

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 02/05/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>52091</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity by a staff member during meal service for 1 of 1 resident reviewed for dignity. (Resident 26)</p> <p>Findings include:</p> <p>During an observation, on 1/30/25 at 12:10 p.m., Resident 26 was sitting in his wheelchair in the dining room. Certified Nursing Assistant (CNA) 9 was standing on Resident 26's left side as she assisted him with feeding. CNA 9 remained standing for the entirety of the meal.</p> <p>The clinical record for Resident 26 was reviewed on 2/4/25 at 10:27 a.m. The diagnoses included, but were not limited to, Alzheimer's, hypertensive, anxiety disorder, tachycardia, dementia, and acute kidney failure.</p> <p>A care plan, dated 12/27/24, indicated the resident had experienced significant weight loss. The interventions included, but were not limited to, offer the resident encouragement and assistance with eating and report difficulties swallowing.</p> <p>During an interview, on 1/30/25 at 12:19 p.m., CNA 2 indicated she would sometime stand up and walk around feeding multiple residents if the room was full. CNA 2 indicated staff should not stand when feeding residents.</p> <p>During an interview, on 2/4/25 at 8:50 a.m., CNA 9 indicated she was not supposed to stand up while feeding the resident. She indicated standing up while feeding a resident could make the resident feel intimidated.</p> <p>A facility document, titled Resident Rights, indicated .examples of treating residents with dignity and respect include .promoting resident independence and dignity while dining, such as avoiding .staff standing over residents while assisting them to eat</p> <p>A current facility policy, titled Resident Rights Guidelines, dated 12/31/23 and received at the entrance conference, indicated .To ensure resident rights are respected and protected and provide an environment in which they can be exercised .Our residents have a right to .be treated with dignity and respect .</p> <p>(continued on next page)</p>

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 02/05/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility procedure, titled FEEDING, undated and received from the Executive Director (ED) on 2/4/25 at 10:34 a.m., indicated .confirm dietary card/tray .explain procedure .have resident wash hands .sit on unaffected side eye level with resident and facing them .make conversation with the resident; atmosphere should be pleasant</p> <p>3.1-3(t)</p>

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 02/05/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49891</p> <p>Based on interview and record review, the facility failed to promptly implement a do not resuscitate (DNR) order based on a resident's signed advance directive wishes for 2 of 3 residents reviewed for advance directives. (Resident 152 and 160)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 152 was reviewed on 2/4/25 at 2:31 p.m. The diagnoses included, but were not limited to, cerebral infarction, metabolic encephalopathy, Alzheimer's disease, pneumonia, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure, and chronic diastolic (congestive) heart failure.</p> <p>An Indiana advance directive form, signed on 1/13/25, indicated the resident wished to not have life prolonging measures.</p> <p>An Indiana Physician Orders for Scope of Treatment (POST) form, signed on 1/13/25, indicated the resident chose to be a DNR.</p> <p>A physician's order, dated 1/23/25 at 2:32 p.m., indicated full code status.</p> <p>A State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order form, signed on 1/23/25, indicated the resident was to be a DNR upon admission to the facility on [DATE].</p> <p>A physician's order, dated 1/24/25, indicated DNR code status.</p> <p>During an interview, on 2/5/25 at 10:40 a.m., the Legacy Director indicated the facility met with the resident and their representative at admission and discussed their desired code status. Then they make sure the paperwork was signed, scan the forms into the electronic medical record, and put the order in the computer for the chosen code status. As the facility prepared for a new admission, sometimes they would already have advance directive information and would only need to review the choices to make sure those are the current wants. The current code status was listed on the face sheet and at the top of the resident's information bar in the electronic medical record based on the physician's order so staff could quickly see the information during an emergency.</p> <p>2. The clinical record for Resident 160 was reviewed on 2/3/25 at 12:57 p.m. The diagnoses included, but were not limited to, fracture of neck of right femur, fracture of the lower end of the right radius, metabolic encephalopathy, sepsis, bilateral acute embolism and thrombosis of tibial vein, chronic myeloproliferative disease, and lumbar spinal stenosis.</p> <p>A physician's order, dated 1/7/25, indicated the resident was a full code.</p> <p>A State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order, dated and signed on 1/9/25, indicated the resident wanted a DNR code status.</p> <p>(continued on next page)</p>

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 02/05/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A social service progress note, dated 1/9/25 at 11:59 a.m., indicated the desired advance directive was reviewed with the resident and her family during the admission care plan meeting.</p> <p>A current care plan, dated 1/13/25, indicated the resident had chosen an advance directive of DNR.</p> <p>A physician's order, dated 1/17/25, indicated the resident's code status was DNR.</p> <p>During an interview, on 2/5/25 at 11:07 a.m., QMA 3 indicated during an emergency she would know the resident's code status by looking at the top of the resident information section in the electronic medical record or the resident's information sheet.</p> <p>A current facility policy, titled Guidelines for Advanced Directives, dated 9/26/24 and received from the Clinical Support Nurse on 2/4/25 at 9:00 a.m., indicated .Advanced Directives will be reviewed with resident and/or resident representative .at time of admission The resident or representative will advise .regarding wishes for end of life directives and code status .The nursing staff will obtain an order from the attending physician for the desired code status</p> <p>3.1-4(f)(5)</p>		

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 02/05/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>50956</p> <p>Based on interview and record review, the facility failed to ensure a revised Preadmission Screen and Resident Review (PASARR) level I was submitted to reflect a resident's current diagnoses and medications for 1 of 2 residents reviewed for PASARR. (Resident 32)</p> <p>Findings include:</p> <p>The clinical record for Resident 32 was reviewed on 2/4/25 at 11:05 a.m. The diagnoses included, but were not limited to, anxiety, depression, and adjustment disorder with mixed anxiety and depressed mood.</p> <p>A PASARR level I, dated 1/7/25, indicated no mental health diagnoses were known, or suspected and no mental health medications were being prescribed.</p> <p>A physician's order, dated 1/6/25, indicated to give trazodone (an antidepressant medication) 50 milligram (mg) daily.</p> <p>A physician's order, dated 1/7/25, indicated to give sertraline (an antidepressant medication) 25 mg daily.</p> <p>A physician's order, dated 1/7/25, indicated to give buspirone (an anxiety medication) 5 mg daily.</p> <p>There was no PASARR level I completed to reflect the resident's orders for sertraline, trazodone, and buspirone and the resident's mental health diagnoses.</p> <p>During an interview, on 2/5/25 at 2:27 p.m., the Social Service Director (SSD) indicated a new level I PASARR was not completed to reflect the diagnoses and medications, and no mental health diagnoses or medications were included on the PASARR, dated 1/7/25, and submitted by the facility admissions coordinator.</p> <p>A current facility policy, titled PASRR Level 1 and 2 General Quick Reference Guide, undated and received from the Director of Nursing (DON) on 2/5/25 at 3:08 p.m., indicated .Below are items that can/will trigger a Level II PASRR .Individual has a severe mental illness .diagnosis ex .Major Depression Disorder, Anxiety Disorder .individual has a Psych DX and/or Psych Rx regimen from a MD</p> <p>3.1-16(d)(1)(A)</p> <p>3.1-16(d)(1)(B)</p>		

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 02/05/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50956</p> <p>Based on interview and record review, the facility failed to ensure medications were held according to the physician's ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 4)</p> <p>Findings include:</p> <p>The clinical record for Resident 4 was reviewed on 2/4/25 at 10:31 a.m. The diagnoses included, but were not limited to, essential primary hypertension, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, and type 2 diabetes mellitus.</p> <p>A physician's order, dated 4/11/23, indicated to give lisinopril (a blood pressure medication) 20 milligrams (mg) daily with special instructions to hold the medication for a systolic blood pressure less than 110.</p> <p>A Medication Administration Record (MAR), dated 7/1/24 through 7/31/24, indicated lisinopril was administered on 7/7/24 with a systolic blood pressure of 105 and on 7/14/24 with a systolic blood pressure of 102.</p> <p>A MAR, dated 8/1/24 through 8/31/24, indicated lisinopril was administered on 8/15/24 with a systolic blood pressure of 102 and on 8/26/24 with a systolic blood pressure of 103.</p> <p>A MAR, dated 9/1/24 through 9/30/24, indicated lisinopril was administered on 9/11/24 with a systolic blood pressure of 99.</p> <p>A MAR, dated 10/1/24 through 10/31/24, indicated lisinopril was administrated on 10/8/24 with a systolic blood pressure of 97.</p> <p>A care plan, dated 1/28/25, indicated Resident 4 had CKD (chronic kidney disease) with an intervention to administer medications as ordered.</p> <p>During an interview, on 2/4/25 at 2:38 p.m., an anonymous nurse indicated if a resident's blood pressure was outside of a hold parameter, the medication should be held. When a medication was held, there would be parenthesis on the MAR indicating a medication was held.</p> <p>A current facility policy, titled Preparation and General Guidelines IIA2: Medication Administration- General Guidelines, dated 11/18 and received from the Director of Nursing (DON) on 2/4/25 at 10:50 a.m., indicated . Medications are administered as prescribed</p> <p>A current facility policy, titled Specific Medication Administration Procedures IIB2: Oral Medication Administration, dated 11/18 and received from the Clinical Support nurse on 2/4/25 at 11:48 a.m., indicated . Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications .Review medication administration record for any tests or vitals that need to be determined prior to preparing the medication</p> <p>(continued on next page)</p>

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 02/05/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.1-37(a)</p>

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 02/05/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49891</p> <p>Based on observation, interview and record review, the facility failed to ensure a physician's order was obtained for the administration of oxygen for 2 of 4 residents reviewed for respiratory care. (Resident 150 and 156)</p> <p>Findings include:</p> <p>1. During an observation, on 1/30/25 at 10:20 a.m., the resident was sitting in the chair in his room wearing 2 liters of oxygen via nasal cannula. He indicated he had been wearing oxygen yesterday and all during the night.</p> <p>The clinical record for Resident 150 was reviewed on 1/31/25 at 2:30 p.m. The diagnoses included, but were not limited to, pulmonary fibrosis, metabolic encephalopathy, chronic obstructive pulmonary disease, atelectasis, hypertensive heart and chronic kidney disease with heart failure, pulmonary hypertension, atrial fibrillation, and peripheral vascular disease.</p> <p>A vital signs report, dated 1/27/25 through 1/31/25, indicated the resident was on 1.5 liters of oxygen on 1/30/25 at 2:51 a.m. and on 2 liters of oxygen at 8:49 a.m.</p> <p>A current care plan, dated 1/28/25, indicated the resident had shortness of breath related to pulmonary fibrosis and to administer oxygen per the physician's order.</p> <p>A nursing progress note, dated 1/29/25 at 9:49 p.m., indicated the resident used oxygen at night at the hospital prior to his arrival at the facility.</p> <p>A nursing progress note, dated 1/30/25 at 9:03 a.m., indicated the resident was on 2 liters of oxygen via nasal cannula.</p> <p>An Interdisciplinary Team (IDT) progress note, dated 1/30/25 at 5:10 p.m., indicated the hospital reported the resident used oxygen at night.</p> <p>A physician's order, dated 1/30/25 at 5:13 p.m., indicated to administer oxygen at 2 liters per minute per nasal cannula as needed to keep sats >92%.</p> <p>During an interview, on 2/3/25 at 9:53 a.m., the Clinical Support Nurse indicated the resident did not have an order for oxygen administration prior to 1/30/25.</p> <p>2. The clinical record for Resident 156 was reviewed on 1/31/25 at 2:27 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, facial weakness, type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, acute systolic congestive heart failure, chronic kidney disease, non-ST elevation myocardial (NSTEMI), and asthma.</p> <p>A nursing progress note, dated 1/25/25 at 2:23 a.m., indicated the resident was placed on oxygen at 2 liters per nasal cannula for O2 saturations of 88%.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 1/25/25 at 11:30 p.m., indicated the resident's oxygen was increased to 3 liters per nasal cannula.</p> <p>An IDT Respiratory/Emesis/SOB event note, dated 1/27/25 at 11:40 a.m., indicated the nurse practitioner was notified of the resident's signs and symptoms and multiple orders were received which did not include an order for oxygen administration.</p> <p>A nursing progress note, dated 1/27/25 at 11:05 p.m., indicated the resident was on oxygen.</p> <p>A nursing progress note, dated 1/28/25 at 10:31 p.m., indicated the resident was on oxygen.</p> <p>A physician's order, dated 1/29/25, indicated to administer oxygen at 1-5 liters per minute per nasal cannula to keep O2 saturation about 92%.</p> <p>During an interview, on 2/3/25 at 9:53 a.m., the Clinical Support Nurse indicated the resident did not have an order for oxygen administration prior to 1/29/25.</p> <p>During an interview, on 2/5/25 at 2:43 p.m., RN 2 indicated if a resident needed oxygen due to low saturations, she would call the physician to let him know and get an order for oxygen.</p> <p>A current facility policy, titled Administration of Oxygen, dated 12/13/24 and provided by the Clinical Support Nurse on 2/4/25 at 9:00 a.m., indicated .Verify physician's order for the procedure. 2. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained</p> <p>3.1-47(a)(6)</p>		

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 02/05/2025
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>49891</p> <p>Based on interview and record review, the facility failed to ensure an order to give Augmentin 500 milligrams (mg) was discontinued when a new order to give Augmentin 875 mg was received which resulted in double doses of the antibiotic for pneumonia for 1 of 2 residents reviewed for antibiotics. (Resident 156)</p> <p>Findings include:</p> <p>During an interview, on 1/31/25 at 10:32 a.m., the resident indicated she had been sick and coughing with pneumonia.</p> <p>The clinical record for Resident 156 was reviewed on 1/31/25 at 2:27 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, facial weakness, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease with heart failure, congestive heart failure, non-ST elevation myocardial (NSTEMI), and asthma.</p> <p>A lab report, dated 1/21/25, indicated the resident's GFR (glomerular filtration rate: a blood test to measure kidney function) was low at 24. The normal range was greater than 60.</p> <p>A physician's order, dated 1/24/25, indicated to give Augmentin (amoxicillin and clavulanate potassium) 500-125 milligram (mg) tablet every 12 hours with a stop date of 2/2/25.</p> <p>A physician's order, dated 1/27/25, indicated to give Augmentin 875-125 mg tablet every 12 hours with a stop date of 2/2/25.</p> <p>A Medication Administration Record (MAR), dated 1/27/25 through 2/3/25, indicated the resident received the generic form of Augmentin 875-125 mg at 7:00 a.m. and 7:00 p.m. and the generic form of Augmentin 500-125 mg at 9:00 a.m. and 9:00 p.m. until 2/2/25.</p> <p>During an interview, on 2/4/25 at 3:45 p.m., the Assistant Director of Nursing/Infection Preventionist indicated she was aware the resident was ordered a second dosing of the same antibiotic for pneumonia but had not verified the first dose had been discontinued.</p> <p>During an interview, on 2/5/25 at 2:44 p.m., Pharmacist 4 indicated when the pharmacy received a new order the pharmacist looked for duplicates and would cancel the previous order in their system. The facility usually sent a discontinue order for the duplicate with the new order, but he did not see one for the Augmentin. The pharmacy system did not flow over to the facility's MAR, so both doses would remain on the facility's MAR if the facility did not discontinue the order for the first dose. Residents with impaired kidney function needed a lower dose of Augmentin. He thought the 500 mg dose would have been okay for the resident but not the 875 mg. She should not receive both doses with her GFR of 24.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 2/5/25 at 3:59 p.m., LPN 5 indicated if she would see a duplicate medication on the MAR with different doses, she would check the doctor's orders and the progress notes to see what she should give. If she still was not sure, she would call the pharmacy number and get in touch with a pharmacist who could help her determine what to do. LPN 5 had not given the resident medications during the double dosing period.</p> <p>A Medication Error Event progress note, dated 2/4/25 at 4:34 p.m., indicated a medication error occurred on 1/27/25 at 12:51 p.m. of a duplicate order resulting in the resident receiving Augmentin 875-125 mg every 12 hours and Augmentin 500-125 mg every 12 hours.</p> <p>FDA DOSAGE AND ADMINISTRATION: HIGHLIGHTS OF PRESCRIBING INFORMATION. Augmentin (amoxicillin and clavulanate potassium), https://www.accessdata.fda.gov. Accessed 4 February 2025. indicated The usual adult dose is one 500-mg tablet of AUGMENTIN every 12 hours or one 250-mg tablet of AUGMENTIN every 8 hours. For more severe infections and infections of the respiratory tract, the dose should be one 875-mg tablet of AUGMENTIN every 12 hours or one 500-mg tablet of AUGMENTIN every 8 hours .Patients with impaired renal function .Severely impaired patients with a glomerular filtration rate of <30 mL/min. should not receive the 875-mg tablet. Patients with a glomerular filtration rate of 10 to 30 mL/min. should receive 500 mg or 250 mg every 12 hours, depending on the severity of the infection</p> <p>3.1-48(a)(1)</p>		

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 02/05/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44598</p> <p>Based on observation, interview and record review, the facility failed to ensure compromised controlled substance medications were disposed of and unopened insulin was stored in the refrigerator for 2 of 2 medication carts (200 hall and 300 hall) and to ensure supplies were not stored under the sink in a medication room for 1 of 2 medication rooms reviewed for medication storage. (the 200-medication room)</p> <p>Findings include:</p> <p>1. During an observation, on [DATE] at 1:18 p.m., the 200-hall medication cart had a compromised controlled substance card of lorazepam (for anxiety) 0.5 milligrams (mg) for Resident 26 with the 8 and 16 slots taped on the back of the card.</p> <p>The clinical record for Resident 26 was reviewed on [DATE] at 10:27 a.m. The diagnoses included, but were not limited to, Alzheimer's, hypertensive, anxiety disorder, tachycardia, dementia, and acute kidney failure.</p> <p>The medication card indicated the lorazepam 0.5 mg tablets had expired on [DATE].</p> <p>There was no current order for the lorazepam 0.5 mg tablets in the Electronic Health Record (EHR).</p> <p>During an interview, on [DATE] at 1:20 p.m., Licensed Practical Nurse (LPN) 10 indicated when she started the shift, she counted the narcotics with the nurse and did not notice the tape on the back of the card. The two pills would need to be destroyed by two nurses.</p> <p>During an interview, on [DATE] at 1:23 p.m., the Assistant Director of Nursing (ADON) indicated the medication card should not have tape on the back of the card. The pills needed to be destroyed by two nurses.</p> <p>2. During an observation, on [DATE] at 1:36 p.m., the 300-hall medication cart had a plastic bag with an unopened Humalog 100 unit/milliliter (ml) insulin pen for Resident 250. The bag had a sticker with instructions to keep the insulin in the refrigerator until it was opened.</p> <p>The clinical record for Resident 250 was reviewed on [DATE] at 3:40 p.m. The diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, acute kidney failure, congestive heart failure, and anxiety disorder.</p> <p>A physician's order, dated [DATE], indicated to inject Humalog 100 unit/ml insulin subcutaneous before meals and to use according to the sliding scale.</p> <p>During an interview, on [DATE] at 1:41 p.m., LPN 11 indicated the package containing the insulin pen had instructions to keep the pen refrigerated until it was opened.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on [DATE] at 2:05 p.m., the Director of Nursing (DON) indicated an unopened insulin pen should be stored in the refrigerator until it was needed. The insulin pen should be destroyed and not put back in the refrigerator.</p> <p>3. During an observation, on [DATE] at 1:25 p.m., the 200-medication room had two sleeves of drinking cups stored under the sink.</p> <p>During an interview, on [DATE] at 1:30 p.m., the Assistant Director of Nursing (ADON) indicated nothing should be stored under the sink in the medication room and the cups needed to be destroyed.</p> <p>A current policy, titled Guidelines for Disposal of Controlled Drugs, dated as revised [DATE] and received by the DON on [DATE] at 2:10 p.m., indicated .To ensure controlled substances are destroyed in accordance with State Laws and Federal Regulations .Immediately upon discontinuation, but no longer than three (3) business days after discontinuation of a patient's-controlled substance medication .The same two nurses - and DHS or DON .who removed the controlled substance medication from the medication cart shall transfer the medication to the Med Safe collection receptacle for disposal</p> <p>A current policy, titled Medication Storage in the Facility, dated as revised ,d+[DATE] and received by the DON on [DATE] at 2:10 p.m., indicated .Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .Expiration dates (beyond-use date) of dispensed medication shall be determined by the pharmacist at the time of dispensing .When the beyond-use dating for a medication identifies a month and year, the medication can be used through the last day of the month .Blister-pack cards .12 months from the date of dispensing .The medication administration personnel will check the expiration date of each medication before administrating it .Disposal of any medications prior to the expiration dating will be required if contamination or decomposition is apparent</p> <p>3XXX,d+[DATE](m)</p> <p>3XXX,d+[DATE](o)</p>		

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 02/05/2025
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>49891</p> <p>Based on observation, interview and record review, the facility failed to accurately initiate the correct diet orders upon admission and to provide a lunch tray in the correct consistency for 2 of 6 residents reviewed for dining. (Resident 151 and 156).</p> <p>Findings include:</p> <p>1. During an observation, on 1/30/25 at 11:43 a.m., Resident 151 was sitting at a table in the dining room waiting for her lunch. The Administrator entered the dining room carrying the resident's plate and placed it in front of the resident with the chicken tenders facing her. The meal ticket indicated to serve a regular consistency diet, and the plate had 2 large whole chicken tenders, fries, and a piece of blueberry pie with regular crust. The resident grabbed a fry and began eating it. CNA 2 was assisting the resident with getting her fork when the cook brought out another piece of pie. The Speech Therapist looked over and told them Resident 151 was on a mechanical soft diet. The cook took the extra piece of pie with him and exited the dining room. The Speech Therapist indicated the fries were considered a mechanical soft food, but the chicken tenders and pie were not. CNA 2 stood up and turned the plate around so that the fries were in front of the resident and left the resident with the chicken fingers and pie while the CNA went out of the room. The Speech Therapist continued to assist another resident with eating. CNA 2 returned to the speech therapist and told her the kitchen was preparing another plate. The cook brought in a mechanical soft meal and exchanged the plates. He also took the white regular meal ticket and replaced it with a blue mechanical soft ticket. The new plate had cottage cheese, fries, and mechanical soft chicken pot pie covered with brown gravy. The resident started dipping her fry into her cottage cheese and cleared her throat with a soft cough. After a drink and eating a bite of cottage cheese without difficulty, she cleared her throat with a cough after another bite of the fry.</p> <p>The clinical record for Resident 151 was reviewed on 2/3/25 at 2:07 p.m. The diagnoses included, but were not limited to, cerebrovascular accident (CVA), altered mental status, Alzheimer's dementia, hypertension, and dysphagia.</p> <p>A hospital speech therapy note, dated 1/24/25, indicated the recommended diet was minced and moist with 1:1 feeding assistance to implement safe swallow strategies which included to alternate bites of food with drinks, add moisture to foods, and to clear pocketing.</p> <p>A hospital discharge summary, dated 1/27/25, indicated a discharge diet of Level 5 Minced and Moist.</p> <p>A facility nurse's progress note, dated 1/27/25 at 8:00 p.m., indicated the resident was noted to pocket food on a minced diet.</p> <p>A physician's order, dated 1/27/25 and discontinued 1/28/25 at 10:08 a.m., indicated a regular consistency diet.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility speech therapy note, dated 1/28/25 at 3:09 p.m., indicated to continue the hospital discharge diet with supervision and assistance. To have Resident 151 take small bites and sips, eat slowly, alternate liquids and solids, use a lingual sweep and then provide oral care after meals due to pocketing. A safe feeding technique form was provided at the nursing station and education to the floor nurse was provided.</p> <p>A current care plan, dated 1/28/25, indicated a regular diet and to provide a diet as ordered.</p> <p>A physician's order, dated 1/28/25 and discontinued on 1/29/25 at 8:33 p.m., indicated a mechanical soft consistency diet.</p> <p>A physician's order, dated 1/29/25, indicated to give a mechanical soft diet with pureed meat.</p> <p>During an interview, on 2/5/25 at 10:40 a.m., the Legacy Neighborhood Director indicated they used the hospital discharge orders as the facility admission orders.</p> <p>During an interview, on 2/5/25 at 11:02 a.m., the Director of Dining Services indicated the kitchen's ticket system relied on the diet order placed in the electronic medical record transferring over into their system. The diet tickets for each resident were already printed for lunch, so if the diet had changed close to a mealtime, the staff would need to come let the kitchen know.</p> <p>During an interview, on 2/5/25 at 11:07 a.m., QMA 3 indicated diet modifications and any cueing or swallowing assistance needed by residents were easy to find and on the resident's profile sheet.</p> <p>During an interview, on 2/5/25 at 2:55 p.m., the Speech Therapist indicated she would initially use the hospital discharge summary and speech therapy notes to recommend the diet. She did not change a resident's diet from the hospital's recommendation until she had watched Resident 151 over several days and mealtimes and talked to the staff and family.</p> <p>A current Diet Order Formulary and Translation Guide, dated 2/24 and provided by the Administrator on 2/4/25 at 12:15 p.m., indicated the Mechanical Soft with Pureed meats should be ordered in place of Level 5 Mincd and Moist from the hospital.</p> <p>2. During an observation, on 1/31/25 at 9:08 a.m., Resident 156 was in her room coughing up sputum with 2 liters of oxygen administered via nasal cannula. She indicated she had been sick and coughing for a few days with pneumonia.</p> <p>The clinical record for Resident 156 was reviewed on 1/31/25 at 2:27 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, facial weakness, type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, acute systolic congestive heart failure, chronic kidney disease, non-ST elevation myocardial (NSTEMI), and asthma.</p> <p>A hospital after visit summary, dated 1/4/25, indicated a discharge diet order of Level 6 Soft and Bite-Sized consistency.</p> <p>A physician's order, dated 1/4/25, indicated to give a regular consistency diet.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A dietitian note, dated 1/8/25 at 9:44 p.m., indicated the Resident 156 was on a regular consistency diet.</p> <p>A speech therapist note, dated 1/10/25 at 4:38 p.m., indicated she attempted to evaluate the resident but was unable to evaluate her due to the resident vomiting.</p> <p>A physician's order, dated 1/14/25, indicated a diet of regular consistency was ordered.</p> <p>A nursing progress note, dated 1/24/25 at 12:30 p.m., indicated the resident had a productive cough and the nurse practitioner was concerned about aspiration due to the resident reported coughing with meals and pneumonia.</p> <p>A speech therapist note, dated 1/24/25 at 3:16 p.m., indicated nursing had reported the resident had pneumonia, and the nurse practitioner would like the resident evaluated for possible aspiration.</p> <p>During an interview, on 2/4/25 at 2:03 p.m., the Clinical Support Nurse indicated the facility did not see the Soft and Bite-sized diet consistency order on the hospital discharge orders, so they ordered a regular diet.</p> <p>A current Diet Order Formulary and Translation Guide, dated 2/24 and provided by the Administrator on 2/4/25 at 12:15 p.m., indicated the Mechanical Soft should be ordered in place of Level 6 Soft and Bite-Sized from the hospital.</p> <p>3.1-21(a)(3)</p> <p>3.1-21(b)</p>

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 02/05/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50956</p> <p>Based on observation, interview and record review, the facility failed to ensure staff wore gloves when touching a resident's medication for 1 of 1 resident randomly observed for infection control. (Resident 31)</p> <p>Findings include:</p> <p>During an observation, on 1/31/25 at 10:40 a.m., QMA 3 brought a pain pill in for the resident along with his morning pills in a small medication cup. The resident indicated he did not want his morning pills until he had food, but he did want to take the pain pill. QMA 3 then picked the pain pill out of the other pills without donning gloves and handed it to Resident 31. The resident attempted to put the pill into his mouth but dropped it onto his shirt. QMA 3 picked the pill up off the resident's shirt and placed it in his mouth without gloves.</p> <p>The clinical record for Resident 31 was reviewed on 2/4/25 at 9:06 a.m. The diagnoses included, but were not limited to, end stage renal disease, chronic diastolic (congestive) heart failure, hypertensive heart and chronic kidney disease, end stage renal disease, and dependence on renal dialysis.</p> <p>A physician's order, dated 1/20/25, indicated give hydrocodone-acetaminophen 7.5-325 mg three times a day as needed for pain.</p> <p>During an interview, on 1/31/25 at 11:01 a.m., QMA 3 indicated she should not have touched the pill with her bare hands and should have worn gloves when handling the medication.</p> <p>A current facility policy, titled Specific Medication Administration Procedures IIB2: Oral Medication Administration, dated 11/18 and received from the Clinical Support nurse on 2/4/25 at 11:48 a.m., indicated . For solid medications: pour or push the correct number of tablets or capsules into the souffle' cup, taking care to avoid touching the tablet or capsule, unless wearing gloves</p> <p>3.1-18(b)(5)</p>		

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 02/05/2025
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>49891</p> <p>Based on interview and record review, the facility failed to ensure the antibiotic stewardship program included a system to monitor duplicate dosing antibiotic use for 1 of 2 residents reviewed for antibiotic stewardship. (Resident 156)</p> <p>Findings include:</p> <p>During an interview, on 1/31/25 at 10:32 a.m., Resident 156 indicated she had been sick and coughing with pneumonia</p> <p>The clinical record for Resident 156 was reviewed on 1/31/25 at 2:27 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, facial weakness, type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, acute systolic congestive heart failure, chronic kidney disease, non-ST elevation myocardial (NSTEMI), and asthma.</p> <p>A lab report, dated 1/21/25, indicated the resident's GFR (glomerular filtration rate: a blood test to measure kidney function) was low at 24. The normal range was greater than 60.</p> <p>A nursing progress note, dated 1/24/25 at 12:30 p.m., indicated the resident had nausea, vomiting, head congestion, and a productive cough. A chest x-ray was completed and a verbal order from the nurse practitioner for Augmentin and nausea medication was received.</p> <p>A physician's order, dated 1/24/25, indicated to give Augmentin (amoxicillin and clavulanate potassium) 500-125 milligram (mg) tablet every 12 hours with a stop date of 2/2/25.</p> <p>A physician's order, dated 1/27/25, indicated to give Augmentin 875-125 milligram (mg) tablet every 12 hours with a stop date of 2/2/25.</p> <p>The electronic medical record did not include a discontinue order for Augmentin 500-125 mg. The electronic medical record did not include documentation of the need for the increased dosage of the antibiotic.</p> <p>A Medication Administration Record (MAR), dated 1/27/25 through 2/3/25, indicated the resident received the generic form of Augmentin 875-125 mg at 7:00 a.m. and 7:00 p.m. and the generic form of Augmentin 500-125 mg at 9:00 a.m. and 9:00 p.m. until 2/2/25.</p> <p>A nursing progress note, dated 1/28/25 at 2:07 p.m., indicated the resident was complaining of nausea but was having no signs or symptoms of an adverse reaction to the antibiotics.</p> <p>An Antibiotic Tracking log, dated January 2025, indicated the resident was on Augmentin 500 mg for pneumonia on 1/24/25 and the resident was listed again on 1/27/25 for Augmentin 875 mg for pneumonia.</p> <p>(continued on next page)</p>		

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 02/05/2025
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 2/4/25 at 3:45 p.m., the Assistant Director of Nursing/Infection Preventionist indicated she was not aware the resident was receiving 2 doses of the same antibiotic for pneumonia and had not questioned or investigated the higher dosing for the same infection.</p> <p>During an interview, on 2/5/25 at 2:44 p.m., Pharmacist 4 indicated when the pharmacy received a new order the pharmacist looked for duplicates and would cancel the previous order in their system. The facility usually sent a discontinue order for the duplicate with the new order, but he did not see one for the Augmentin. The pharmacy system did not flow over to the facility's MAR so both doses would be on the facility MAR if they did not discontinue the order for the first dose. Residents with renal failure needed a lower dose of Augmentin. The resident could have the 500 mg dose, but 875 mg dose was too high for her. She should not have received both doses with her renal function.</p> <p>During an interview, on 2/5/25 at 3:50 p.m., the Assistant Director of Nursing/Infection Preventionist indicated she received a report of new antibiotic orders to review each morning, and they discussed it during the daily clinical morning meeting. Normally, when they noticed a problem, such as a second antibiotic dose ordered, she would call the physician and question it, but she did not this time. No one in the clinical meeting investigated the second antibiotic dose.</p> <p>A Medication Error Event progress note, dated 2/4/25 at 4:34 p.m., indicated a medication error occurred on 1/27/25 at 12:51 p.m. of a duplicate order resulting in the resident receiving Augmentin 875-125 mg every 12 hours and Augmentin 500-125 mg every 12 hours.</p> <p>A current facility policy, titled Antibiotic Stewardship Guidelines, dated 12/16/24 and received from the Clinical Support Nurse on 2/4/25 at 9:00 a.m., indicated .Purpose .Reduce the risk of adverse events .from unnecessary or inappropriate antibiotic use .New orders for antibiotic usage will be reviewed during the campus Clinical Care Meeting on regular business days</p> <p>3.1-18(b)(1)(A)</p>		

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 02/05/2025
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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49891</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on interview and record review, the facility failed to provide an influenza vaccination during the current influenza season when requested with a signed consent form for 1 of 5 residents reviewed for immunizations. (Resident 13)</p> <p>Findings include:</p> <p>The clinical record for Resident 13 was reviewed on 2/3/25 at 3:40 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, morbid (severe) obesity due to excess calories, Alzheimer's disease, bacterial pneumonia, atrial fibrillation, shortness of breath, dysphagia, and dependence on supplemental oxygen.</p> <p>An influenza vaccination consent form, dated 1/2/24 at 3:50 p.m., was signed by Resident 13 at 3:57 p.m. requesting the influenza immunization.</p> <p>A vaccination record for the resident, received from the Clinical Support Nurse on 2/4/25 at 9:00 a.m., indicated the resident received an influenza vaccine on 10/4/24 at 1:40 a.m.</p> <p>During an interview, on 2/4/25 at 11:00 a.m., the Clinical Support Nurse indicated the resident's medical record did not include any influenza vaccination between the signed consent on 1/2/24 and the administration on 10/4/24.</p> <p>During an interview, on 2/5/25 at 2:27 p.m., the Assistant Director of Nursing indicated after a resident signed a consent, she educated the resident or family in her role as the infection preventionist and then ordered the vaccine. She occasionally needed to batch the vaccines but would give them within a few days to a week.</p> <p>A current facility policy, titled Guidelines for Influenza, Pneumococcal, and COVID-19 Immunizations, dated 12/17/24 and received on 1/30/25 upon entrance, indicated .Upon admission, each resident .will sign an informed consent form indicating the acceptance .of immunization .Each resident will .receive the immunization per their request.</p> <p>3.1-18(b)(5)</p>		

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 02/05/2025
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>49891</p> <p>Based on interview and record review, the facility failed to provide a Covid-19 vaccination when requested with a signed consent form for 1 of 5 residents reviewed for immunizations. (Resident 13)</p> <p>Findings include:</p> <p>The clinical record for Resident 13 was reviewed on 2/3/25 at 3:40 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, morbid (severe) obesity due to excess calories, Alzheimer's disease, bacterial pneumonia, atrial fibrillation, shortness of breath, dysphagia, and dependence on supplemental oxygen.</p> <p>A Covid-19 vaccination consent form, dated 1/2/24 at 3:50 p.m., was signed by Resident 13 at 3:57 p.m. requesting the Covid-19 immunization.</p> <p>A vaccination record for the resident, received from the Clinical Support Nurse on 2/4/25 at 9:00 a.m., indicated the resident received a Covid-19 vaccine on 10/4/24 at 1:40 a.m.</p> <p>During an interview, on 2/4/25 at 11:00 a.m., the Clinical Support Nurse indicated the resident's medical record did not include any Covid-19 vaccination between the signed consent on 1/2/24 and the administration on 10/4/24.</p> <p>During an interview, on 2/5/25 at 2:27 p.m., the Assistant Director of Nursing indicated after a resident signed a consent, she educated the resident or family in her role as the infection preventionist and then ordered the vaccine. She occasionally needed to batch the vaccines but would give them within a few days to a week.</p> <p>A current facility policy, titled Guidelines for Influenza, Pneumococcal, and COVID-19 Immunizations, dated 12/17/24 and received on 1/30/25 upon survey entrance, indicated .Upon admission, each resident .will sign an informed consent form indicating the acceptance .of immunization .Each resident will .receive the immunization per their request.</p> <p>3.1-18(b)(5)</p>		