STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155419		10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT CRAWFORDSVILLE	817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00182720. Complaint IN00182720 - Substantiated. Federal/State deficiency related to the allegations is cited at F309. Survey Dates: October 13, 2015 Facility Number: 000533 Provider Number: 155419 AIM Number:100267230 Census bed type: SNF/NF: 34 Total: 34 Census payor type: Medicare: 4 Medicaid: 27 Other: 3 Total: 34 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on October 19, 2105.	F 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Crawfordsville desires this Plan of Correction to be considered the facility's Allegation of Compliance effective October 30, 2015	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CRAWFORDSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933	

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F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a system for pace maker function monitoring was in place for 1 of 3 residents reviewed with pacemakers (Resident B). Findings include: Resident B's record was reviewed on 10/13/15 at 12:44 p.m. Resident B had a diagnosis which included, but was not limited to, atrial fibrillation. The record lacked indication pace maker function checks had been completed. A care plan originally dated 6/7/14 and last updated 8/14/15, indicated Resident B was at risk for cardiac issues related to having a pacemaker. A goal indicated Resident B would not experience cardiac issues. Interventions to meet this goal	F 0309	F 309 It is the standard of practice and policy of this facility to ensure that a system for pacemaker function monitoring is in place for all residents who have pacemakers. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Nursing has developed a facility policy regarding the importance of checking pacemaker function on a regular basis as indicated by the physician. All nurses have been in-serviced regarding the Pacemaker policy and procedure by the Director of Nursing. Resident B is no longer at the facility. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with pacemakers have the potential to be affected by this	10/30/2015

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	included pace maker function checks. During an interview on 10/13/15 at 3:00 p.m., Registered Nurse (RN) #1 indicated she recalled doing a remote pacemaker function check sometime in 2014 however, could not remember what month in 2014 the check was done and was unable to provide documentation which indicated it was done. She indicated she put the next scheduled function check on a calendar and was unsure why it wasn't done. During an interview on 10/13/15 at 3:30 p.m., Staff #2, from the provider who preformed the pacemaker function checks for Resident B, indicated Resident B last had her pace maker checked on June 5, 2014. She indicated she was scheduled to have the next check in September of 2014 but failed to have it done. She indicated their standard of care was for checks to be completed every three months. Staff #2 indicated after Resident B missed the next two scheduled pacemaker function checks they deactivated the monitoring system due to non compliance. During an interview on 10/13/15 at 3:40 p.m., the Director of Nursing indicated the facility did not have a policy or procedure for pace maker function		practice. The care plans for the one remaining resident have been reviewed and a follow-up pacemaker appointment has been scheduled for January 22, 2016. In the future, if the DON finds that any resident with a pacemaker has not had the pacemaker function monitored as scheduled, she will make sure that the physician is notified regarding the resident's condition as soon as possible. A pacemaker monitoring appointment will be made at the same time for the resident. Once the resident is cared for, the DON will review the facility's policy and procedure for pacemaker monitoring with the nurses involved. Progressive disciplinary action will be done, as well, for continued noncompliance. 3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Upon admission, any resident with a pacemaker will receive a physician's order for the pacemaker monitoring checks. The resident's cardiologist's information will also be obtained as well as any equipment needed to complete the monitoring checks. A list of scheduled pacemaker checks will be added to the Treatment Administration Record (TAR) and the Nursing Daily Appointment Calendar. The monitoring appointment scheduled for the current resident	

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	checks. This Federal tag relates to Complaint IN00182720. 3.1-37(a)		with a pacemaker has been placed on both the TAR and the Nursing Daily Appointment Calendar. The DON/designee will ensure the facility has cardiologist information on the charts of newly admitted residents, who have a pacemaker, by performing a chart audit, the day following admission. The audits will continue daily, until all needed cardiology information has been obtained. The DON/designee will check the 24 hour report for cardiologist orders, as well as the Nursing Daily Appointment Calendar and the TAR, for scheduled pacemaker checks, 5 days a week x 4 weeks, then 3 days a week x 3 weeks then 2 days a week x 2 weeks, then weekly for compliance. The Administrator will be notified of any identified issues and any concerns will be followed up as indicated in question #2. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The DON will notify the QA Committee of any pacemaker monitoring appointments that are scheduled, any needed cardiologist information, as well as the results of any pacemaker monitoring that has occurred since the last meeting to each monthly meeting of the Quality Assurance Committee for further review. The DON will continue to monitor	

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			pacemaker appointments and the results on an ongoing basis. Date of Compliance: October 30, 2015	