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	07/03/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure a resident's nebulizer (a medical device that turns liquid medication into a fine mist, which is then inhaled through a mask or mouthpiece to deliver medication directly to the lungs) mask was maintained in a safe and sanitary manner for 1 of 2 residents reviewed for respiratory care (Resident 88). Findings include: During a random observation, on 6/30/25 at 9:54 a.m., Resident 88's nebulizer mask was observed sitting un-bagged, on the resident's bedside table. During a random observation, on 6/30/25 at 11:55 a.m., the resident's nebulizer mask was observed sitting un-bagged, on the resident's bedside table. During a random observation, on 6/30/25 at 2:11 p.m., the resident's nebulizer mask was observed sitting un-bagged, on the resident's bedside table. Resident 88's record was reviewed on 6/30/25 at 1:48 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a chronic lung disease that makes it hard to breathe) and acute and chronic respiratory failure with hypercapnia (hypercapnic respiratory failure occurs when the lungs cannot remove enough carbon dioxide [CO2] from the blood, leading to a buildup of CO2). A care plan, dated 6/25/25, indicated the resident had the potential for impaired gas exchange related to COPD. Interventions included, but were not limited to, administer nebulizer treatments as ordered. A physician's order, dated 6/26/25, indicated to administer 3 milliliters (ml) of 0.5 milligrams (mg)-3 mg of ipratropium-albuterol solution (a combination medication used to help control the symptoms of COPD) via nebulization (nebulizer) every 4 to 6 hours as needed. The June 2025 medication administration record (MAR) indicated the resident had received a treatment of ipratropium-albuterol, via nebulizer, on 6/30/25 at 8:58 a.m. During an interview, on 7/1/25 at 11:24 a.m., the Assistant Director of Nursing (ADON) indicated the expectation was that nebulizers should be stored in a bag when not in use. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at 11:35 a.m., the Director of Nursing (DON) provided a skills competency document, with a revision date of 5/2025, titled, Nebulizer (Small Volume Nebulizer-SVN-Medicated Aerosol Therapy, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure Steps: .13. Store nebulizer tubing per facility policy. 14 .c .place nebulizer .in plastic bag 3.1-47(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure Registered Nurse (RN) coverage of at least 8 consecutive hours each day for 7 days a week, for 1 of 4 quarters of the Payroll Based Journal (PBJ-a detailed report that tracks staffing and payroll information, primarily used in the healthcare sector) report reviewed. Findings include: During the entrance conference meeting, on 6/27/25 at 9:56 a.m., review of the PBJ report indicated the facility had failed to have at least 8 consecutive hours of RN coverage on, 1/12/25, 1/17/25, 1/26/25, 2/2/25, 2/8/25, 2/9/25, 2/16/25, and 2/23/25. On 6/27/25 at 12:11 p.m., staffing sheets were provided by the Executive Director (ED). The staffing sheets indicated the following: a. The staffing sheets for 1/12/25, lacked documentation of an RN working in the facility on any shift for that date. b. The staffing sheets for 1/17/25, lacked documentation of an RN working in the facility on any shift for that date. c. The staffing sheets for 1/26/25, lacked documentation of an RN working in the facility on any shift for that date. d. The staffing sheets for 2/2/25, lacked documentation of an RN working in the facility on any shift for that date. e. The staffing sheets for 2/8/25, lacked documentation of an RN working in the facility on any shift for that date. f. The staffing sheets for 2/9/25, lacked documentation of an RN working in the facility on any shift for that date. g. The staffing sheets for 2/16/25, lacked documentation of an RN working in the facility on any shift for that date. h. The staffing sheets for 2/23/24, lacked documentation of an RN working in the facility on any shift for that date. During an interview, on 6/27/25 at 12:11 p.m., the ED indicated he was aware of the dates without RN coverage on the PBJ report for the second quarter of 2025. He was expecting the citation. The expectation was that the facility would comply with the regulation for having an RN for at least 8 consecutive hours a day. 3.1-17(a)(3)

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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 ensure infection control procedures were followed to prevent possible contamination of work surfaces, with potential to affect residents for 1 of 1 glucometer (a small, portable device that measures the amount of glucose in the blood) observation. Findings include: On 6/30/25 at 10:42 a.m., observed Licensed Practical Nurse (LPN) 7 complete glucometer blood sugar assessment for Resident 13. The LPN placed the glucometer on top of the medication cart without a barrier. Once the assessment was completed the nurse removed a hand sanitizing wipe from a canister and wrapped the glucometer in the wipe and placed the glucometer into a plastic cup. On 6/30/25 at 10:45 a.m., during an interview, LPN 7 indicated the hand sanitizing wipes were the wipes she used to clean the glucometer after use. On 6/30/25 at 11:00 a.m., during an interview, the Director of Nursing (DON) indicated the nurse should use specific disinfecting wipes to clean the glucometer after use. The hand sanitizing wipes were not the approved wipes to be used to disinfect the glucometer. The DON indicated that the facility shared glucometers between residents. On 6/30/2025 at 1:17 p.m., the DON provided a document titled, Shared Glucometer Cleaning and Disinfecting, dated 1/2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: Shared glucometers will be cleaned and disinfected aster every use with an approved germicidal wipe .1 .b. Place clean paper towel, plastic cup, or other clean barrier on solid surface such as medication cart .c. Use a fresh approved disinfectant wipe each time the glucometer is cleaned and disinfected. d. Wipe all surfaces, top, bottom and sides of the blood glucose meter with wipe and allow the surface of the meter to remain wet for 3 minutes or recommended contact time for the disinfecting wipe. You may wrap the glucometer in the disinfecting wipe after all surfaces have been wiped to assist in the glucometer remaining wet per contact time. e. Allow to air dry on clean paper towel, in a clean plastic cup, or other clean barrier before use on the next resident 3.1-18(b)