1. What corrective action will be accomplished for those residents	04/30/2024

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	Based on interview and record review, the facility failed to develop and implement care plans for the utilization of oxybutynin and NicoDerm for Resident 7, dementia medication for Resident 13, and iron, Jardiance, and omeprazole for Resident 14. This affected 3 of 5 residents reviewed for medication management. Findings include: 1. The clinical record for Resident 7 was reviewed on 4/4/2024 at 11:45 a.m. The medical diagnosis included acute and chronic respiratory failure with hypoxia. A Significant Change Minimum Data Set (MDS) Assessment, dated 3/6/2024, for Resident 7 indicated she was cognitively intact. A physician order, dated 2/29/2024, indicated for Resident 7 to utilize Ditropan 5 milligrams (mg) daily. A physician order, started on 3/7/2024 and discontinued on 4/4/2024, indicated for Resident 7 to utilize a NicoDerm transdermal patch daily. No care plans were developed and implemented to address the utilization of the aforementioned medications for Resident 7. 2. The clinical record for Resident 13 was reviewed on 4/3/202 at 1:30 p.m. The medical diagnosis included dementia. A Quarterly MDS Assessment, dated 2/72/2024, indicated that Resident 13 was moderately cognitively impaired and had a progressive neurological condition.		found to have been affected by deficient practice? Resident 7 was care planned for oxybutryn use and she no longer receives the nicoderm patch. Resident 13 was care planned for dementia medication. Resident 14 no longer receives jardiance and was care planned for iron and omeprazole use. 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. No residents were affected by this deficiency. All residents have the potential to be affected. A complete audit of all resident care plans was completed on 4-29-24 and care plans were implemented if indicated by IDT members. IDT members were re-educated on IDT comprehensive care plan policy by Regional Director of Clinical Services on 4-24-24. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? IDT will review all new admissions and new orders daily in clinical meeting to ensure that residents have care plans in place to address medication use. Correct action will be taken as needed. IDT members were re-educated on IDT comprehensive care plan	

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	A physician order, dated 8/22/2023, indicated for Resident 13 to utilize donepezil 5 mg daily for dementia. A physician order, dated 8/22/2023, indicated for Resident 13 to utilize memantine 5 mg twice daily for dementia. A dementia care plan for Resident 13, dated 11/22/2022, did not indicate the utilization of medication. This dementia care plan was revised on 4/5/2024 at 10:34 a.m. 3. The clinical record for Resident 14 was reviewed on 4/3/2024 at 11:35 a.m. The medical diagnosis included gastro-esophageal reflux disease (GERD). A Quarterly MDS Assessment, dated 2/20/2024, indicated that Resident 14 was cognitively intact. A physician order, dated 10/14/2023, indicated for Resident 14 to utilize ferrous sulfate 325 mg daily. A physician order, dated 10/14/2023, indicated for Resident 14 to utilize Jardiance 10 mg daily. A physician order, dated 10/15/2023, indicated for Resident 14 to utilize omeprazole 20 mg daily. No care plans were developed and implemented to address the utilization and monitoring of the aforementioned medications for Resident 14. An interview with the Administration on 04/05/24 at 10:40 a.m. indicated that she had spoken with the MDS Coordinator regarding the care plans for Resident 7, 13, and 14. The facility did not have care plans in place for the utilization of oxybutynin and NicoDerm for Resident 7,		policy by Regional Director of Clinical Services on 4-24-24. 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? POC QAPI Tool will be utilized weekly x's 4 weeks, monthly x's 6 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. Date of completion 4-30-24	

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	dementia medication for Resident 13, nor for iron, Jardiance, and omeprazole for Resident 14, but the MDS coordinator would develop care plans for those medications for those residents. A policy, entitled "IDT Comprehensive Care Plan Policy", was provided by the Administrator on 4/5/2024 at 10:45 a.m. The policy indicated, " ...The care plan must include measurable goals and resident specific interventions base on the resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychological well-being ..." 3.1-35(a) 3.1-35(b)(1)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure there was Registered Nurse (RN) coverage for at least eight consecutive hours a	F 0727	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has	04/30/2024

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	day, seven days a week for 14 of 31 days reviewed. This had the potential to affect 27 residents. Findings include: Review of the schedule and RN time sheets from 3/1/2024 to 4/1/2024, indicated that eight hours of RN coverage were not completed on 3/6/2024, 3/7/2024, 3/8/2024, 3/9/2024, 3/10/2024, 3/16/2024, 3/17/2024, 3/24/2024, 3/25/2024, 3/26/2024, 3/27/2024, 3/28/2024, 3/30/2024, and 3/31/2024. An interview with the Director of Nursing on 4/4/2024 at 11:25 a.m. verified that eight hours of RN coverage was not provided on the 14 aforementioned dates. An interview with the Director of Nursing on 4/4/2024 at 11:35 a.m. indicated that there was no specific policy to RN coverage, but the facility would follow the federal regulation of RN coverage of at least eight consecutive hours a day, seven days a week.		obtained RN coverage for 8 consecutive hours/7 days a week. RN waiver has been submitted and pending approval. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? RN waiver submitted and pending approval. The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. If RN coverage is needed the facility will contact staffing agencies and the in-company staffing group to obtain an RN. The Executive Director and Director of Nursing are continuing to recruit and hire RN's full and part-time. 4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? To ensure	

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			compliance the ED/DNS will review the staffing schedule showing RN coverage monthly for 6 months with the QAPI committee, after which the QAPI team will re-evaluate the continued need for review. If RN coverage has not been achieved as required, an action plan will be developed and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours. 5. Date of compliance 4-30-24	