

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Hickory Creek at New Castle		STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16th Street New Castle, IN 47362	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure a resident was free from verbal and mental abuse by a staff member to where the resident exhibited behaviors such as irritability and verbal disappointment in response to the staff member's presence for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 8/11/25 at 11:27 a.m. His diagnoses included, but were not limited to, depression, anxiety, pseudobulbar affect, hemiplegia, and hemiparesis. The 6/24/25 Quarterly MDS (Minimum Data Set) assessment indicated he was moderately cognitively impaired. A care plan, last reviewed/revised 7/7/25, indicated his cognition level could fluctuate throughout the day. A care plan, last reviewed/revised 7/7/25, indicated he was at risk for signs and symptoms of anxiety, and could have episodes of uncontrolled outbursts. The goal was for him to not have increased signs and symptoms of anxiety or uncontrolled outbursts. Approaches were to encourage him to verbalize fears and anxiety, and to offer validation and reassurance, and to maintain a calm environment. A care plan, last reviewed/revised 7/7/25, indicated he had a diagnosis of pseudobulbar affect and was known to exhibit angry outbursts related to extreme irritability, low frustration tolerance and a history of quick temper. The goal was for him to accept staff redirection/reassurance when angry. Approaches were for staff to always approach him calmly and in a non-confrontational manner; for staff to approach him only one at a time and not in a group; for staff to give him space and time to calm; and for staff to quietly ask him to stop his behavior. On 8/12/25 at 11:15 a.m., the Administrator provided the investigative file into an incident that occurred between Resident D and the Maintenance Director on 7/10/25 at 12:15 p.m. The file included the 7/15/25 follow-up incident report, the documented 7/10/25 CNA (Certified Nurse Aide) 3 interview, the documented 7/10/25 SSD (Social Services Director) interview, the undated written SSD statement, the documented 7/10/25 Resident C interview, and the documented 7/10/25 Resident D interview. The 7/15/25 follow-up incident report, completed by the Administrator, indicated a resident reported concerns with a staff member using harsh tones. An investigation was started, and the Maintenance Director was suspended pending investigation. The follow-up section of the report indicated the investigation was completed. Resident and staff interviews were conducted with no concerns noted. Resident D showed no signs or symptoms of psychosocial distress and denied staff using harsh tones. The Maintenance Director returned to work. The 7/10/25 CNA 3 interview, documented by the Administrator and signed by CNA 3, indicated CNA 3 was at the nurse's station when she heard Resident D yelling. Resident D sounded angry. CNA 3 went to Resident D's room. Resident D was sitting on the side of his bed, crying. Resident D informed CNA 3 he wanted to lay down, so CNA 3 covered him up in bed. The Maintenance Director and the SSD walked into the room, and Resident D started attempting to get out of bed. The Maintenance Director was standing at the foot of Resident D's bed, pointing his finger at Resident D and saying, You don't talk to me like that, in a loud voice. An interview was conducted with CNA 3 on 8/11/25 at 4:22 p.m. She indicated she worked at the facility for about a year as a CNA. About a week before her scheduled last day at the facility, due to transferring to a sister facility, she was sitting at the nurse's station and heard Resident D yelling. He sounded upset, so she went to check on him. When she walked toward Resident D's room, she saw the Maintenance Director walking down the hallway. When she entered the room, Resident D was crying and really upset. She calmed him down by changing the subject, talked about a local NFL (National Football League) team, and covered him up in bed. Then the Maintenance Director and SSD walked into the room. Resident D immediately freaks out, went into fight or flight. She remembered the Maintenance Director saying to Resident D, You don't f***** talk to me like that, while standing at the end of Resident D's bed, pointing his finger at Resident D. It was like a Walmart video. People yelling and crazy. It gives me chills. There were five people in the room at the time, including CNA 3, Resident D, Resident C who was Resident D's roommate, The Maintenance Director, and the SSD. The SSD ended up taking the Maintenance Director out of the room, and she followed. CNA 3 explained to the Maintenance Director that Resident D was cognitively impaired, and that he couldn't correct someone who was cognitively impaired like that. After explaining this the Maintenance Director, the Maintenance Director acted as if he didn't care. The Maintenance Director was mad and brushed it off. Resident C informed her that all Resident D wanted was for the Maintenance Director to take his lunch tray. Resident D had only one hand and one leg that worked, so if he saw anyone being lazy, it kind of pisses him off. CNA 3 had Resident D laid down, covered up, and calmed down but as soon as the Maintenance Director came in the room, Resident D pulled his blankets off</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>Based on interview and record review, the facility failed to administer Resident B's psychotropic medications as ordered and failed to implement Resident D's behavioral care plan for management of behavioral outburst for 2 of 3 residents reviewed for behavioral care management. (Resident B and Resident D) Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 8/11/2025 at 1:10 p.m. The medical diagnoses included stroke and behavioral disturbances.</p> <p>A Quarterly Minimum Data Set assessment, dated 7/16/2025, indicated Resident B had moderate cognitive impairment and exhibited behaviors of verbal aggression towards others.</p> <p>A psychotropic medication care plan for Resident B, initiated on 8/1/2024 and revised 7/28/2025, indicated an intervention to administer medications as ordered.</p> <p>A physician's order, dated 6/25/2025, indicated to administer an antipsychotic medication via intramuscular injection every second month on the 25th of the month. Review of the Medication Administration Record for June of 2025, indicated that Resident B did not receive her dose of intramuscular antipsychotic medication.</p> <p>During an interview on 8/12/2025 at 11:56 a.m., the Psychiatric Nurse Practitioner (NP) indicated she had treated Resident B on and off for ten years. She resumed care for Resident B in July of 2025. During this time, she was concerned about Resident B not receiving her June dose of antipsychotic medication via intramuscular injection based on the escalating behaviors Resident B was exhibiting.</p> <p>During an interview on 8/12/2025 at 12:45 p.m., the Interim Director of Nursing Services (DNS) indicated it was the expectation for staff to follow physician orders as written unless clinically contraindicated.</p> <p>2. The clinical record for Resident D was reviewed on 8/11/25 at 11:27 a.m. His diagnoses included, but were not limited to, depression, anxiety, pseudobulbar affect, hemiplegia, and hemiparesis.</p> <p>The 6/24/25 Quarterly MDS (Minimum Data Set) assessment indicated he was moderately cognitively impaired.</p> <p>A care plan, last reviewed/revised 7/7/25, indicated his cognition level could fluctuate throughout the day.</p> <p>A care plan, last reviewed/revised 7/7/25, indicated he was at risk for signs and symptoms of anxiety, and could have episodes of uncontrolled outbursts. The goal was for him to not have increased signs and symptoms of anxiety or uncontrolled outbursts. Approaches were to encourage him to verbalize fears and anxiety, and to offer validation and reassurance, and to maintain a calm environment.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, last reviewed/revised 7/7/25, indicated he had a diagnosis of pseudobulbar affect and was known to exhibit angry outbursts related to extreme irritability, low frustration tolerance and a history of quick temper. The goal was for him to accept staff redirection/reassurance when angry. Approaches were for staff to always approach him calmly and in a non-confrontational manner; for staff to approach him only one at a time and not in a group; for staff to give him space and time to calm; and for staff to quietly ask him to stop his behavior.</p> <p>On 8/12/25 at 11:15 a.m., the Administrator provided the investigative file into an incident that occurred between Resident D and the Maintenance Director on 7/10/25 at 12:15 p.m.</p> <p>The 7/15/25 follow-up incident report, completed by the Administrator, indicated a resident reported concerns with a staff member using harsh tones. An investigation was started, and the Maintenance Director was suspended pending investigation. The follow-up section of the report indicated the investigation was completed. Resident and staff interviews were conducted with no concerns noted. Resident D showed no signs or symptoms of psychosocial distress and denied staff using harsh tones. The Maintenance Director returned to work.</p> <p>An interview was conducted with Certified Nurse Aide (CNA) 3 on 8/11/25 at 4:22 p.m. She indicated she worked at the facility for about a year as a CNA. About a week before her scheduled last day at the facility, due to transferring to a sister facility, she was sitting at the nurse's station and heard Resident D yelling. He sounded upset, so she went to check on him. When she walked toward Resident D's room, she saw the Maintenance Director walking down the hallway. When she entered the room, Resident D was crying and really upset. She calmed him down by changing the subject, talked about a local NFL (National Football League) team, and covered him up in bed. Then the Maintenance Director and SSD walked into the room. Resident D "immediately freaks out, went into fight or flight." She remembered the Maintenance Director saying to Resident D, "You don't f***** talk to me like that," while standing at the end of Resident D's bed, pointing his finger at Resident D. "It was like a Walmart video. People yelling and crazy. It gives me chills." There were five people in the room at the time, including CNA 3, Resident D, Resident C who was Resident D's roommate, The Maintenance Director, and the Social Services Director (SSD). The SSD ended up taking the Maintenance Director out of the room, and she followed. CNA 3 explained to the Maintenance Director that Resident D was cognitively impaired, and that he couldn't correct someone who was cognitively impaired "like that." After explaining this to the Maintenance Director, the Maintenance Director acted as if "he didn't care." The Maintenance Director was mad and brushed it off. Resident C informed her that all Resident D wanted was for the Maintenance Director to take his lunch tray. Resident D had only one hand and one leg that worked, so if he saw anyone being lazy, it "kind of pisses him off." CNA 3 had Resident D laid down, covered up, and calmed down, but as soon as the Maintenance Director came in the room, Resident D pulled his blankets off immediately, and got himself to the side of his bed, "like he was trying to get at" the Maintenance Director. Resident D normally needed assistance to get to the side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the SSD on 8/12/25 at 9:19 a.m. He indicated he worked at the facility for three and a half years as the SSD and Marketing Director. He was let go about a week ago. On 7/10/25, he was walking down the hallway, when the Maintenance Director asked him to go into Resident D's room. As soon as the SSD and Maintenance Director walked into the room, Resident D was screaming, "Get this guy out my room," referencing the Maintenance Director. CNA 3 was present in the room as well. The SSD and CNA 3 were trying to prevent Resident D from getting out of bed, because he can't walk. The Maintenance Director was saying, "This is what I'm talking about." The SSD witnessed how the Maintenance Director raised his voice, saying you're not going to talk to me like that, being confrontational. It was getting louder and louder. The SSD did not hear the Maintenance Director curse, just had a tone to his voice. When the SSD and the Maintenance Director first came to the room, the Maintenance Director stayed by the door, but by the end of the incident, he was at the end of Resident D's bed. The SSD was in between the Maintenance Director and Resident D, who was "red in the face." The Maintenance Director was pointing at Resident D, saying, "Look, this is what I'm talking about." Resident D was screaming at the top of his lungs, and the Maintenance Director was "matching his energy." The SSD was trying to calm down both Resident D and the Maintenance Director, and keep Resident D safe. "This went on for like ten minutes." The SSD saw the Maintenance Director in the hallway prior to entering Resident D's room with him, "so there was clearly something that happened before then." Eventually the Maintenance Director left the room. The SSD remained in the room for a bit, to try and assist with calming Resident D down. Resident C, Resident D's roommate, informed him Resident D and the Maintenance Director were "jaw jacking," raising their voices. The SSD informed the nurse on duty, the DON at the time, and the Administrator. The SSD informed the Administrator there was "craziness" going on down there. The SSD went back to check on Resident D, and things had calmed down. The SSD interviewed residents for the investigation later on, including Resident C. Resident C informed him Resident D and the Maintenance Director were going back and forth. Resident D yelled at the Maintenance Director. Then the Maintenance Director yelled at Resident D. The SSD did not know why the Maintenance Director went back into the room a second time, because he would not have done that.</p> <p>An interview was conducted with Resident C on 8/11/25 at 1:20 p.m. He indicated he witnessed an incident between Resident D and the Maintenance Director last month. Resident D became "snippy and curses at people," and he cursed at the Maintenance Director. The Maintenance Director "got huffy," when he realized he "couldn't win," and left to get the SSD. They all came back into their room with another staff member. The Maintenance Director pointed his finger at Resident D, while standing towards the end of Resident D's bed. The Maintenance Director was not abusive, but he did yell.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Maintenance Director on 8/11/25 at 1:38 p.m. He indicated when he brought Resident D his lunch tray, Resident D asked him to remove an inhaler from his room. He did not feel comfortable removing the medication, and informed Resident D of that. Only he, Resident D, and Resident C were present in the room when he delivered the lunch trays. Resident D told him to get the f*** out of there, so the Maintenance Director left to get the SSD to handle it. The Maintenance Director also went back into the room with the SSD, but eventually left. CNA 3 was also present in the room. The Maintenance Director indicated he did not yell at or raise his voice at Resident D. He only asked if Resident D would please not cuss at him. "I did not point my finger at him at all." The reason he went back into the room with the SSD was to explain what was going on, "so he would get full picture," and so that "everyone was on the same page as to what was going on." He explained it in the room in front of Resident D. He'd been trained on abuse upon hire, in April 2025, and again after this incident. He was told he handled the situation appropriately, that he backed out of the situation, because he wasn't helping.</p> <p>An interview was conducted with Resident D on 8/11/25 at 1:25 p.m. He indicated he did not recall an incident with the Maintenance Director.</p> <p>An interview was conducted with the Administrator on 8/11/25 at 2:15 p.m. and 8/12/25 at 11:56 a.m. She indicated when she spoke with Resident D and Resident C, neither of them said anything happened, so she unsubstantiated the allegation of abuse. Resident C said it was not abusive in any way. The Maintenance Director was trying to talk to Resident D, but when Resident D was upset, you couldn't talk to him. The Maintenance Director being a newer employee, didn't know that about Resident D. The Maintenance Director just needed to walk away, instead of continuing to try to explain. The Maintenance Director was in-serviced on abuse, zero tolerance, and better ways to handle resident behaviors.</p> <p>The Behavior Management policy was provided by the Administrator on 8/11/25 at 1:50 p.m. It indicated, "It is the policy of [name of facility] to provide behavior interventions for resident with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions... Direct care staff will be educated as to the interventions for residents reviewed by the IDT (Interdisciplinary Team)."</p> <p>This citation relates to Complaint 2582411 and Complaint 2568713.</p> <p>3.1-37(a)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review, the facility failed to determine residents' ability to consent and establish individualized resident-centered care plans for a resident-to-resident relationships for 2 of 3 residents reviewed for resident-to-resident relationships. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 8/11/2025 at 1:10 p.m. The medical diagnoses included stroke and behavioral disturbances. A Quarterly Minimum Data Set assessment, dated 7/16/2025, indicated Resident B had moderate cognitive impairments. During an interview with Resident B on 8/11/2025 at 12:38 p.m., Resident B indicated she was in a relationship with Resident C. The relationship entailed her holding hands, playing cards, and kissing Resident C. Review of clinical record did not establish an assessment of Resident B's ability to consent nor care plans for Resident B's sexuality and relationship with Resident C. 2. The clinical record for Resident C was reviewed on 8/11/2025 at 1:30 p.m. The medical diagnoses included chronic obstructive pulmonary disease and depression. A Quarterly Minimum Data Set assessment, dated 5/13/2025, indicated Resident C was cognitively intact. During an interview on 8/11/2025 at 12:52 p.m., Resident C indicated he was in a relationship with Resident B, but they had recently broken up. During the time they were together, they would spend time together, hold hands, and kiss each other. Resident C stated it did not go further than kissing in the mouth. Review of the clinical record did not establish an assessment for Resident C's ability to consent nor care plans for Resident C's sexuality and relationship with Resident B. An interview with the Executive Director, on 8/12/2025 at 12:20 p.m., indicated she was unable to find documentation of Resident B or C's capacity to consent and Resident B and C's care plans for resident-to-resident relationship. It was the responsibility of the Social Service Director to develop the care plans. A policy entitled, Resident Sexuality, was provided by the Executive Director on 8/11/2025 at 1:40 p.m. The policy indicated .A determination of the ability to consent to sexual activities must be made in conjunction with the IDT and physician. Determination of capacity to make decision regarding sexual activity will be documented by the physician in the medical record. This citation relates to Complaint 2582411.3. 1-34(a)(1)</p>		