STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was served in a sanitary manner during a kitchen observation of the preparation of pureed food. This deficient practice had the potential to effect 5 of 5 residents who received pureed diets from the facility kitchen.Findings include:During a pureed food observation, on 2/25/26 at 11:13 a.m., the following was observed:Dietary Aide 6 lacked a cover over his long facial hair. Dietary Aide 6 cut up chicken patties in the food processor and blended them together with some hot water. He then scraped the mixture down off the sides and blended it again while adding some hot water to the mixture. He performed a thickness test of the mixture. He added more water and blended the mixture again. He performed another spoon test. He added more water and blended the mixture. He performed another spoon test. During an interview, on 2/25/26 at 11:27 a.m., Dietary Aide 6 indicated he should have worn a beard net.During an interview, on 2/25/26 at 11:27 a.m., the Dietary Manager indicated Dietary Aide 6 had just returned from break. She did not notice he wasn't wearing a beard cover and acknowledged he should have worn one.On 2/25/26 at 11:34 a.m., a posted sign on the kitchen door indicated the following: Notice: Hair net and beard cover required beyond this pointDuring an interview, on 2/26/26 at 9:29 a.m., the Administrator indicated he would expect staff to wear hair net coverings, including beard nets, when entering the kitchen area.16.2-3.1-21(i)(2)16.2-3.1-21(i) (3)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency for 1 of 1 resident-to resident altercations reviewed for abuse (Residents 4 and 17). Finding includes:Resident 4's clinical record was reviewed on 2/25/26 at 3:05 p.m. Diagnoses included Alzheimer's disease, dementia, severe, with behavioral disturbance, restlessness/agitation, major depressive disorder, mood disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident was severely cognitively impaired. He used a walker. He required supervision/touching staff assistance with walking. He required substantial/maximal staff assistance with toileting hygiene and toilet transfers. A care plan, initiated 7/10/25 and last revised 1/13/26, indicated the resident exhibited verbal aggression, agitation, and demanding behaviors. He had threatened physical aggression and struck staff. The resident became aggressive and confused regarding the location of his personal belongings (e.g., his coat). Interventions included educating staff on identifying early behavioral cues prior to escalation (10/29/25), reassuring the resident of the location of his coat (10/29/25), redirecting the resident to a quiet area to promote calming (7/10/25), and engaging the resident in conversation about his car trophies when he becomes agitated or aggressive. A care plan, initiated 7/10/25 and last revised 1/13/26, indicated the resident had a diagnosis of unspecified mood disorder and was prescribed an antipsychotic medication for the management of this condition. His symptoms were agitation, pacing, demanding behaviors, and episodes of aggression. Interventions included offering the resident a snack, specifically a banana if available (1/13/26), talking with the resident about his past and his life story (1/13/26), and talking with the resident about his car trophies if he was becoming agitated (7/10/25). A care plan, initiated 11/7/25 and last revised 1/13/26, indicated the resident had exhibited physically aggressive behaviors toward staff and peers. Behaviors included attempting to strike others, swinging his walker at individuals, punching, and making threats with utensils. Interventions included ensuring the safety of other residents and staff and attempting redirection (11/7/25) and transferring the resident to a geriatric psychiatric hospital per nurse practitioner (NP) order to ensure the safety of the resident and others. A care plan, initiated 7/10/25 and last revised 1/13/26, indicated the resident had a diagnosis of unspecified mood disorder and was prescribed an antipsychotic medication for the management of this condition. His symptoms were agitation, pacing, demanding behaviors, and episodes of aggression. Interventions included offering the resident a snack, specifically a banana if available (1/13/26), talking with the resident about his past and his life story (1/13/26), and talking with the resident about his car trophies if he was becoming agitated (7/10/25). A care plan, initiated 1/16/26, indicated the resident, at times, entered other residents' rooms and took items. The resident could become verbally aggressive and threaten physical aggression. The resident was confused and had poor judgement and impulse control. Interventions included redirecting the resident with snacks/drinks or an activity (1/16/26) and talking to the resident in a calm voice and listening understandingly to the resident. A progress note, dated 11/6/25 at 8:35 a.m., indicated the resident became violent and punched his roommate in the face. He attempted to attack his roommate with his silverware. Staff separated the residents to ensure the roommate's safety. The resident continued to have aggressive behaviors and attempted to collect silverware from other residents' trays. When the staff attempted to redirect the resident, he clinched his fist and moved towards them. The medical NP, psychiatric NP, and POA were notified. A progress note, dated 11/6/25 at 2:12 p.m., indicated the staff were unable to redirect the resident, and he continued to be a danger to himself and others. The psychiatric NP was notified and gave orders to transfer the resident to a geriatric psychiatric hospital. The hospital was contacted, the resident's paperwork was sent, and the hospital approved the resident for admission. A progress note, dated 11/6/25 at 5:02 p.m., indicated the resident was very aggressive toward staff and other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff attempted to deescalate the aggressive behaviors by leaving the resident alone, giving snacks, engaging in conversation, providing music and activities. The resident denied having any pain and yelled at staff with the redirection attempts. The resident's representative was called. She indicated the resident had been dangerous in the past, attempting to hurt neighbors and other people. She was unable to suggest any methods to assist in calming the resident. A progress note, dated 11/6/25 at 5:20 p.m., indicated the resident was transported to the geriatric psychiatric hospital. A progress note, dated 11/7/25 at 10:14 a.m., indicated the resident had demonstrated verbal and physical aggression toward staff and his peers, specifically cursing, throwing things, using his walker as a weapon, and attacking his roommate. The immediate interventions utilized were redirection with conversation, offering of snacks, provision of activities, and assist resident to his room for calming. The assessment of the potential correlation to the root cause was identified as Alzheimer's disease. The root cause of the behavioral expression was identified as the resident was verbally and physically aggressive. He was a danger to himself and others. He attacked his roommate and was not redirectable. Attempts with redirection escalated the resident's behaviors. The situation quickly became unsafe and unstable for the resident and others. The resident was given a one-time injection of haloperidol (antipsychotic medication) and sent to a geriatric psychiatric hospital. A geriatric psychiatric hospital progress note, dated 11/8/25, indicated in the history of present illness section (HPI), the facility reported the resident had been displaying physical aggression over the past 72 hours. On 11/6/25 the resident had a physical altercation with his roommate. The resident punched the roommate in the face and attempted to stab the roommate with a fork. The roommate obtained a small laceration to his cheek. The resident balled up his fists and swatted staff away with staff redirection attempts. Resident 17's clinical record was reviewed on 2/25/26 at 3:34 p.m. Diagnoses included anoxic brain damage, bipolar disorder, unspecified psychosis not due to a substance or known physiological condition, generalized anxiety disorder, and major depressive disorder, recurrent, moderate. A quarterly MDS assessment, dated 8/27/25, indicated the resident was severely cognitively impaired. He required supervision/touching staff assistance with walking and toilet transfers. A care plan, initiated 1/27/23 and revised 2/19/26, indicated, at times, the resident became impatient and moved a resident and wheelchair from where the resident was trying to go such as the bathroom. He was demanding and aggressive with staff wanting a soda when he had none available. Interventions included staff speaking with the resident to understand why he is so upset (2/27/24), educating the resident that staff are here to provide assistance (1/27/23), redirecting the resident to another area such as another bathroom (1/27/23), and resident will ask staff for assistance prior to moving a peer's wheelchair (1/27/23). A progress note, dated 11/6/25 at 10:00 a.m., indicated the NP saw the resident. She indicated the resident was involved in a resident-to-resident altercation where he was not the aggressor. The resident had notable facial injuries from the prior altercation and did not appear to be suffering psychological distress from the altercation. A progress note, dated 11/6/25 at 12:19 p.m., indicated the resident declined to move to another room so that he was no longer with his current roommate. He indicated he was fine and did not want to move. The resident's representative was notified of the resident-to-resident altercation and the resident's wishes to remain in the same room. She was agreeable to the resident's wishes. A progress note, dated 11/6/25 at 1:34 p.m., indicated the resident was safe with no agitation noted. A progress note, dated 11/12/25 at 11:49 a.m., indicated the resident exhibited no distress from the previous argument with his roommate. He was eating and sleeping well. He was performing his usual daily routines. During an interview, on 2/26/26 at 1:10 p.m., the Administrator indicated he would look for the investigation for the resident-to resident altercation between Resident 4 and Resident 17 on 11/6/25. He did not have a state report, because the incident was not a state reportable. During an interview, on 2/26/26 at 1:21 p.m., the Administrator indicated he and the DON had heard a noisy ruckus with lots of yelling on the hall and had gone down to the area to see what was happening. He and the DON did not see anything happen. The residents were yelling. He believed the altercation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened in the bathroom. Resident 4 mentioned that he hit Resident 17. The residents were separated. Resident 17 did not say anything. Resident 4 became increasingly agitated as the day progressed. Someone stayed with him throughout the day. During an interview, at the same time, the DON indicated. Resident 4 said I punched that guy. Resident 4 said a lot of things like that. During an interview, on 2/26/26 at 1:41 p.m., the ADON indicated Resident 4 said he punched Resident 17 in the face. Resident 17 said no. She documented that Resident 4 punched Resident 17 just to cover it. Both residents were severely cognitively impaired. What happened that day was she heard the residents talking very loudly, and she went towards the noise. Resident 4 went to the bathroom, then went back to his room. She saw Resident 4 holding his fork and heading toward Resident 17. She removed all the silverware from their room. Resident 4 had an appointment that day and left the facility for several hours. When he returned, his behaviors escalated. Someone stayed with him throughout the time he came back, they got the order to send him to the geriatric psychiatric hospital, and when he was transported to the geriatric psychiatric hospital. Resident 17 did not have any marks on his face, but she wanted to make sure she charted everything in case a bruise popped up later. During an interview, on 2/26/26 at 1:59 p.m., the Administrator indicated he was unable to provide camera footage as the cameras only went back a week. He had been told the incident happened just outside the bathroom. Resident 4 said he hit Resident 17. But, Resident 17 said no. Taking the silverware was more of a precautionary thing, as Resident 4 would put silverware in his socks. During an interview, on 2/26/26 at 2:17 p.m., CNA 9 (worked 6 a.m. to 6 p.m. on day of the altercation) indicated Resident 4 and Resident 17 were in the bathroom. She watched them walk out of the bathroom. They walked out calmly, no yelling. Then, Resident 4 said he hit Resident 17. She didn't see anything. She tried to find out what happened. She thought Resident 4 stabbed Resident 17 on the side of the neck with something, because his neck was bleeding. The QMA bandaged him. She thought the incident happened around lunch time. Then, later they packed up Resident 4's clothing because he was transferred to a hospital. She indicated Resident 4 could escalate and deescalate within minutes. He went back and forth. Resident 4 said he hit Resident 17 because Resident 17 kept talking. During an interview, on 2/26/26 at 2:28 p.m., QMA 7 indicated Resident 4 and Resident 17 came barreling out of the bathroom together. Resident 4 said he had hit Resident 17. She separated them and got them all checked out. She believed LPN 10 was working that day. She did not see a mark on either of the residents. Resident 4 did try to hide silverware, but she had never seen him be aggressive with it. During an interview, on 2/26/26 at 2:42 p.m., LPN 10 indicated that she heard yelling from the back of the facility and saw Resident 4 and Resident 17 yelling at each other. They were separated. Resident 4 kept yelling and threatening the staff. The NP gave an order because he would not calm down. Resident 4 kept repeating he hit Resident 17. Resident 17 did not say a lot, but he was not scared. Resident 17 did not have a mark on him. During an interview, on 2/26/26 at 3:05 p.m., NP 12 indicated she had spoken to Resident 17 and assessed him before speaking to the nurses that day. She had seen a few marks on his face, but she did not know what had happened. He did not seem upset or talk about anything that happened. She had assumed the marks on his cheeks were from the altercation. She thought the altercation was in the morning that day, but was not certain. During an interview, on 2/26/26 at 3:09 p.m., CNA 11 indicated she heard arguing that day. They separated Resident 4 and Resident 17. The residents were both trying to get into the bathroom and did not want to wait for their turn. The residents were in the doorway of the bathroom. There were no marks on Resident 17. She thought it happened at midday. During an interview, on 3/2/26 at 3:37 p.m., the Administrator indicated he heard the commotion and went to see what was happening. He made sure both residents were okay. He tried to deescalate Resident 4. Then, Resident 4 went to an appointment. As the day progressed Resident 4 became increasingly agitated and aggressive. The order was received to send him to the geriatric psychiatric hospital. During an interview, on 3/3/26 at 11:54 a.m., CNA 9 indicated when a resident made an allegation of abuse, staff were to make sure the resident was safe and then report it immediately to the nurse. During an interview, on 3/3/26 at 11:59 a.m., LPN 10 indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whenever a resident made an allegation of abuse or a resident-to-resident altercation, she would remove them from danger and immediately report to the Administrator. During an interview, on 3/3/26 at 1:39 p.m., RN 8 indicated she was in the facility on the day Resident 4 and Resident 17 had the altercation. She did not participate in taking care of those residents that day. If she came across the situation where a resident said they hit someone, she would try to get all the story, then report it to the DON. If a resident said they hit someone, she considered that it would be an allegation of abuse, no matter the resident's cognitive status. During an interview, on 3/3/26 at 1:52 p.m., the DON indicated if a resident said they had been hit, then she would consider it an allegation of abuse. She would separate the resident, make sure everyone is safe, ask the staff what was witnessed. Resident 4 and Resident 17 were yelling. Resident 4 was always yelling. She reported allegations to the Administrator. If she had written anything down about the investigation, she would not have kept it, because she did not think it was abuse. During an interview, on 3/3/26 at 2:27 p.m., the Administrator indicated he knew the resident-to-resident altercation happened because he heard the ruckus. Resident 4 was severely cognitively impaired. He did not see anything on Resident 17. He had the nurses check out the residents to be on the safe side. He felt Resident 4 made an outburst statement. During an interview, on 3/3/26 at 2:58 p.m., the Administrator indicated he had found his investigation on the computer. He had forgotten that Resident 4 had said he was going to punch someone - not that he had punched someone. A current facility policy, last revised 2/2020, titled Abuse Prohibition, Reporting and Investigation, provided by the Administrator during entrance conference on 2/24/26, indicated the following: .The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed.Resident to Resident Abuse:.It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, immediately, within 2 hours to the Indiana State Department of Health via the ISDH gateway system. 410 IAC 16.2-3.1-28(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure the resident and/or resident's representative was notified in writing of the transfer/ discharge appeal rights and bed hold policy for 1 of 3 residents reviewed for discharge. (Resident 37).Findings include:Resident 37's clinical record was reviewed on 2/26/26 at 8:39 a.m. Diagnoses include encephalopathy (change in brain function), aphasia (, major depressive disorder, and history of a stroke.A progress note, dated 1/29/26 at 10:20 a.m., indicated Resident 37 was discharged home. Discharge summary, medications, follow-up appointments and other paperwork were discussed with Resident 37 and representative.The clinical record lacked indication that the resident and the resident's representative were notified of the transfer/discharge appeal rights and bed hold policy in writing for Resident 37's discharge.During an interview, on 2/26/26 at 9:38 a.m., the DON indicated they discussed resident appeal rights, ombudsman notification and transfer/discharge information during admission and during resident council meetings. The Business Office Manager (BOM) was responsible for discussing appeal rights and bed hold policy.During an interview, on 2/26/26 at 12:29 p.m., the BOM indicated she completed resident discharge paperwork. She tried to get those completed 48 hours before the resident discharges. She did not have the resident and/ or representative sign the paperwork or put in a progress note stating the resident or their representative was notified of appeal rights or bed hold policy.During an interview, on 2/26/26 at 1:41 p.m., the ADON indicated resident medications and follow up appointments were discussed during discharge. Any contact information for the ombudsman, facility, the resident's primary care physician and the bed hold policy would also be discussed. She would have the resident and/or their representative sign the discharge summary, which did not include the bed hold or appeal rights. She did not put in a progress note indicating the residents appeal rights or the bed hold policy was discussed during discharge.A current facility policy, dated 11/2017 and revised 1/2019, titled Bed Hold Policy, provided by the Administrator, on 3/2/26 at 4:08 p.m., indicated the following: .3. The Resident's Representative will be informed of the bed hold policy at the time of notification of transfer. The Resident Representative will be provided a copy of the bed hold policy. 4. The facility staff will document the notification to the resident and the resident representative of the bed hold policy on the Emergency Resident Transfer Form.16.2-3.1-12(a)(6)(A)(i)16.2-3.1-12(a)(6)(A)(ii)16.2-3.1-12(a)(6)(A)(iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a qualified medication aide obtained authorization from a licensed nurse to administer an as needed (PRN) medication prior to the medication's administration for 2 of 10 residents observed during medication administration (Resident 3 and 29). Findings include: 1. During a medication administration observation, on 2/25/26 at 12:24 p.m., Resident 3 asked for pain medication. She had a 10 on a 1 to 10 scale of back pain. QMA 7 returned to the medication cart, removed a morphine tablet from the narcotics drawer, signed out the morphine, returned to the resident's room with the morphine, and gave the resident the morphine along with her nitrofurantoin and protein supplement. She did not ask a nurse for permission to administer the PRN medication or mention to the nurses at the nurses' station while she pulled the medication from the cart that the resident had requested the pain medication. The ADON, DON, and RN 8 sat at the nurses' station. Resident 3's clinical record was reviewed on 2/26/25 at 10:01 a.m. Diagnoses included chronic kidney disease, generalized anxiety disorder, dysphagia, intervertebral disc degeneration of the lumbar region, pressure area to the sacrum, peripheral vascular disease, obesity, impaired mobility, gastroesophageal reflux disease, and osteomyelitis of the vertebrae sacral region. Current orders included morphine immediate release 15 mg every four hours PRN for moderate to severe pain (2/16/26). A quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A care plan, initiated 5/10/19, indicated the resident was at risk for pain related to intervertebral disc degeneration of the lumbar region, pressure area to the sacrum, peripheral vascular disease, obesity, impaired mobility, gastroesophageal reflux disease, and osteomyelitis of the vertebrae sacral region. An intervention, initiated 3/12/21, indicated to administer oral and topical medication per order and notify the physician if they are not effective. 2. During a medication administration observation, on 2/25/26 at 12:41 p.m., Resident 29 requested pain medication as he walked by the QMA. He indicated his pain was 5 on a 1/10 pain scale. QMA 8 retrieved a 600 mg ibuprofen tablet from the medication cart. She did not ask for permission to administer the medication. The ADON and DON sat at the nurses' station and did not appear to hear the resident's request as they made no comments about the resident's request for pain medication. QMA 8 administered the ibuprofen to the resident in his room. Resident 29's clinical record was reviewed on 2/26/26 at 10:25 a.m. Diagnoses included traumatic brain injury, pain in left hip, and gastroesophageal reflux disease. Current orders include ibuprofen 600 mg every four hours PRN (12/16/25). A quarterly MDS, dated [DATE], indicated the resident was cognitively intact. A care plan, initiated 4/28/25, indicated the resident was at risk for pain related to traumatic brain injury, pain in left hip, and gastroesophageal reflux disease. Interventions included administer medications as ordered (4/28/25). During an interview, on 2/25/26 at 12:53 p.m., QMA 8 indicated she was supposed to ask a nurse prior to giving a PRN medication to a resident. She had been nervous and messed up two times, once with Resident 3 and then with Resident 29. During an interview, on 2/25/26 at 12:54 p.m., the ADON indicated QMAs are supposed to ask for permission prior to the administration of a PRN medication. During an interview, on 3/3/26 at 11:49 a.m., the DON indicated a QMA needed to ask permission prior to giving a PRN medication. According to the Qualified Medication Aide Scope of Practice (for Indiana), accessed 2/25/26 at 1:00 p.m. at https://www.in.gov/health/files/QMAScopeofPractice.pdf, The following tasks are within the scope of practice for the QMA unless prohibited by facility policy: .Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. A current facility procedure, revised 4/2025, titled Medication Administration, provided by the Administrator on 3/3/26 at 12:47 p.m., indicated .Procedure Steps: PRN Medications 31. Licensed nurse assessed resident to determine the need for the PRN medication. 410 IAC 16.2-3.1-35(g)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on record review and interview, the facility failed to obtain ordered labs for 1 of 5 residents reviewed for unnecessary medications (Resident 17). Finding includes:Resident 17's clinical record was reviewed on 2/25/26 at 3:34 p.m. Diagnoses included epilepsy, unspecified, intractable, without status epilepticus, other cystic kidney disease, hepatic encephalopathy, and alcoholic cirrhosis of liver without ascites Current orders included levetiracetam (seizure medication) 750 mg twice a day (2/11/26), divalproex (seizure medication) 125 mg three times a day (10/22/25), lactulose (laxative) 10 grams/ 15 mL - 15 mL three times a day (12/23/25), rifaximin (antibiotic) 550 mg twice a day (9/24/20), and ammonia, divalproex, and levetiracetam laboratory levels every second Monday of February, May, August, and November (1/19/22). A care plan, initiated 3/13/18 and revised 2/12/26, indicated the resident was at risk for functional decline due to toxic encephalopathy. The goal, with a target date of 5/15/26, indicated the resident will continue treatment for high ammonia levels. Interventions included obtain lab draws as ordered and send to the physician for review (3/13/18). A progress note, dated 7/7/25 at 4:26 p.m., indicated the resident had returned from an appointment with the neurologist with an unclear note to discontinue medications that the NP had wanted to continue upon return from the hospital. The psychiatric NP was to evaluate the medications. A call was placed to the neurology office, and a message was left to clarify orders. An ammonia level and liver profile were to be scheduled with the next blood draw day. A progress note, dated 7/9/25 at 10:00 a.m., indicated NP 13 had received a call from the resident's neurologist concerning the continued use of divalproex due to chronically elevated ammonia levels. The neurologist suggested discontinuing divalproex as it was not being used for seizure control as the resident was taking levetiracetam for seizures. The NP indicated consider decreasing divalproex and consult with the psychiatric NP regarding the decrease. An ammonia level order was sent to the laboratory for the 7/10/25 lab draw. A review of the 7/10/25 lab draw lacked an ammonia level. A progress note, dated 7/10/25 at 2:04 p.m., indicated NP 12 saw the resident for an acute visit for a psychotropic medication review and management, and continue evaluation of moods and behaviors. She had been notified of the neurologist's request to decrease divalproex due to ammonia levels. She had been told labs had been drawn in the morning (7/10/25). She decreased the resident's divalproex [250 mg] from three times a day to two times a day. A progress note, dated 7/15/25 at 6:41 a.m., indicated NP 12 visited the resident for behavior management meeting, recent medication changes, psychotropic medication review and management, and continued evaluation of moods and behaviors. She ordered an ammonia level to be drawn in two weeks. A progress note, dated 7/16/25 at 10:00 a.m., indicated NP 13 visited the resident for interpretation of labs. He reviewed the labs drawn on 7/10/25. He ordered an ammonia level for the next week. The clinical record lacked documentation of an ammonia level from 7/7/25 through 8/10/25. A progress note, dated 8/11/25 at 6:09 a.m., indicated a blood draw was performed for labs. A progress note, dated 8/13/25 at 11:00 a.m., indicated NP 13 visited the resident for interpretation of labs. He indicated the ammonia level was very low and considered very good from the recent lab draw. During an interview, on 3/3/26 at 8:56 a.m., the DON indicated she would look for the ammonia lab results for 2025. During an interview, on 3/3/26 at 1:13 p.m., NP 12 indicated she gave orders verbally to the nurses. She did not enter orders in her documentation that had not already been discussed with the nursing staff. During an interview, on 3/3/26 at 2:00 p.m., NP 13 indicated Resident 17 had difficulties with his ammonia levels being high. Neurology had wanted to decrease the resident's divalproex in July. He referred Neurology's concerns to NP 12 (the psychiatric provider). He had ordered an ammonia level on 7/16/25. The facility had ordered the lab. He had tried looking for the lab on his lab access site. He was unable to locate the ammonia level lab. He wrote the residents' new orders himself for the staff unless it was an order that he gave over the phone. He noted the ammonia level was completed on 8/11/25. He usually put a reminder on his phone (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if he had something to follow up on. During an interview, on 3/3/26 at 2:20 p.m., the DON indicated the lab said they did not draw the ammonia lab on 7/10/25. The requisition had been turned in on MatrixCare, the lab had missed it. The facility had not put in orders for the ammonia labs ordered on 7/15/26 and 7/16/26. The ADON was responsible for following up on lab draws and putting in orders for labs. The nurses also put in lab orders. She followed up on labs even if the NP ordered the labs. The DON and nurses could put in labs if the ADON was not available. The ammonia level was completed on 8/11/25. A current facility policy, revised 4/2024, titled Guidelines for Lab and Radiology Tracking, provided by the Administrator on 3/3/26 at 3:21 p.m., indicated the following: .All lab and/or radiology orders will be entered into MatrixCare Physician Orders upon receipt of order. Daily order checks by medical records or designee will ensure all orders have been entered in MatrixCare and are accurate. 410 IAC 16.2-3.1-49(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Huntington	1425 Grant St Huntington, IN 46750

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to prevent contamination of clean resident clothing while distributing resident laundry during a random observation. Findings include:During an observation, on 2/24/26 at 12:23 p.m., the following was observed:A laundry staff member delivered clothing to residents. She pulled clothing out of a covered laundry cart. The resident's clean laundry was pressed up against the front of her body while she knocked on the resident's door and proceeded into the residents room. She opened the closet door and hung the clean laundry up. She performed hand hygiene upon exiting the resident's room.She pushed the covered cart down the hallway. She stopped in front of another resident's room where she pulled their clean laundry out of the cart. The clean laundry was placed against the front of her body as she entered the resident's room. She proceeded to hang clothing in the resident's closet. Hand hygiene was performed while exiting the resident's room.She removed another resident's laundry from the covered cart. The clothing touched the front of her body when she knocked on the resident's door before proceeding into the resident's room. She opened the closet door before putting the clothing away. Hand hygiene was performed upon exiting the room.She pulled another resident's laundry from the covered cart. As she turned to enter the resident's room, the laundry touched the front of her body. Hand hygiene was performed upon exiting the resident's roomDuring an interview, on 2/24/26 at 12:33 p.m., Laundry Aide 5 indicated when delivering clean clothing it should not touch one's body.During an interview, on 3/3/26 at 1:46 p.m., the DON indicated staff should keep laundered clothing or linens away from their body to prevent cross contamination.A current facility policy, dated 8/2017 and revised 12/2021, titled Laundry Policy, provided by the Administrator, on 3/2/26 at 4:41 p.m., indicated the following: .Personnel shall handle, store, process and transport personal clothing and linen in a manner that prevents the spread of infection as follows: 1. Clean linen should be carried away from the body to prevent cross contamination 410 IAC (Indiana Administrative Code) 16.2-3.1-19(g)