STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creasy Springs Health Campus	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure medications were transcribed correctly upon admission for 1 of 2 residents reviewed for significant medication errors. (Resident B)Findings include: During an interview, on 9/29/25 at 12:37 p.m., Resident B's family member indicated, on 8/16/25, she witnessed a staff member attempting to administer her husband medication he had never received before. The staff member called the physician and did not administer the medication. A staff member informed her, on 8/18/25, Resident B had received the wrong medications on 8/15/25, 8/16/25, 8/17/25 and 8/18/25. The Director of Health Services (DHS) informed her the facility was monitoring Resident B for reactions related to receiving the wrong medications. Resident B's family was very upset with the nursing staff and was more distressed to see the same nurses still working and administering Resident B's medications. She had told the administration staff about her concerns, and nothing was done. Resident B was at home now and was doing okay. She wanted the facility to prevent this from occurring to other residents.The clinical record for Resident B was reviewed on 9/29/25 at 2:10 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy, myocardial infarction, non-traumatic subdural hemorrhage, and malignant neoplasm of prostate.A nursing progress note, dated 8/16/25 at 3:57 p.m., indicated Resident B's wife reported the resident had not previously taken tramadol or lorazepam medications prior to his hospitalization. LPN 3 contacted the Nurse Practitioner (NP) regarding the wife's concern, and the NP discontinued the medications for lorazepam and tramadol. A nursing progress note, dated 8/18/25 at 2:57 p.m., indicated a medication error had been discovered on Resident B's medication orders and medication administration record. The family and physician were notified of the errors. Resident B was monitored for adverse reactions. The physician's orders were updated in the matrix.The discharge medication orders from the hospital on 8/15/25 and the admission medication orders placed at the facility on 8/15/25 were reviewed and indicated there were 11 medication orders which were not found on the medication orders from the transferring hospital.The 11 medications included the following:1. Memantine (a medication used to treat Alzheimer's disease) 10 milligrams (mg) tablet twice a day. This medication was administered on 8/15/25, 8/16/25, 8/17/25 and 8/18/25 for a total of six (6) times given in error.2. Mirabegron (a medication used to treat overactive bladder) 50 mg tablet once a day. This medication was administered on 8/16/25, 8/17/25 and 8/18/25 for a total of three (3) times given in error.3. Lorazepam (a medication used to treat anxiety disorders) 1 mg tablet twice a day.4. Lisinopril (a medication used to treat high blood pressure) 20 mg tablet once a day. This medication was administered on 8/16/25, 8/17/25 and 8/18/25 for a total of three (3) times given in error.5. Loperamide (a medication used to treat symptoms of diarrhea) 2 mg one or two capsules every 8 hours as needed. This medication was administered on 8/16/25 for a total of two (2) given in error.6. Pantoprazole (a medication used to treat excessive acid in the stomach) 40 mg tablet once a day. This medication was administered on 8/16/25, 8/17/25 and 8/18/25 for a total of three (3) times given in error.7. Potassium chloride (a supplement used to treat low potassium) 10 milliequivalent (mEq) capsule once a day. This medication was administered on 8/16/25, 8/17/25 and 8/18/25 for a total of three (3) times given in error.8. Tramadol (a medication used to treat pain) 50 mg tablet once a day.9. Trazodone (a medication used to treat depression) 50 mg tablet at bedtime. This medication was administered on 8/15/25, 8/16/25 and 8/17/25 for a total of three (3) times given in error.10. Meclizine (a medication used to control nausea, vomiting, and dizziness) 12.5 mg tablet every 8 hours as needed.11. Senna (a medication used to treat constipation) 8.6 mg tablet as needed at bedtime. During an interview, on 9/29/25 at 12:10 p.m., the Director of Health Services (DHS) indicated LPN 3 transcribed the correct medications for Resident B from the hospital. RN 2 was to review the transcriptions. RN 2 did not review the transcriptions for Resident B and instead entered the admitting medications for Resident C into Resident B's record. The records for Resident B and C were not double checked per the policy and procedure. The admitting records for Resident B and C were reviewed on 8/18/25, and the error was found. Resident C did not have any medication errors. Resident B had 11 entries which were entered incorrectly. Resident B received 23 medications in error on 8/15/25, 8/16/25, 8/17/25 and 8/18/25. Some of the medications entered in error had been discontinued on 8/16/25 after Resident B's wife had reviewed some of the medications with LPN 3. The NP was called and medications were discontinued. A complete review of Resident B's medications was not completed by the NP or LPN 3. A second check was not completed until 8/18/25 and the error was discovered. The physician reviewed Resident B's medications, and the orders were updated. Resident B did receive some medications which he should not have received