STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155419	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Crawfordsville	817 N Whitlock Ave Crawfordsville, IN 47933

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure staff (RN 4) were properly trained, monitored, and compliant with medication administration and infection control practices for 4 of 6 residents observed for medication administration (Residents B, D, E, and F). Findings include:A complaint during the survey indicated Qualified Medication Aide (QMA) 6 had not administered eye medications to Resident B according to her orders or failed to administer the eye medications but documented she had administered them. QMA 6 also was not placing lidocaine patches (used to relieve localized pain) on residents but documenting she had. Grievances logs, dated 2/11/26, 3/10/26, and 4/21/26, indicated Resident B or her representative had reported the resident had not been receiving her eye drops as ordered from QMA 6. During a random observation on 5/4/26 at 7:40 a.m., Registered Nurse (RN) 4 was presetting medications on top of a medication cart on the back hallway. There were 15 medications cups on the top of the cart with resident names written in black sharpie, and 2 medication cups already had medication in them. RN 4 indicated he rarely administered medications as that was a QMA job, and his system was to preset all the medications before administering to avoid making mistakes. 1. On 5/4/26 at 7:35 a.m., RN 4 was observed taking a preset cup of unidentified medications for Resident N from the top of a medication cart and going to the main dining room where he obtained Resident N's vital signs and then administered her medications. Preset cups of other residents' medications were left on top of the unlocked medication cart at the end of the back hallway out of sight of the RN. RN 4 was not observed to sanitize his hands before or after administering the resident's medications. 2. On 5/4/26 at 7:45 a.m., RN 4 was observed taking a preset cup of unidentified medications for Resident D from the top of a medication cart and going to her room at the opposite end of the hallway. An electronic tablet was left open on top of the medication cart displaying Resident D's medication names and administration record. RN 4 obtained Resident D's vital signs and then administered her oral medications in her room, out of sight of the medication cart. RN 4 donned gloves and administered Restasis drops into both of Resident D's eyes, then immediately instilled Systane 0.6% eye drops into both of her eyes. RN 4 was not observed to sanitize his hands before or after administering Resident N's medications. Resident D's clinical record was reviewed on 5/4/26 at 10:58 a.m. Diagnoses on Resident D's profile included low back pain and dry eye syndrome. Physician's orders included, a. On 10/3/25, Lidocaine patch 4% on in the a.m. and off at night, as needed (prn) for pain.b. On 4/3/26, Restasis 0.05% (cyclosporine - prescription eye lubricant used to treat chronic dry eye syndrome) eye drops administer 1 drop in each eye twice a day.c. On 4/20/26, Systane 0.6% (over-the-counter eye lubricant used to treat dry eye symptoms) eye drops 1 drop in each eye twice a day. Drugs.com indicated to apply the lubricant drop (Systane) first to soothe the eyes, then apply the prescription drop (Restasis) later to allow it to directly contact the eye surface. It indicated to wait at least 15 minutes between applications to ensure proper absorption and prevent washing out the medication. 3. On 5/4/26 at 7:58 a.m., RN 4 was observed pulling 7 medication cards from the medication cart. RN 4 then walked to Resident B's room at the opposite end of the hallway and left the medication cards unsecured on top of the cart while he obtained Resident B's vital signs. An electronic tablet was left open on top of the medication (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart displaying Resident B's medication names and administration record, and the medication cart was left unlocked. While RN 4 was out of sight, he left Resident M sitting in her wheelchair near the medication cart waiting for his return. RN 4 popped out Resident B's pills from bubble pack cards directly into his hand, then placed the pills into a medication cup. RN 4 administered Refresh Relieva 0.5-1% eye drops into both of Resident B's eyes, then immediately instilled Gentear eye ointment into the resident's right eye. RN 4 donned gloves to administer the eye drops/ointment but was not observed to sanitize his hands before or after administering the oral and eye medications. Resident B's clinical record was reviewed on 5/4/26 at 11:48 a.m. Diagnoses on Resident B's profile included pain in the left shoulder, presbyopia (age-related loss of eye flexibility causing difficulty focusing on near objects), myopia right eye (distant objects appear blurry) and hypermetropia in the left eye (farsightedness), and dry eye syndrome of bilateral eyes. Physician's orders included,a. On 12/7/25, lidocaine 5 % adhesive patch, apply 1 patch PRN (as wanted) daily.b. On 4/9/26, Refresh Relieva PF 0.5-1 % instill 1 drop every 2 hours while awake.c. On 2/12/26, Systane Nighttime (white petrolatum-mineral oil) 94-3 % ointment apply a thin amount to the right eye four times a day. 4. On 5/4/26 at 8:17 a.m., RN 4 was observed pulling medication cards from the medication cart for Resident E. RN 4 popped 4 pills into his hand and placed them into a medication cup when he stopped and indicated he needed to go get vital signs for the resident who was sitting in the main dining room. The popped medications included aspirin 81 mg (used to prevent blood clotting), Amlodipine (used to treat high blood pressure), Clopidogrel 75 mg (Plavix - a blood thinner), and Isosorbide ER 30 mg (used to prevent chest pain). An electronic tablet was left open on top of the medication cart displaying Resident E's medication names and administration record, the medication cart was left unlocked, and the 7 cards of medications and cup with popped pills were left unsecured on top of the medication cart, all out of sight of the nurse. The Director of Nursing (DON) arrived and was observed to stop RN 4 from obtaining vital signs in the main dining room and told the nurse to pick another resident to administer medications to as the resident was in the dining room. RN 4 was observed to place Resident E's partially filled cup of medications to the back of the medication cart surface and began preparing medications for Resident F. The nurse was not observed to sanitize his hands before or after preparing the oral medications. 5. On 5/4/26 at 8:22 a.m., RN 4 was observed pulling 10 medication cards from the medication cart for Resident F. The nurse then indicated he needed to go get vital signs for the resident who was lying in her bed in a room directly across the hallway from the medication cart. An electronic tablet was left open on top of the medication cart displaying Resident F's medication names and administration record, the medication cart was left unlocked, the 10 cards of medications and the cup with Resident E's popped pills were left unsecured on top of the medication cart, all out of sight of the nurse. The DON was observed approaching the medication cart as Resident P walked by and stayed until the nurse exited the resident room. The DON was observed telling RN 4 he could not preset medications, to throw away the medication cups with resident names that were on top of the cart, and that he had to lock the medication cart and electronic tablet when he was out of sight of the cart. The DON left the area as RN entered the room to administer Resident F's medications. Resident E's cup of 4 pills was left unsecured on top of the medication cart. The nurse was not observed to sanitize his hands before or after administering the oral medications. 6. On 5/4/26 at 8:50 a.m., RN 5 was observed putting a date and her initials on a medicated pain patch, then preparing to apply the patch on top of Resident G's right shoulder. An old patch, dated 5/3/26, was observed still on the resident's shoulder and had to be removed before placement of the new patch. RN 5 indicated Resident G had an order to place an Aspercreme patch daily in the morning and remove it at bedtime. Resident G's clinical record review was completed on 5/4/26 at 11:18 a.m. Diagnoses on Resident G's profile included fibromyalgia and chronic pain. A physician's order, dated 5/9/25, indicated Aspercreme (lidocaine) 4 % apply 1 adhesive to the right shoulder in the a.m. and remove in the p.m. The website, https://www.aspercreme.com, undated, indicated Aspercreme with lidocaine patch instructions for use included, .apply to clean, dry skin for up to 12 hours, and follow safety (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions to ensure effective pain relief. Do not apply to broken or irritated skin. Take the patch out of its packaging and remove the protective liner from one side of the patch. Place the sticky side of the patch directly onto the painful area. Press down firmly to ensure it adheres well.The patch can be left on for up to 12 hours. Do not apply more than 3 patches in a 24-hour period. When done using the patch, fold it in half with the sticky sides together and dispose of it safely, out of reach of children and pets. Wash the hands after applying or removing the patch to prevent accidental contact with sensitive areas. On 5/4/26 at 8:52 a.m., residents with medicated Aspercreme/lidocaine orders were interviewed with the DON, to include,a. Resident D indicated she had an order for a pain patch, but it was only for when she needed one and she had not worn one in a while.b. Resident J indicated she had been wearing a patch from the night before but had removed it herself earlier.d. Resident K indicated she had been wearing a patch from the night before but had removed it herself earlier.e. Resident B indicated the Assistant Director of Nursing (ADON) had removed a patch from her left shoulder that morning, but the patch had not yet been reapplied.f. Resident L indicated that the ADON had come into her room minutes earlier to check for her patch, and she was not wearing one that was ordered to be put on twice a day. A Job Specific Orientation list for RN 4, signed by the employee as having completed the requirements necessary to perform his duties on 3/5/26, including a clinical skills checklist and medication management. On 5/4/26 at 1:45 p.m., RN 4 indicated when administering multiple eye medications, there was a 5-minute wait time between medications. During an interview on 5/4/26 at 1:54 p.m., the DON indicated nurses were checked off for medication administration and hand hygiene competency as part of the new-hire orientation. The procedure for administering multiple eye medications included hand hygiene both before and after administration of the drops and waiting at least 5 minutes between eye drops. There were 6 residents that had physician's orders for medicated patches. A once daily patch order indicated to place a patch in the am and remove in the pm. A twice daily patch order indicated placing the first patch in the a.m. and removing and replacing with a second patch in the p.m. RN 4 should have used hand sanitizer before and after setting up each resident's medications. On 5/4/26 at 3:06 p.m., the DON provided a Suggested Medication Administration Procedures, revised 6/30/23, and indicated the policy was the one currently being used by the facility. The policy indicated, Ophthalmic medication procedure.3. Wash hands and wear gloves.9. Gently pull-down lower lid to expose conjunctival sac. 10. Eye drops: hold dropper in dominant hand approximately 1/2 - 3/4 above conjunctival sac. Do not touch dropper to eye.13. If multiple eye drops are to be administered, wait 5 minutes between medications.16. Wash hands and document dose administered. This citation relates to Intake 2994771. 410 IAC (Indiana Administrative Code) 3.1-16(q)(7)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, when 2 errors were observed during 25 opportunities for errors during medication administration resulting in an error rate of 8.0% (Residents D and B). Findings include: 1. On 5/4/26 at 7:45 a.m., RN 4 was observed taking a preset cup of unidentified medications for Resident D from the top of a medication cart and going to her room at the opposite end of the hallway. RN 4 donned gloves and administered Restasis drops into both of Resident D's eyes, then immediately instilled Systane 0.6% eye drops into both of her eyes. RN 4 was not observed to sanitize his hands before or after administering Resident N's medications. Resident D's clinical record was reviewed on 5/4/26 at 10:58 a.m. Diagnoses on Resident D's profile included low back pain and dry eye syndrome. Physician's orders included, a. On 4/3/26, Restasis 0.05% (cyclosporine - prescription eye lubricant used to treat chronic dry eye syndrome) eye drops administer 1 drop in each eye twice a day.b. On 4/20/26, Systane 0.6% (over-the-counter eye lubricant used to treat dry eye symptoms) eye drops 1 drop in each eye twice a day. Drugs.com indicated to apply the lubricant drop (Systane) first to soothe the eyes, then apply the prescription drop (Restasis) later to allow it to directly contact the eye surface. It indicated to wait at least 15 minutes between applications to ensure proper absorption and prevent washing out the medication. 2. On 5/4/26 at 7:58 a.m., RN 4 administered Refresh Relieva 0.5-1% eye drops into both of Resident B's eyes, then immediately instilled Gentear eye ointment into the resident's right eye. RN 4 donned gloves to administer the eye drops/ointment but was not observed to sanitize his hands before or after administering the oral and eye medications. Resident B's clinical record was reviewed on 5/4/26 at 11:48 a.m. Diagnoses on Resident B's profile included pain in the left shoulder, presbyopia (age-related loss of eye flexibility causing difficulty focusing on near objects), myopia right eye (distant objects appear blurry) and hypermetropia in the left eye (farsightedness), and dry eye syndrome of bilateral eyes. Physician's orders included,a. On 4/9/26, Refresh Relieva PF 0.5-1 % instill 1 drop every 2 hours while awake.b. On 2/12/26, Systane Nighttime (white petrolatum-mineral oil) 94-3 % ointment apply a thin amount to the right eye four times a day. On 5/4/26 at 1:45 p.m., RN 4 indicated when administering multiple eye medications, there was a 5-minute wait time between medications. During an interview on 5/4/26 at 1:54 p.m., the DON indicated nurses were checked off for medication administration and hand hygiene competency as part of the new-hire orientation. The procedure for administering multiple eye medications included hand hygiene both before and after administration of the drops and waiting at least 5 minutes between eye drops. On 5/4/26 at 3:06 p.m., the DON provided a Suggested Medication Administration Procedures, revised 6/30/23, and indicated the policy was the one currently being used by the facility. The policy indicated, Ophthalmic medication procedure.3. Wash hands and wear gloves.9. Gently pull-down lower lid to expose conjunctival sac. 10. Eye drops: hold dropper in dominant hand approximately 1/2 - 3/4 above conjunctival sac. Do not touch dropper to eye.13. If multiple eye drops are to be administered, wait 5 minutes between medications.16. Wash hands and document dose administered. Cross Reference to Tag F726. This citation relates to Intake 2994771. 410 IAC (Indiana Administrative Code) 3.1-48(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff (RN 4) washed his hands per policy before, between, and after medication administration for 5 of 6 residents observed for medication administration (Residents B, D, E, F, and N). Findings include:1. On 5/4/26 at 7:35 a.m., RN 4 was observed taking a preset cup of unidentified medications for Resident N from the top of a medication cart and going to the main dining room where he obtained Resident N's vital signs and then administered her medications. RN 4 was not observed to sanitize his hands before or after administering the resident's medications. 2. On 5/4/26 at 7:45 a.m., RN 4 was observed taking a preset cup of unidentified medications for Resident D from the top of a medication cart and going to her room at the opposite end of the hallway. RN 4 obtained Resident D's vital signs and then administered her oral medications in her room. RN 4 donned gloves and administered Restasis drops into both of Resident D's eyes, then immediately instilled Systane 0.6% eye drops into both of her eyes. RN 4 was not observed to sanitize his hands before or after administering Resident N's medications. 3. On 5/4/26 at 7:58 a.m., RN 4 was observed pulling 7 medication cards from the medication cart. RN 4 was observed to pop out Resident B's pills from bubble pack cards directly into his hand, then place the pills into a medication cup. RN 4 administered Refresh Relieva 0.5-1% eye drops into both of Resident B's eyes, then immediately instilled Gentear eye ointment into the resident's right eye. RN 4 donned gloves to administer the eye drops/ointment but was not observed to sanitize his hands before or after administering the oral and eye medications. 4. On 5/4/26 at 8:17 a.m., RN 4 was observed pulling medication cards from the medication cart for Resident E. The nurse had popped 4 pills into his hand and placed them into a medication cup when he stopped and indicated he needed to go get vital signs for the resident who was sitting in the main dining room. The popped medications included aspirin 81 mg (used to prevent blood clotting), Amlodipine (used to treat high blood pressure), Clopidogrel 75 mg (Plavix - a blood thinner), and Isosorbide ER 30 mg (used to prevent chest pain). The Director of Nursing (DON) arrived and was observed to stop RN 4 from obtaining vital signs in the main dining room and told the nurse to pick another resident to administer medications to as the resident was in the dining room. RN 4 was observed to place Resident E's partially filled cup of medications to the back of the medication cart surface and began preparing medications for Resident F. The nurse was not observed to sanitize his hands before or after preparing the oral medications. 5. On 5/4/26 at 8:22 a.m., RN 4 was observed pulling 10 medication cards from the medication cart for Resident F. The nurse then indicated he needed to go get vital signs for the resident who was lying in her bed in a room directly across the hallway from the medication cart. RN entered the room to administer Resident F's medications. The nurse was not observed to sanitize his hands before or after administering the oral medications. During an interview on 5/4/26 at 1:54 p.m., the DON indicated, nurses were checked off for medication administration and hand hygiene competency as part of the new-hire orientation. RN 4 should have used hand sanitizer before and after setting up each resident's medications. On 5/4/26 at 3:06 p.m., the DON provided a Suggested Medication Administration Procedures, revised 6/30/23, and indicated the policy was the one currently being used by the facility. The policy indicated, Ophthalmic medication procedure.3. Wash hands and wear gloves.9. Gently pull-down lower lid to expose conjunctival sac. 10. Eye drops: hold dropper in dominant hand approximately 1/2 - 3/4 above conjunctival sac. Do not touch dropper to eye.13. If multiple eye drops are to be administered, wait 5 minutes between medications.16. Wash hands and document dose administered. On 5/4/26 at 3:06 p.m., the Director of Nursing (DON) provided a Hand Hygiene Policy, revised 12/2021, and indicated the policy was the one currently being used by the facility. The policy indicated healthcare professionals should use an alcohol-based hand rub or wash with soap and water for clinical indications that included immediately before touching a resident, before performing an aseptic task, after touching a resident or the resident's immediate environment, immediately after glove or PPE (personal protective equipment i.e. gloves) removal, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before starting a medication preparation. Cross reference to Tag F726. This citation relates to Intake 2994771. 410 IAC (Indiana Administrative Code) 3.1-18(l)(2)