

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Creasy Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S Creasy LN Lafayette, IN 47905	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Creasy Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S Creasy LN Lafayette, IN 47905	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a diagnosis of dementia, who resided in the secured locked unit, was not allowed to leave the facility unsupervised for 1 of 1 resident reviewed for elopement. (Resident B) The deficient practice was corrected on 8/25/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: The clinical record for Resident B was reviewed on 9/8/25 at 2:58 p.m. The diagnoses included, but were not limited to, dementia and Alzheimer's disease. Resident B admitted to the facility on [DATE] at 11:21 a.m. An admission assessment, dated 8/22/25 at 11:24 a.m., indicated Resident B was not exit seeking, had no history of elopement, and ambulated without assistive devices. In a facility documented interview, dated 8/22/25, CNA 5 indicated she heard the door alarm and had directed CNA 2 to check the alarm. In a facility documented interview, dated 8/22/25, CNA 2 indicated she heard the door alarm on 8/22/25 at 6:30 p.m. She identified the location of the alarm. CNA 2 observed Resident B had sounded the alarm to the door. She opened the door with the code and reset the alarm. Resident B indicated he needed to go outside, she reentered the code and allowed the resident to go outside. CNA 2 indicated the resident asked where the [NAME] were located and she directed him toward the [NAME]. She then closed the door and reset the alarm. CNA 2 observed Resident B returning to the facility at 6:55 p.m. and was then aware of what had occurred. In a facility documented interview, dated 8/22/25, CNA 4 indicated around 6:45 p.m., she was riding in a car and recognized Resident B walking on the sidewalk north from the facility. She engaged Resident B in conversation, and she walked the resident back to facility. She indicated CNA 2 thought the resident was a family member and let him outside the facility. A nursing progress note, dated 8/23/25 at 12:38 p.m., indicated Resident B was found by CNA 4. The resident was found in a field area down from the facility before the intersection. Resident B was found at 6:45 p.m. The facility was not aware of Resident B's elopement until they were notified by CNA 4. The door alarm in the memory care unit did alarm when the resident opened the door. During an interview, on 9/8/25 at 12:50 p.m., the Executive Director (ED) indicated Resident B was allowed out of the facility by CNA 2 who thought the resident was a visitor. The resident had been admitted at 11:21 a.m. on 8/22/25 and left the facility at 6:30 p.m. Resident B attempted to leave the facility through the back door of the unit. Resident B had asked CNA 2 for directions to the independent [NAME]. CNA 2 let Resident B out the back door. The resident was found by staff at 6:45 p.m. and escorted back to facility by 6:55 p.m. Resident B was 10 minutes away and 0.5 miles. Resident B was assessed and had no injuries. The staff had been reeducated, CNA was disciplined, and audits were ongoing. During an interview, on 9/8/25 at 4:40 p.m., the Director of Health Service (DOHS) indicated CNA 2 should not have allowed Resident B to exit the facility. All staff have been re-educated on the elopement policy and procedures. Staff were the only ones allowed to leave the facility through a door which was not the front door. The facility had ongoing audits, elopement drills, resident assessments related to elopement and exit seeking behaviors. A current facility policy, titled Guideline of Elopement/ Missing Resident, dated as revised on 12/17/24 and provided by the ED on 9/8/25 at 4:48 p.m., indicated .It is the responsibility of all personnel to report any residents attempting to leave the premises or suspected of being missing to the charge nurse as soon as possible The deficient practice was corrected by 8/25/25, after the facility implemented a plan which included a thorough investigation, door checks, elopement assessments and care plans were updated, all staff members were re-educated on elopement, ongoing elopement drills and audits are being conducted, CNA 2 was suspended and disciplined. This citation relates to Intake 2598553.3.1-45(a)(2)</p>		