STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155436	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Winamac	515 E 13th St Winamac, IN 46996

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview , the facility failed to serve food under sanitary conditions related to dishes stored upright near the stove top, not allowing the blender pieces to air dry after washing and sanitizing between each use, the cook allowing blender pieces to touch his clothes, holding food temperatures not up to temperature before serving, storing a scoop in a food container, and the cook touching the inside of the blender blade with ungloved hands. This had the potential to affect all 24 residents who received food from the kitchen. (Main Kitchen)Findings include:1. The Initial Kitchen Tour was completed on 11/17/25 at 10:30 a.m. with the Dietary Manager (DM).Plates were observed stored upright and not covered next to the stove top. During an interview at the time of the observation, the DM indicated the plates were not stored inverted because the heating element would not work correctly if the plates were stored inverted. Plates were stored upright so that the heating element worked. The staff should keep the plates covered when they were stored. 2. On 11/20/25 at 11:29 a.m., with [NAME] 1 and the Executive Director (ED), the following was observed: The cook was pureeing meatballs, rice and broccoli for lunch. He was making two servings of pureed foods for lunch. He put six meatballs in a blender and then added 3/4 cup of beef broth to blender. He indicated he had been doing this for a while and knows how much liquid it would take. He blended the meat and broth, then had to add three scoops of thickener to get the correct consistency. The scoop was already in the thickener container, and he reached in with an ungloved hand and scooped three scoops into the blender. He then put the scoop back into the container and closed the lid. After the meatballs were pureed, the blender and its parts were washed and sanitized, but not allowed to air dry. When he got the parts of the blender out of the dishwasher they were dripping with water, and he touched the blender parts to his clothing. [NAME] 1 next pureed the broccoli. He measured two servings of broccoli and put it in the blender and added an unmeasured amount of water from the pitcher. After blending the broccoli and water, he reached in with an ungloved hand and got a scoop out of the container of thickener and proceeded to add two scoops of thickener to broccoli and blended it. He tested it with a fork and indicated it was the desired consistency. The blender and its parts were then washed and sanitized but again were still dripping with water when he added food to them again. He then added two servings of rice to blender; he reached in with an ungloved hand into the thickener container and put one scoop in the blender and blended with no liquid added. He then tested it with fork and indicated it was the correct consistency. [NAME] 1 then indicated he needed more rice as he did not have enough for two servings. He then put the blender through the dishwasher again. The blender parts were dripping water after cleaning, and he added another serving of rice to the blender then added one scoop of thickener from the container with an ungloved hand and unknown amount of water from a pitcher. He blended and then needed another scoop of thickener. This time he put the scoop for the thickener in a small cup outside of the thickener tub. He then proceeded to blend the mixture. After blending, he reached in with his ungloved hand, picked up the blender blade and then placed the blender blade back into the blender and proceeded to blend some more. He then tested the rice mixture with fork and indicated it was the correct consistency. 3. On 11/20/25 12:12 p.m., [NAME] 1 completed the holding temperature check (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for food on the tray line. The following foods were not at the correct holding temperatures:- meatballs were 127 degrees Fahrenheit (F)- pureed rice was 120 degrees FDuring an interview at the time of the observation, the [NAME] indicated the food was ready to be served and he was unaware what the holding temperatures should be. During an interview on 11/20/25 at 12:30 p.m., the ED was made aware of the above concerns and indicated she would follow up with the cook regarding the concerns. A policy titled, Storing Equipment, Utensils, Linens, and Single-Service and Single-Use Articles and received as current from the ED on 11/20/25, indicated, . (B) Clean Equipment and Utensils shall be stored as specified.(2) Covered or inverted.A policy titled, Time/Temperature Control for Safety Food, Hot and Cold Holding, and received as current from the ED on 11/20/25, indicated, .TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees Celsius (135 degrees F) or above.3.1-21(i)(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure an ADL (activities of daily living) Care Plan was updated to include the use of a hand splint for 1 of 2 residents reviewed for range of motion. (Resident 2)Finding includes:On 11/17/2025 at 10:50 a.m., Resident 2 was observed lying in his bed. He had an edema glove on his left hand and there was a hand splint on the bed. He indicated he wore the hand splint at night only. The resident's record was reviewed on 11/18/25 at 10:20 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one-sided weakness) following a cerebral infarction (stroke) affecting the left side, diabetes mellitus, and hypertension. The admission Minimum Data Set assessment, dated 9/28/25, indicated the resident was cognitively intact and had hemiparesis and hemiplegia affecting the left side. A Physician's Order, dated 10/2/25, indicated to wear a resting hand splint to the left hand at bedtime. An ADL Care Plan, dated 9/22/25, indicated the resident requires assistance with ADLs including bed mobility, transfers, eating, and toileting related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus (DM), atrial fibrillation, hypertension (HTN), chronic kidney disease (CKD) and anemia. Interventions included, but were not limited to, a.m./p.m. care, assist with bed mobility as needed, and assist with bathing as needed per resident preference. There was no indication the resident used a resting hand splint.During an interview on 11/20/25 at 12:20 p.m., the Director of Nursing indicated the hand splint should have been included on the care plan. 3.1-35(b)(1)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure twice weekly one-to-one activities were implemented for a cognitively impaired and dependent resident for 1 of 2 residents reviewed for activities. (Resident 11) Finding includes: On 11/17/25 at 10:03 a.m., Resident 11 was observed lying in her bed awake. On 11/17/25 at 11:29 a.m., Resident 11 was observed lying in her bed. On 11/18/25 at 12:34 p.m., Resident 11 was observed making noises while eating in the dining room, she was receiving assistance from staff at the time. After she had finished lunch, the staff assisted her to return to bed. On 11/19/25 at 11:37 a.m., Resident 11 was lying in her bed. There was a group activity going on in the dining room at the time. Resident 11's record was reviewed on 11/19/25 at 3:47 p.m. Diagnoses included, but were not limited to, cerebral palsy, moderate intellectual disabilities, legal blindness, and hearing loss. The Quarterly Minimum Data Set (MDS) assessment, dated 10/15/25, indicated the resident was severely cognitively impaired for daily decision making. She was dependent on staff for all activities of daily living including, but not limited to, bed mobility, transfers, personal hygiene, and bathing. The Care Plan, dated 3/24/22, indicated the resident enjoyed working on puzzles and sorting buttons. She also liked to participate in exercise and ice cream socials. She liked to sit in during group activities even though she might not be able to participate. The resident enjoyed being in the room during exercise activities. The goals included the resident would passively participate in group activities while awake and she would be provided with one-to-one activities twice weekly at 15 minutes each. Interventions included, but were not limited to, sign language book kept in resident room and at nursing station, provide hand massages, let resident sort buttons and work on puzzles, assist in smelling new flowers or scents, assist with feeling for new items, and use sign language to assist with resident's need or wants. The Activities Charting Report, dated 10/20/25 thru 11/20/25, indicated the resident attended karaoke and dancing with staff and visited with [NAME] the dog on 10/25/25, sorted buttons on 10/27/25 and 11/3/25, attended table talk with high school seniors on 11/7/25, and attended live gospel music on 11/12/25. There were no other activities documented. During an interview on 11/20/25 at 2:57 p.m., the Activity Director indicated the resident liked to sort buttons and put together puzzles. The puzzles were frustrating the resident lately so they had been providing her with buttons most of the time. They kept some in the dining area so that she could have them in there if she was out of bed. The CNAs helped with the one-to-one activities with the residents but had not completed the documentation. During an interview on 11/21/25 at 10:35 a.m., CNA 3 and CNA 4 indicated the resident preferred to stay in bed lately. The resident would sign when she wanted to stay in bed or eat. They would take her buttons into her room and sit with her while she sorted them. They had provided this activity to her this morning as well as doing passive range of motion exercises with her which she did every day. 3.1-33(b)(8)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure a resident received timely treatment for itching skin for 1 of 1 resident reviewed for non-pressure skin conditions. (Resident 8)Finding includes:On 11/17/25 at 11:51 a.m., Resident 8 was observed in bed. She was rubbing her left arm against her body and indicated she had a rash and her arm was itching. She indicated this had been ongoing for a few weeks and there was no treatment being applied. On 11/19/25 at 3:25 p.m., the resident was observed in bed again rubbing her arm against her body and indicated it was itching. The Director of Nursing (DON) was present and observed her left arm. There was a pink, slightly raised rash on her forearm. The resident indicated it had been there for several weeks and she had told the nurse about it, but was unable to identify the nurse she reported it to. The DON indicated she had not been made aware of the concern, and the rash had not been identified during a shower on the previous day. The resident's record was reviewed on 11/19/25 at 2:45 p.m. Diagnoses included, but were not limited to, hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction (stroke) right side, unspecified dementia and unspecified convulsions. The Significant Change Minimum Data Set assessment, dated 9/3/25, indicated the resident had moderate cognitive impairment and was dependent for transfers and toileting. A Physician's Order, dated 4/14/25, indicated hydrocortisone lotion 1% (used to treat various skin conditions including eczema, dermatitis, psoriasis and insect bited by reducing inflammation and itching) apply a thin layer twice daily as needed. The October and November 2025 Medication Administration Record indicated the hydrocortisone cream had not been used. The cream was last used four times in July for itching skin. During an interview on 11/20/25 at 2:30 p.m., CNA 1 and CNA 2 indicated the resident had been complaining of itching to her forearm for about a week. They indicated they applied barrier cream or lotion to the area and had notified three different nurses. 3.1-37(a)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet the individual needs related to not making pureed food using the Pureed Food Preparation Guidelines to ensure nutritional value of food. This had the potential to affect the 2 residents who received a pureed diet.Finding includes:On 11/20/25 at 11:29 a.m., [NAME] 1 was observed making pureed foods. He started with two servings of pureed meatballs. He added six meatballs to the blender and a 3/4 cup of beef broth and blended the mixture. He then added three scoops of thickener and blended again. He tested it and indicated it was correct consistency. The cook indicated he had been doing this for a while and was aware of how much beef broth and thickener was needed. The cook then pureed two servings of broccoli. He put the broccoli in the blender and added an unmeasured amount of water from a pitcher, then added two scoops of thickener and blended again, then indicated it was the correct consistency. The cook indicated he normally put water in with vegetables when he pureed them and he just knew how much water to put in since he had been doing it for a while. The cook then pureed two servings of rice. He added two scoops of rice into the blender and then added one scoop of thickener. He then blended and tested it with a fork and indicated it was the correct consistency. [NAME] 1 then indicated he needed more pureed rice. More rice was added to the blender with one scoop of thickener and an undetermined amount of water from a pitcher. He then blended and added another scoop of thickener. The cook indicated he followed the Pureed Food Preparation Guidelines that was on the wall. The Pureed Food Preparation Guidelines, received as current from the ED on 11/20/25, indicated, .The Pureed Food Preparation Guidelines. indicated, .1. Add the desired number of servings of the regular consistency food item to a blender or food processor. 2. Begin processing the food until it starts to break down. 3. If the mixture is too thick or not blending smoothly, add 1-2 Tbsp (15- 30 ml) of fluid per 1/2 cup (125ml) of food. Refer to the table below for recommended types of fluids to use. 4. Continue blending, gradually adding more liquid as needed to reach a smooth, uniform consistency. Test the texture to ensure it meets IDDSI Level 4 standards per the testing methods below. 5. For thin or liquid foods, use a commercial thickener as needed (follow product-specific instructions) A typical amount is 1/4 to 1 tsp (1.25-5ml) per 1/2 cup of food.Sample Foods and Recommended Fluids.Cooked vegetables recommended liquid is residual cooking water or broth.During an interview on 11/20/25 at 12:30 p.m., the ED was made aware of the above concerns and indicated she would follow up with the cook regarding the concerns.3.1-21(a)(1)