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	04/25/2024

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

(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: 04/25/24 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 31. Quality Review completed on 04/26/24	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: 04/25/24 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	05/07/2024

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 31 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 04/26/24		compliance is effective 5-15-24 Hickory Creek New Castle respectfully asks for paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egress were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for	K 0211	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Staff immediately removed the PPE 3	05/15/2024

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	wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 3 staff in the facility. Findings include: Based on observations and interview during a tour of the facility with the Business Manager on 04/25/24 between 11:30 a.m. and 1:30 p.m., in the corridor near the Clean Utility Room, a Personal Protective Equipment (PPE) cart was being stored without wheels which would allow the cart to be moved out of the corridor during an emergency. The business Manager stated the PPE cart did not have wheels and would need to be replaced with a PPE cart with wheels. This finding was acknowledged by the Business Manager at the time of discovery and again by the Executive Director at the time of exit. 3.1-19(b)		drawer cart from corridor and staff informed of importance of keeping corridors clear. 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 and staff have the potential to be affected. Any items in corridors will be equipped with wheels to allow for items to be moved in the event of an emergency. Audits will be conducted by maintenance director/designee daily x5 days to ensure compliance. Staff will be educated on egress requirements. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff to be in-serviced on 5-8-24 of keeping corridor clear. Maintenance Director/designee will audit corridors 5 times weekly and remove any items found immediately. 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? Maintenance director/designee will report on compliance with corridors being clear of obstructions during QAPI meeting until facility has gone six months with no issues. 5. Date of completion 5-15-24.	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Business Manager on 04/25/24 between 11:30 a.m. and 1:30 p.m., the door between the Clean Utility and the Dryer room, equipped with a self-closing device, failed to self-close and latch into the doorframe when tried at least 4 times. This finding was acknowledged by the Business Manager at the time of discovery and again by the Executive Director at the time of exit. 3.1-19(b)	K 0363	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance Director got a quote for replacement of affected door. Item has been ordered. 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? Two residents have the potential to be affected; no residents were affected. Maintenance Director will replace the affected door to ensure compliance with passage smoke resistance. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director/designee will check corridor doors weekly to ensure they resist the passage of smoke. 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? Maintenance Director will report on compliance with corridor doors being able to resist the passage of smoke during QAPI meeting until facility has gone six months with no issues.	05/15/2024

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			5. Date of completion 5-15-24	