PRINTED: 05/23/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING	00	COMPL	ETED
		155459	B. WING	G		03/24/	/2023
HICKOR	PROVIDER OR SUPPLIER Y CREEK AT NEW	CASTLE	STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00 F 0557 SS=D Bldg. 00	Licensure Survey. Survey dates: Marci Facility Number: 00 Provider Number: 1 AIM Number: 1002 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type Medicare: 1 Medicaid: 22 Other: 4 Total: 27 These deficiencies accordance with 41 Quality review com 483.10(e)(2) Respect, Dignity/F §483.10(e) Respert are sident has a respect and dignit §483.10(e)(2) The personal possessi and clothing, as sign of would infringe and safety of othe	reflect State Findings cited in 0 IAC 16.2-3.1. Right to have Prsnl Property ect and Dignity. a right to be treated with y, including: e right to retain and use ions, including furnishings, pace permits, unless to do upon the rights or health	F 000		Hickory Creek at New Castle survey exit date 3-24-23 plan of correction due 4/15/23. This F of Correction constitutes the written allegation of compliance the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that was cited correctly. The Plan Correction is submitted to meet requirements established by so and federal law. Hickory Cree New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliant is effective 4/24/23. We respectfully request paper compliance.	Plan ce for eer, n one of eet tate ek at of ne nnce	04/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/24/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/24/2023 155459 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 901 N 16TH STREET HICKORY CREEK AT NEW CASTLE NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to maintain a dignified environment for a accomplished for those residents resident requested assistance with care for 1 of 2 found to have been affected by residents reviewed for abuse (Resident 4). deficient practice? Resident #4 was put to bed that evening. CNA Finding include: was educated on 3/22/23 regarding incident and resident During an interview with Resident 4 on 3/21/23 at rights. 1:45 p.m., indicated CNA 1 yelled at her the other (2) How other residents having day on 3/17/23. The resident indicated she wanted the potential to be affected by the to go to bed and CNA 1 yelled and told her that same deficient practice will be she had to wait her turn. The resident indicated identified and what corrective she told her she wasn't going to treat her like a action will be taken? Any resident dog. The nurse heard CNA 1 yelling at me. The has the potential to be affected. resident indicated it made her mad and she told Administrator conducted resident CNA 1 she paid to live at the facility and she was interviews with residents regarding not allowed to yell at me. the care and services they receive. There were no other Review of the record of Resident 4 on 3/23/23 at allegations as a result of the 1:05 p.m., Cerebral palsy, respiratory failure, interviews. Staff in-serviced on cerebral infarction, personal history of transient 4-7-23 regarding Resident Rights ischemic attack, hypertensive heart disease, and Abuse Policies. obstructive sleep apnea, diabetes, anxiety (3) What measures will be put disorder, major depressive disorder and muscle into place and what systemic weakness. changes will be made to ensure that the deficient practice does not recur? Administrator will be The Quarterly Minimum Data Set (MDS) for Resident 4, dated 2/14/23, indicated the resident immediately notified of any was moderately impaired for daily decision allegations of abuse. Investigation making. The resident had no behaviors. The will begin immediately. resident required extensive assistance of two Administrator or designee will people for transfers and toileting. The resident conduct resident interviews utilized a wheelchair for mobility. The resident did monthly for 6 months and any not ambulate. identified issues will be handled immediately. Staff will be The plan of care for Resident 4, dated 1/24/23, in-serviced on types of Abuse and indicated the resident was at risk for signs and Resident rights monthly for 6 symptoms such as withdrawal, decreased months. appetite, tearfulness and insomnia. The (4) How corrective action will be interventions included, but were not limited allow monitored to ensure the deficient resident to express feelings and frustrations; offer practice will not recur, i.e. what

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155459	B. W	ING		03/24	/2023
		<u>I</u>	1	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			6TH STREET		
HICKUD.	Y CREEK AT NEW	CASTLE			ASTLE, IN 47362		
HICKOR	- ONLLN AT INEW	UNO I LL		INE VV C	AO I LE, III 47 502		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ort, emphasize and promote			quality assurance program wil		
	independence, enco	ourage activities of interest.			put into place. Administrator v		
	The plan of care for Resident 4, dated 1/24/23, indicated the resident was at risk for signs and				report findings of interviews to		
					monthly QAPI meeting and fol	llow	
					QAPI recommendations until		
	1	ty. The interventions included,			facility has gone 6 months with	h	
		d to, encourage the resident to			100% compliance.		
		anxiety and offer validation			(5) Date of completion 4/24/2	23	
		aintain a calm environment and					
	move to a quiet area	a.					
	TE1 '4 4 4	4 C CNIA 1 1 4 12/21/22					
		ent for CNA 1, dated 3/21/23					
	, ,	that on 3/17/23 Resident 4 and					
	_	argument regarding assisting CNA 1 told the resident that					
		r the first opportunity she					
	_	resident indicated she needed					
		om, CNA 1 told the resident to					
		vay and she would come assist					
	_	ent 4 kept arguing with CNA 1,					
		er there were 27 other residents					
		care of and the resident was					
		the building and she would					
	_	it her turn. The resident began					
		re treating her like a dog and					
	' '	ove to another facility. CNA 1					
		at was her choice if she wanted					
		ility. LPN 2 then told CNA 1 to					
		alk away from Resident 4.					
		-					
	During an interview	w with the Administrator on					
	_	., indicated the abuse					
	allegations made by	Resident 4 were not founded					
	after the facility con	nducted an investigation. The					
	facility suspended (CNA 1 and brought her back					
	after the investigati	on was completed.					
	_	w with CNA 1 on 3/23/23 at 3:09					
	l -	3/17/23 during the evening time					
	Resident 4 was beir	ng demanding wanting to be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155459	B. W	NG		03/24/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			6TH STREET		
HICKOR	Y CREEK AT NEW	CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	dent "stalks" staff in her					
		its us to stop everything we					
	_	care of her. The resident					
	started getting "mouthy" and "back talking" the CNA. The CNA told her she had to wait her turn. The nurse came and told me to take a break and not to provide care for the resident the rest of the night. The Director Of Nursing (DON) and the						
	_	Of Nursing (ADON) did					
		o the CNA on 3/22/23 that if a					
	-	gument to walk away.					
	Toblashi biant and	Summer to want away.					
	During an interview	with the DON on 3/23/23 at					
	_	she did provide education to					
		l how she reacted to residents					
	with behaviors and	to get the charge nurse if a					
		g her feel uncomfortable.					
	.	'.1 I DN 2 2/22/22 . 2 40					
	_	with LPN 2 on 3/23/23 at 3:40					
	-	was the nurse on 3/17/23 when					
		at 4 had the incident. LPN 2 ened and told CNA 1 to walk					
		of other residents. CNA 1 was					
		sident 4 but LPN 2 could tell it					
	was going to escalar						
	was going to escala	te mo an argument.					
	The resident rights i	policy provided by the					
		24/23 at 11:10 a.m., indicated					
		recognize the rights of the					
		s and residents assume					
	responsibilities to en	nable personal dignity, well					
	being, and proper de						
	3.1-3(a)(1)(t)						
F 0558	483.10(e)(3)						
SS=D	Reasonable Acco	mmodations					
Bldg. 00	Needs/Preference						
		right to reside and receive					
		ility with reasonable					
		•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/24/2023	
	PROVIDER OR SUPPLIER		901 N	ADDRESS, CITY, STATE, ZIP COD 16TH STREET CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	preferences excelendanger the hear or other residents. Based on observative review the facility of daily for 1 of 1 resi (Resident 20). Finding include: During an observat Resident 20 had no During an observat Resident 20 was lay small medication of table. Review of the recon 11:03 a.m., indicate included, but were obstructive pulmon Alzheimer's diseased diabetes, muscle were the Quarterly Minicassessment for Resindicated the reside daily decision making with drinking. During an observat Resident 20 was sit resident had no was During an observat and puring an observat resident had no was present the property of	on, interview and record failed to provide fresh ice water dent's reviewed for hydration ion on 3/21/23 at 11:05 a.m., water available in his room. ion on 3/22/23 at 11:50 a.m., ying in bed, the resident had a up of water on his bedside and of Resident 20 on 3/22/23 at ed the resident's diagnoses not limited to, chronic ary disease (COPD), e, hypertensive heart disease, eakness and pneumonia. Imum Data Set (MDS) ident 20, dated 3/14/23, ant was severely impaired for ing. The resident required set ion on 3/22/23 at 2:00 p.m., ting on the side of his bed, the	F 0558	1. What corrective action wibe accomplished for those residents found to have been affected by deficient practice? Res 20 was given fresh ice wa 2. How other residents havi the potential to be affected by same deficient practice will be identified and wat corrective ac will be taken? No residents we affected by this deficiency. All residents have potential to be affected. Staff passed water to residents and hydration management policy reviewed r changes needed at this time. 3. What measures will be prin place and what systemic changes will be made to ensure that the deficient practice does recur? DON/Designee to roun daily each shift to ensure residents received fresh ice was 4. How corrective action will monitored to ensure the deficient practice will not recur i.e. what quality assurance program will put into place?DON/Designee complete Annual POC QAPI to weekly x4 weeks and monthly times 6 weeks. If 100% compliance is not achieved an action plan will be developed. 5. Date of completion 4-24-	ater. ing the ction ere o all no ut re s not ad ater. Il be ent be will bool

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155459	B. W	ING		03/24/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				6TH STREET		
HICKOBY	Y CREEK AT NEW	CASTLE			ASTLE, IN 47362		
HICKOK	T CREEK AT NEW	CASTLE		NEW C	ASTLE, IN 47302		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an observati	on on 3/23/23 at 11:20 a.m.,					
	Resident 20 had a si	mall medicine cup of water on					
	his bedside table.						
	During an interview	with the Director Of Nursing					
	(DON) on 3/23/23 a	at 2:30 p.m., indicated nursing					
	_	ensure Resident 20 had fresh					
	ice water available a	and it should be passed during					
	medication adminis	tration.					
	3.1-3(v)(1)						
E 0057	400 04(1.)(0)(:) (:::)						
F 0657	483.21(b)(2)(i)-(iii)						
	SS=D Care Plan Timing and Revision						
Bldg. 00	- , ,	rehensive Care Plans					
	- ', ', ', ',	omprehensive care plan					
	must be-						
		in 7 days after completion					
	of the comprehens						
	. , .	n interdisciplinary team, that					
	includes but is not						
	(A) The attending	· ·					
	the resident.	urse with responsibility for					
		vith responsibility for the					
	resident.	with responsibility for the					
		ood and nutrition services					
	staff.	ood and nutition services					
	(E) To the extent p	practicable the					
	• •	e resident and the resident's					
		An explanation must be					
		ent's medical record if the					
		e resident and their resident					
		letermined not practicable					
	•	nt of the resident's care					
	plan.	in or the resident's cale					
		ate staff or professionals in					
		ermined by the resident's					
	-	ested by the resident.					
	(iii)Reviewed and	-					
	(III)I TEVIEWEU AIIU	ioviacu by tile					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 03/24		ETED			
	ROVIDER OR SUPPLIER			901 N 1	ADDRESS, CITY, STATE, ZIP COD 16TH STREET CASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	interdisciplinary te including both the quarterly review a Based on interview failed to complete c residents reviewed. Findings include: 1. During an interview facility. Resident 9 indicated care plan meeting we facility. Resident 9's record 11:30 a.m. The record diagnoses that inclust chronic respiratory obstructive pulmons pressure, heart disease schizophrenia, bipo anxiety, epilepsy, ty osteoarthritis, difficant difficulty in was assessment, dated 1 was cognitively inta No documentation delectronic record the quarterly care plan interview Social Service Direction plan meeting on 2/1 notes of the meeting	am after each assessment, comprehensive and ssessments. and record review, the facility are plan meetings for 2 of 21 (Residents 9 and 4) ew, on 3/21/23 at 11:42 a.m., d she has only been to one when she first came to the swas reviewed on 3/22/23 at ord indicated Resident 9 had ded, but were not limited to, failure with hypoxia, chronic ary disease, high blood asse with heart failure, paranoid lar disorder, depression, the 2 diabetes mellitus, ulty swallowing, sleep terrors, liking, ge Minimum Data Set 1/24/23 indicated Resident 9 aret. evould be located in the at Resident 9 had had a meeting. 7, on 3/23/23 at 2:24 p.m., the ctor indicated they had a care 5/23 and he is looking for the	F 06		1. What corrective action was be accomplished for those residents found to have been affected by deficient practice. Resident #9 and #4 Had care conferences held on 3-29-23 a 4-19-23 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action will be taken? No reside were affected by this deficient All residents have the potential be affected. SSD completed a audit of all resident care plan conferences and is scheduling care plan conferences with all families. SSD was re-educated the IDT comprehensive care policy on 4-13-23. 3. What measures will be point place and what systemic changes will be made to ensure the deficient practice does recur? ED and SSD will revied MDS schedule weekly and SS will inform resident and familied upcoming care conference meetings following the IDT comprehensive care plan polic Any identified issues will be addressed immediately. 4. How corrective action with monitored to ensure the deficient practice will not recur i.e. what quality assurance program will appear to the program appear to the program appear to t	plan and ving the edents cy. all to an old on old on old on old on old	DATE 04/24/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155459	B. W	ING		03/24/	2023
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
LUCKOD	V ODEEK AT NEW	CACTLE		1	6TH STREET		
HICKOR	Y CREEK AT NEW	CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	On 3/23/23, at 4:40	p.m., the Social Service Director			put into place? SSD/Designee	will	
		sciplinary Team Care Plan			complete the Annual POC Q		
	1 ~	4/23 that had the components			tool weekly x4 weeks and mor		
		out failed to provide			x6 weeks to ensure compliance	-	
		re plan meeting had been held,			has occurred. If 100% complia		
		ho attended, or any notes from			is not achieved an action plan		
		ring an interview with Resident			be completed.		
		5 p.m., indicated the facility did			5. Date of completion 4-24	-23	
		neetings with her and her			2. Bate 3. 30///piotion 4-24		
	family.	go www.mor uniu nor					
	1441111						
	Review of the recor	ed of Resident 4 on 3/23/23 at					
		palsy, respiratory failure,					
	cerebral infarction, personal history of transient						
		pertensive heart disease,					
		onea, diabetes, anxiety					
		ressive disorder and muscle					
	weakness.	ressive disorder and muscle					
	weakiiess.						
	The core plan meeti	ing for Resident 4, dated					
	_	he resident and her sister					
	attended.	he resident and her sister					
	attended.						
	During on interview	with the Social Service					
	1	1 3/23/23 at 1:50 p.m., indicated					
	` ′	locumentation of a care plan					
		-					
	meeting since May	ZUZZ.					
	Duning on intermi	with the S.S.D. or 2/22/22 of					
	1	with the S.S.D. on 3/23/23 at l care plan meetings were					
	suppose to be comp	leted every three months.					
	The sere mism mail:	u provided by the					
	The care plan policy						
		23/23 at 3:45 p.m., indicated all					
		eam (IDT) should promptly					
		ent and resident representative.					
	1	go over advanced directives,					
	" "	ion, dental, hearing, podiatry					
		treatments, Activities Of					
	Daily (ADL) status,	, update preferences, pain,					

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review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living be accomplished for those residents found to have been affected by the deficient practice.	- · · · · · · · · · · · · · · · · · · ·
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living STRET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362 ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION CEACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ADATE AS TRET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362 ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION CEACH CORRECTION CEACH CORRECTION (X5) COMPLETION CEACH CORRECTION CEA	UMBER A. BUILDING <u>00</u> COMPLETED
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 483.24(a)(2) ADL Care Provided for Dependent Residents \$483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living 901 N 16TH STREET NEW CASTLE, IN 47362 ID PROVIDERS PLAN OF CORRECTION GEACH CORRECTION GE	B. WING 03/24/2023
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 483.24(a)(2) ADL Care Provided for Dependent Residents \$483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living 901 N 16TH STREET NEW CASTLE, IN 47362 ID PROVIDERS PLAN OF CORRECTION GEACH CORRECTION GE	OTDEET ADDRESS SITEVIOLATE SID COD
HICKORY CREEK AT NEW CASTLE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 483.24(a)(2) ADL Care Provided for Dependent Residents \$\frac{4}{8}\$3.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living NEW CASTLE, IN 47362 ID PREFIX PREFIX FAG CROSS-REFERENCE TOWN STOLLD BE PREFIX TAG PREFIX TAG PREFIX PRANT CORRECTION (X5) COMPLETION COMPLETION DATE 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 SS=D ADL Care Provided for Dependent Residents Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living BID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE TAG PREFIX TAG F 0677 TAG PREFIX TAG	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 SS=D Bldg. 00 ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living PREFIX TAG PROPRIATE DEFICION SIDULDS CROSS-REFERENCEOC TO NIBLEDS TO SHOULDS TO S	NEW CASTLE, IN 47302
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677 483.24(a)(2) SS=D ADL Care Provided for Dependent Residents S483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living PREFIX TAG REGULATION SHOULD BE CROSS-REFERENCE ATION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE COMPLETION DATE COMPLETION TAG PREFIX TAG PACE TAG PREFIX TAG PACE TAG PREFIX TAG PACE TAG PACE TAG PACE TAG PREFIX TAG PACE TAG PACE TAG PACE TAG PACE TAG PACE TAG PACE	FICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)
Adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677	DED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS REFERENCED TO THE APPROPRIATE
weight, activity preferences and any complaints or concerns. 3.1-35(B) F 0677	INFORMATION TAG DEFICIENCY) DATE
concerns. 3.1-35(B) F 0677 SS=D Bldg. 00 ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	rders,
F 0677 SS=D Bldg. 00 ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living T 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	omplaints or
F 0677 SS=D ADL Care Provided for Dependent Residents Bldg. 00 S483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living ADL Care Provided for Dependent Residents \$\frac{\text{483.24(a)(2)}}{\text{\$\text{\$\text{\$483.24(a)(2)}\$}} \text{\$\text{\$A\$ resident serviewed for Activities Of Daily Living}} F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
F 0677 SS=D ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living ADL Care Provided for Dependent Residents §483.24(a)(2) A resident Residents §483.24(a)(2) A resident Residents §483.24(a)(2) A resident Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
SS=D Bldg. 00 ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
SS=D Bldg. 00 ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	Residents
necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living Testidents reviewed for Activities Of Daily Living	
nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living The facility failed to assist dependent residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	ceives the
hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	od l
Based on observation, interview and record review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living F 0677 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	and oral
review the facility failed to assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living be accomplished for those residents found to have been affected by the deficient practice.	
residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living residents reviewed for Activities Of Daily Living residents found to have been affected by the deficient practice.	record F 0677 1. What corrective action will 04/24/2023
residents reviewed for Activities Of Daily Living affected by the deficient practice.	endent be accomplished for those
	or 2 of 2 residents found to have been
l l	affected by the deficient practice.
(ADL) (Resident 20 and Resident 2). Resident #20 and #2 were shaved	Resident #20 and #2 were shaved
immediately.	immediately.
Findings include: 2. How other residents having	2. How other residents having
the potential to be affected by the	the potential to be affected by the
1.) During an observation on 3/21/23 at 10:59 a.m., same deficient practice will be	at 10:59 a.m., same deficient practice will be
Resident 20 was laying in bed with his eyes identified and what corrective	s eyes identified and what corrective
closed the resident had a moderate amount of action will be taken? No residents	ount of action will be taken? No residents
facial hair. were affected by this deficiency.	were affected by this deficiency.
All dependent residents have the	All dependent residents have the
During an observation on 3/22/23 at 11:50 a.m., potential to be affected by this	1:50 a.m., potential to be affected by this
Resident 20 laying in bed, unshaven with a alleged deficiency. DON/ADON	vith a alleged deficiency. DON/ADON
moderate amount of facial hair. completed rounds focusing on	
facial hair with no other identified	
Review of the record of Resident 20 on 3/22/23 at concerns.	
11:03 a.m., indicated the resident's diagnoses 3. What measures will be put	
included, but were not limited to, chronic into place and what systemic	' ' '
obstructive pulmonary disease (COPD), changes will be made to ensure	
Alzheimer's disease, hypertensive heart disease, that the deficient practice does not	· · · · · · · · · · · · · · · · · · ·
diabetes, muscle weakness and pneumonia. recur? Nursing staff re-educated	
on CNA To Do List and providing	
The Quarterly Minimum Data Set (MDS) ADL care on 4-14-23 A daily	on CNA To Do List and providing
assessment for Resident 20, dated 3/14/23, rounding tool including resident	on CNA To Do List and providing ADL care on 4-14-23 A daily
indicated the resident was severely impaired for shaving to be utilized by Care	on CNA To Do List and providing ADL care on 4-14-23 A daily rounding tool including resident

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155459	B. W	ING		03/24/	2023
				CTREET	ADDRESS STEW STATE ZID SOD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD 6TH STREET		
HICKOD	V ODEEK AT NEW	CACTLE					
HICKOR	Y CREEK AT NEW	CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	daily decision maki	ng. The resident required			Companions/Department		
	extensive assistance	e of one person for personal			managers to ensure residents	are	
	hygiene.	•			shaved per preference.		
	During an observation on 3/22/23 at 2:00 p.m.,				How corrective action will	ll be	
					monitored to ensure the deficie		
	1	ting on the side of his bed,			practice will not recur. What		
	unshaven with a moderate amount of facial hair.				quality assurance program will	be	
					put into place? DON/designed		
	During an observati	ion on 3/23/23 at 11:20 a.m.,			complete the Annual POC QA		
	Resident 20 was laying in bed with his eyes closed, the resident had a moderate amount of facial hair.				tool weekly x4 and monthly x6		
					ensure compliance. If 100%		
					compliance is not achieved an		
	144141				action plan will be completed.		
	During an observati	ion and interview with			5. Date of completion 4-24-	.23	
	_	3/23 at 2:10 p.m., the resident			o. Bate of completion 121	20	
		t like having a beard and would					
		very day, but not right now					
	because he had to u						
		for Resident 2 was reviewed on					
		p.m. The medical diagnoses					
		al injury and convulsions.					
	iliciuded ilitiacialila	in injury and convuisions.					
	An Annual Minimu	ım Data Set Assessment, dated					
		Resident 2 was severely					
	, , ,	d, did not reject care, and					
		assistant for personal hygiene					
	tasks, including sha	lving.					
	A 4: '4' C1 '1						
		ly living care plan, dated					
	l '	d an intervention to assist					
		ivities of daily living as					
	needed.						
		2/01/2022 : 1.22					
		Resident 2 on 3/21/2023 at 1:39					
	p.m., indicated long	g facial hair on the chin.					
		2/20/2022 : 1.22					
		Resident 2 on 3/22/2023 at 1:30					
	p.m., indicated long	g facial hair on the chin.					
	An interview with (CNA 1 on 3/24/2023 at 2:02					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/24/2023
	PROVIDER OR SUPPLIER Y CREEK AT NEW		901 N	ADDRESS, CITY, STATE, ZIP COD 16TH STREET CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=E Bldg. 00	provide shaving by A policy entitled, "A 3/23/2023 at 3:45 p policy indicated, ". [sic] 3.1-38(a)(3)(D) 483.25(i) Respiratory/Trach Suctioning § 483.25(i) Respiratory tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goad 483.65 of this sub Based on observation review the facility frequipment in a bag practices and failed ordered by the physical reviewed for respirate Resident 23, Resident 23, Resident 23, Resident 20 a respiration of the edge of During an observation of the edge of the	A.M. Care", was provided on a.m. by the Administrator. The aShave resident, is needed" eostomy Care and atory care, including and tracheal suctioning. Insure that a resident who care, including and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, is and preferences, and	F 0695	1. What corrective action w be accomplished for those residents found to have been affected by deficient practice? Residents 20, 23, 12 and 26 has their respiratory equipment plain a bag and dated. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action will be taken? DON/AD completed audit of other reside using respiratory equipment wino other identified concerns. Nursing staff re-educated on Oxygen Therapy and Devices Policy on 4-14-23.	ad ced ng the ON ents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		155459	B. W	'ING	_	03/24/	/2023
N	DOLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			16TH STREET		
HICKOR'	Y CREEK AT NEW	CASTLE	NEW CASTLE, IN 47362				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	4	DATE
	raised floor not in a	ece laying on the edge of the			3. What measures will be p	out	
	Taised floor flot fil a	bag.			into place and what systemic changes will be made to ensu	ro	
	Review of the record of Resident 20 on 3/22/23 at 11:03 a.m., indicated the resident's diagnoses included, but were not limited to, chronic				that the deficient practice does		
					recur?DON/Designee will rour		
					Mondays to ensure respiratory		
	obstructive pulmonary disease (COPD),				equipment/tubing were change		
	Alzheimer's disease, hypertensive heart disease,				per standard order on Sunday		
	diabetes, muscle we	eakness and pneumonia.			Corrective action will be taken		
					needed.		
		pitulation (recap) for Resident			4. How corrective action wi		
	7, dated March 2023, indicated the resident was				monitored to ensure the defici	ent	
	order albuterol sulfate aerosol inhaler 90				practice will not recur. What		
	micrograms (mcg), 2 puffs every four hours as needed for wheezing and shortness of breath.				quality assurance program wil		
		lution for nebulization: 2.5			put into place? DON/designe		
		nilliliter (ml) inhalation every 6			will complete the Annual POC QAPI tool weekly x4 and mon		
		shortness of breath or			x6 to ensure compliance. If 10	-	
		um bromide solution: 0.02% for			compliance is not achieved ar		
		or wheezing. The resident was			action plan will be completed.		
	ordered a Trelegy 1	_			5. Date of completion 4-24	-23	
	(fluticasone-umecli	din-vilanter) (respiratory tract			·		
	agent/anti-inflamma	atory agent) one puff one time					
	a day COPD.						
	Domin 1						
	_	on on 3/22/23 at 2:00 p.m.,					
		ting on the side of his bed, respiratory mask and nebulizer					
	1	t in a bag laying on the raised					
	floor.	a in a bag raying on the raised					
	During an observati	ion on 3/23/23 at 10:50 a.m.,					
		espiratory mask was laying on					
		n a bag and his nebulizer					
		on the edge of the raised floor					
	not in a bag.						
	During an charmat	on on 3/23/23 at 11:20 a.m.,					
		atory mask was laying on his					
	_	pag, his nebulizer mouthpiece					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	ETED
		155459	B. WI	NG		03/24/2	2023
		<u>l</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8	l		6TH STREET		
HICKOR'	Y CREEK AT NEW	CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		of the raised floor not in a bag.	+	TAG	DEFICIENCE)		DATE
		rd for Resident 23 was reviewed					
		4 p.m. The medical diagnoses					
		and chronic obstructive					
	pulmonary disease.						
	A Significant Chang	ge of Condition Assessment,					
		dicated that Resident 23 was					
	· · · · · · · · · · · · · · · · · · ·	d, utilized oxygen therapy, and					
	needed assistance w	vith activities of daily living.					
	A physician ordered	d for Resident 23, dated					
	7/17/2022, indicated	d to change oxygen tubing and					
	humidification weekly. An observation on 3/20/2023 at 6:53 p.m. indicated						
	oxygen tubing on th	ne in-room concentrator was					
	dated for 2/27/2023						
		3/20/2023 at 7:10 p.m. with LPN					
	4 indicated the tubin	ng was dated for 2/27/2023.					
	3. The clinical recor	rd for Resident 12 was reviewed					
	on 3/23/2023 at 1:5	5 p.m. The medical diagnoses					
		hypertension and muscle					
	weakness.						
	A Significant Chang	ge of Condition Assessment,					
	,	dicated that Resident 12 was					
		ised oxygen therapy, and					
	needed assistance for	or activities of daily living.					
	A physician order, o	dated 1/25/2023, indicated to					
		's oxygen tubing and					
	humidification ever	y week.					
	An observation on 3	3/20/2023 at 6:55 p.m. indicated					
	oxygen tubing on th	ne in-room concentrator was					
	dated for 2/1/2023.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459		l í	JILDING	nstruction 00	(X3) DATE COMPL 03/24/	ETED	
	PROVIDER OR SUPPLIER			901 N 10	DDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	An interview and o p.m. with LPN 4 in 2/1/2023. LPN 4 in often oxygen tubing 4. The clinical reco on 3/23/2023 at 1:5 included tremor and A Quarterly Minim dated 2/21/2023, in cognitively confuse activities of daily li An observation on indicated Resident drawer of the bedsi An observation on Resident 26's nebul the bedside table w A policy entitled, "was provided by that 3:45 p.m. The pooxygen tubing out oplace in a labeled b A policy entitled, "Therapy", was provided by that 3:45 p.m. The pooxygen tubing out oplace in a labeled by the policy entitled, "Therapy", was provided by the policy entitl	um Data Set Assessment, dicated that Resident 26 was ed and needed assistance with ving. 3/21/2023 at 2:25 p.m., 26's nebulizer was in the top de table with no storage bag. 3/22/2023 at 2:45 p.m. indicated izer was in the top drawer of ith no storage bag. Oxygen Therapy and Devices", e Administrator on 3/23/2023 edicy indicated to change weekly or as needed and to ag when not in use. Aerosolized Medication rided by the Administrator on on. The policy indicated to ear equipment weekly and to ag with patient's name when		TAG	DEPCENCTI		DATE
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/\ §483.35(b) Regist	Wk, Full Time DON tered nurse					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155459	B. W	ING		03/24/	/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	•	DATE
TAG	§483.35(b)(1) Exceparagraph (e) or (in must use the servitor at least 8 constances a week. §483.35(b)(2) Exceparagraph (e) or (in must designate a last the director of in must designate a last the director of in serve as a charge has an average dafewer residents. Based on interview failed to provide eignegistered nurse (Ringereigneigneigneigneigneigneigneigneigneign	rept when waived under f) of this section, the facility ices of a registered nurse ecutive hours a day, 7 days rept when waived under f) of this section, the facility registered nurse to serve nursing on a full time basis. It director of nursing may an unurse only when the facility faily occupancy of 60 or and record review, the facility faily occupancy of 60 or and record review, the facility faily occupancy of 30 days overage for 5 of 30 days overage. Scheduled for dates 2/25/2023, 3, 3/18/2023, and 3/19/2023 No provided direct care to lays. The Assistant Director of 23 at 3:40 p.m. indicated that the coverage on those for the server of the se	F 07		1. What corrective action was be accomplished for those residents found to have been affected by the deficient praction. The facility has obtained RN coverage for 8 consecutive her day/7days a week. 2. How will you identify oth residents having the potential be affected by the same deficing practice and what corrective a will be taken? No residents was affected by this deficiency. Al residents have the potential to affected by the alleged deficiency practice. The daily staffing is reviewed by the Executive Dir and the Director of Nursing to ensure that RN coverage is in place. 3. What measures will be printo place or what systemic changes you will make to ensut that the deficient practice does	er to ent ction ere l b be nt ector	04/24/2023
					recur? The daily staffing is		l

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155459	A. BUILDING <u>00</u> B. WING			COMPLETED 03/24/2023	
		133439	D. W.			03/24/	2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT NEW	CASTLE			ASTLE, IN 47362		
(X4) ID	T	STATEMENT OF DEFICIENCIE	ı	ID	,		(V5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
					reviewed by the Executive Dir	ector	
					and the Director of Nursing to		
					ensure that RN coverage is in		
					place. If RN coverage is need	led,	
					the facility will contact staffing agencies and the in-company		
					staffing group to obtain an RN		
					The executive Director and	·-	
					Director of Nursing are continu	uing	
					to recruit and hire RN's full an	-	
					part time.		
					4. How the corrective actio		
					will be monitored to ensure the		
					deficient practice will not recu	r,	
					i.e.: what quality assurance program will be put into place	2 To	
					ensure compliance the ED/DN		
					will review the staffing schedu		
					showing RN coverage monthl		
					6 months and report on any		
					identified issues during month	ly	
					QAPI meetings and follow QA		
					recommendations. If RN cove	erage	
					has not been achieved as	_	
					required, an action plan will be developed and review will cor		
					until RN coverage has been	ııııu c	
					achieved 7 days a week for 8		
					consecutive hours.		
					5. Date of compliance 4-24	-23	
F 0040	400.00(:)(4)(0)						
F 0812 SS=F	483.60(i)(1)(2) Food						
Bldg. 00		re/Prepare/Serve-Sanitary					
		safety requirements.					
	The facility must	· ·					
		ocure food from sources					
		sidered satisfactory by					
I	federal, state or lo	ocai autnorities.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459			(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 03/24/2023		
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362				
(X4) II PREFI TAC	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
	(i) This may includirectly from local applicable State a regulations. (ii) This provision facilities from using gardens, subject applicable safe gractices. (iii) This provision from consuming facility. §483.60(i)(2) - Structure food in accustandards for food Based on interview failed to maintain relogs to ensure food temperature and falogs for the dish manitized for 7 out effect 27 residents Finding include: During initial tour p.m., Dietary Aide dish machine log, or blank for lunch and 3/19/23. The log in the water temperature dish machine where each meal; breakfal water temperature the dietary manage minimum standard re-washed when is:	de food items obtained producers, subject to and local laws or does not prohibit or preventing produce grown in facility to compliance with rowing and food-handling does not preclude residents roods not procured by the ore, prepare, distribute and ordance with professional diservice safety. If and record review the facility refrigerator/freezer temperature was stored at a appropriate field to maintain temperature reachine to ensure dishes were for 7 days, this had to potential residing in the facility. For the kitchen on 3/20/23 at 6:55 and provided the low temperature flated March 2023, the log was all supper from 3/13/23 to dicated the facility was to check the preparing to wash dishes for st, lunch and supper. If the is below 120 "STOP" and notify re. "Any items washed when is are not met are to be held and	F 0812	1. What corrective action be accomplished for those residents found to have bee affected by deficient practice. Temperatures were on a sepiece of paper that staff mer had and they were added to temperature logs for the refrigerator/freezer and dish machine. 2. How other residents had the potential to be affected to same deficient practice will lidentified and what corrective action will be taken? No residents have the potential to be affected. All residents have the potential be affected. All dietary staff re-educated on the food store policy and recording dish matemperature/sanitizer policy other refrigerators/freezers togs were reviewed. 3. What measures will be	will 04/24/2023 ne? parate mber the aving by the be e sidents ncy. tial to were rage achine All emp		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/24/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR p.m., Dietary Aide 3 refrigerator/freezer 2023, the log was b to 3/19/23. During an interview 3/22/23 at 12:00 p.r. responsibility of code temperatures to ensuappropriate temperatures to log the ensure dishes were than any food borne Manager was unsured or dishwasher temperatures at 1:53 p.m. residing in the facility kitchen. The dish machine to provided by the Die 1:50 p.m., indicated monitor and record assure proper sanitis. The food storage por Manger on 3/22/23 would be stored at a by methods designer Refrigeration temperatures and degrees Fahrenheit, The freezer temperatures.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION By provided the temperature log, dated March lank for evening from 3/13/23 with the Dietary Manager on in., indicated it was the but to log refrigerator/freezer ture food was maintained at tures. The Dishwasher was the dishwasher temperatures to sanitized. The facility had not illness outbreaks. The Dietary the why the refrigerator/freezer teratures were not checked. with the Dietary Manager on in, indicated all 27 residents thy ate meals from the facility temperature/sanitizer policy tary Manager on 3/22/23 at dishwashing staff would dish machine temperatures to			COMPLETION DATE Cosure Des not Frage Cochine			
	3.1-21(i)(3)							

ENTERS FOR I	NTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/24/2023			
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 6TH STREET				
HICKORY	CREEK AT NEW	CASTLE			ASTLE, IN 47362				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE		
SS=E Bldg. 00	information based format. Long-term care far submit to CMS core staffing inform for agency and co payroll and other vina uniform format specifications estat staffing information in a uniform format specifications estat staff at through interpersor resident care mand services to all maintain the higher mental, and psych care staff does no primary duty is materially and psychological staff in the example, houseke staffing information (i) The category of direct care staff (in whether the individual incresed practical nurse, certified nu or other type of mespecified by CMS) (ii) Resident censulation in the case of the control of the specified by CMS) (iii) Resident censulation in the care of the care staff (in whether the individual incresed practical nurse, certified nu or other type of mespecified by CMS) (iii) Resident censulation in the care of	atory submission of staffing on payroll data in a uniform cilities must electronically implete and accurate direct mation, including information intract staff, based on verifiable and auditable data at according to ablished by CMS. Lect Care Staff. Lere those individuals who, anal contact with residents anagement, provide care ow residents to attain or est practicable physical, according the physical elong term care facility (for seping). Lectronically submit to do accurate direct care in, including the following: f work for each person on including, but not limited to, dual is a registered nurse, nurse, licensed vocational ring assistant, therapist, edical personnel as its contact in a uniform in the physical electronically submit to do accurate direct care in, including the following: f work for each person on including, but not limited to, dual is a registered nurse, nurse, licensed vocational ring assistant, therapist, edical personnel as its contact with resident in a uniform in the physical personnel as its contact with resident in a uniform in the physical personnel as its contact with resident in a uniform in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as its contact with resident in the physical personnel as it							

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and tenure, and on the hours of care provided by each category of staff per resident per day

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPL			ETED	
		155459	B. WING 03/24/2023			2023	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	(including, but not date (as applicable each individual). §483.70(q)(3) Dist agency and contra When reporting intstaff, the facility mindividual is an emengaged by the fathrough an agency §483.70(q)(4) Data The facility must sinformation in the CMS. §483.70(q)(5) Sub The facility must sinformation on the CMS, but no less to information on the CMS, but no less to failed to ensure they nursing hours for 14 journal data reviewed Findings include: Payroll Based Journ Quarter 1 of Fiscal indicated the facility licensed nurse cover 10/9/22, 10/15/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/25/22, and 12/29 Review of the as well as a supplicable and the facility licensed nurse cover 10/9/22, 10/15/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/24/22, 11/24/29 Review of the as well as a supplicable and the facility licensed nurse cover 10/9/22, 10/15/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/24/22, 12/3/22, 11/24/24, 12/3/22, 11/24/24, 12/3/24, 11/24/24, 11	limited to, start date, end e), and hours worked for cinguishing employee from act staff. formation about direct care ust specify whether the aployee of the facility, or is cility under contract or y. a format. ubmit direct care staffing uniform format specified by schedule specified by frequently than quarterly. Friew and interview, the facility of accurately reported licensed of 91 days of payroll based ed. and Staffing Data Report for Year 2023 (10/1/22 to 12/31/22) or did not report 24 hours of rage on 10/1/22, 10/8/22, 10/23/22, 11/19/22, 11/20/22, 12/4/22, 12/18/22, 12/23/22, 10/23/22.	F 08		1. What corrective action who be accomplished for those residents found to have been affected by deficient practice. It residents were affected by the alleged deficient practice. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action will be taken? The alleged ficient practice does not have the potential to affect residents. 3. What measures will be printo place and what systemic changes will be made to ensure that the deficient practice does	ill No ing the ged re s. ut	04/24/2023
	aforementioned date	ensed staff was present on the es.			recur? The BOM or designee review employee and agency to		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

1		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/24/2023		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An interview with Administrator on 3/23/2023 at 2:30 p.m. indicated she believed there was an issue with reporting agency staff members to the payroll-based journal. At the time agency and salaried staff would not clock in using the electronic time clock so the offsite reporter was not able to see those shifts as worked. Agency and salaried members would utilize paper time clocks for verification and payment. An interview with the Administrator on 3/24/2023 at 1:35 p.m. indicated there is no policy regarding payroll-based journal reporting but they would follow the CMS guideline.				sheets/logs once daily 5 times week to verify that worked how are reported through Kronos. 4. How corrective action with monitored to ensure the deficit practice will not recur. What quality assurance program will put into place? BOM or design will report on any identified concerns during monthly QAP meeting and follow QAPI recommendations until facility gone 6 months with 100% compliance. 5. Date of completion 4-24 We respectfully disagree with determination that reporting with inaccurate. We contest that a hours worked were accurately reported to the Payroll Based Journal per CMS guidelines.	urs ill be ent I be nee I has -23 ras II		

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