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	02/11/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident was assessed to self-administer medications for 1 of 1 resident randomly reviewed for self-medication administration. (Resident 73)Findings include:During an observation, on 2/4/26 at 2:02 p.m., a clear plastic bag, labeled with prescription information containing Nystatin cream, was found on Resident 73's bedside table.The clinical record for Resident 73 was reviewed on 2/6/26 at 12:14 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with skin complications, rash, and nonspecific skin eruptions.A physician's order, dated 12/22/25, indicated to administer Nystatin ointment topical to the areas of noted rash twice a day.A care plan, dated 1/29/26, indicated the resident had moisture associated skin damage (MASD) to the left buttock. Interventions included, but were not limited to, treatment as ordered.The clinical record did not contain an assessment or a physician's order completed by the interdisciplinary team to determine Resident 73 could self-administer medications.During an interview, on 2/4/26 at 2:02 p.m., Resident 73 indicated the cream on his bedside table was for a sore area.During an observation and interview, on 2/4/26 at 2:10 p.m., the Executive Director (ED) entered Resident 73's room and removed the Nystatin cream from the bedside table. The ED indicated he would need to see if the resident had an evaluation completed to self-administer the medication.During an interview, on 2/4/26 at 2:16 p.m., the ED indicated Resident 73 was not supposed to self-administer the Nystatin cream and it should not have been in his room.During an interview, on 2/11/26 at 10:37 a.m., Registered Nurse (RN) 7 indicated medication cream should be stored in the treatment cart. If a resident had any medication at their bedside, there should be an evaluation completed and a doctor's order to self-administer medications.During an interview, on 2/11/26 at 10:56 a.m., the Director of Nursing (DON) indicated if a resident had a medication at their bedside, there should be a self-administration observation or evaluation completed.A current facility policy, titled Self-Administration of Medications, dated as last revised January 2018 and received from the ED on 2/9/26 at 1:56 p.m., indicated .For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition.if the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted.3.1-11(a)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the physician was notified of a weight gain according to the parameters ordered for 1 of 1 resident reviewed for notification. (Resident 9)Findings include:The clinical record for Resident 9 was reviewed on 2/6/26 at 1:24 p.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), edema, fluid overload, hypertensive chronic kidney disease, depression, and diabetes mellitus. A physician's order, dated 12/10/25 and discontinued on 1/5/26, indicated to notify the physician of a weight gain greater than 2 pounds in 24 hours or 5 pounds in one week. Resident 9 was to be weighed every day right after she got up, had voided, still in bedclothes, and before breakfast.A review of Resident 9's daily weights indicated the following:a. On 12/18/25, Resident 9 had a documented 3.2 pounds weight increase.b. On 12/23/25, Resident 9 had a documented 15.6 pounds weight increase.c. On 12/26/25, Resident 9 had a documented 15.2 pounds weight increase.d. On 12/29/25, Resident 9 had a documented 13 pounds weight increase.e. On 1/1/26, Resident 9 had a documented 4 pounds weight increase.f. On 1/2/26, Resident 9 had a documented 15.2 pounds weight increase.g. On 1/5/26, Resident 9 had a documented 9 pounds weight increase.h. On 2/8/26, Resident 9 had a documented 10 pounds weight increase.During an interview, on 2/9/26 at 11:28 a.m., QMA 10 indicated when if a resident required a daily weight and had an order to notify the physician, she would notify the nurse when needed and the nurse would notify the physician. During an interview, on 2/11/26 at 9:48 a.m., RN 5 indicated daily weights were to be completed every day, at approximately at the same time in the morning, with no shoes or heavy clothing, no portable oxygen concentrators on the back of wheelchairs, in the same wheelchair and with an empty bladder.During an interview, on 2/11/25 at 11:01 a.m., the Director of Nursing (DON) indicated residents with orders for a daily weight had parameters to follow. The nurse would call the physician if the resident had a weight gain of 2 pounds in 2 days and 5 pounds in one week.During an interview, on 2/10/26 at 12:26 p.m., the Clinical Support Nurse 4 indicated the facility did not have a policy related to congestive heart failure or daily weights. The facility followed the state regulations.3.1-5(a)(1)3.1-5(a)(2)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the resident or resident's representative were given notification in writing of the facility bed hold policy for 2 of 3 residents reviewed for hospitalization. (Resident 11 and 3)Findings include:1. The clinical record for Resident 11 was reviewed on 2/8/26 at 11:04 a.m. The diagnoses included, but were not limited to, pneumonia, sepsis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic kidney disease stage 3. a. A nursing progress note, dated 6/21/25 at 7:58 a.m., indicated the resident was sent to emergency room for respiratory distress. A nursing progress note, dated 6/26/25 at 8:30 p.m., indicated the resident returned to the facility after a hospital stay for pneumonia. b. A nursing progress note, dated 9/28/35 at 4:24 a.m., indicated the resident was sent to the emergency room for evaluation of chest pain. A nursing progress note, dated 9/30/25 at 4:10 p.m., indicated the resident returned to the facility after a hospital stay for pneumonia and hyperkalemia (an elevated level of potassium in the blood). The clinical record did not contain documentation the resident or resident's representative were given information in writing of the facility bed hold policy, including the reserve bed payment. During an interview, on 2/10/26 at 9:40 a.m., the Executive Director (ED) indicated the bed hold policy and reserve bed cost were not given to Resident 11 or the resident's representative in writing. During an interview, on 2/11/26 at 10:37 a.m., Registered Nurse (RN) 7 indicated if a resident was sent to the hospital, the resident should be given paperwork, including the facility bed hold policy. 2. The clinical record for Resident 3 was reviewed on 2/10/26 at 11:24 a.m. The diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, influenza with other respiratory manifestations, dysphagia, irritable bowel syndrome, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, acute and chronic respiratory failure, and pneumonia. A nursing progress note, dated 12/5/25 1:07 p.m., indicated Resident 3 was sent to the emergency room for shortness of breath and difficulty breathing. A nursing progress note, dated 12/11/25 at 7:50 p.m., indicated Resident 3 returned from a hospital stay. A nursing progress note, dated 12/30/25 at 9:25 a.m., indicated Resident 3 was sent to the emergency room for a cough, pressure in chest, and a fever. The clinical record did not contain documentation the resident or resident's representative were given information in writing of the facility bed hold policy, including the reserve bed payment. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/11/26 at 9:58 a.m., Registered Nurse 5 indicated a bed hold policy should be given to the resident or the resident's representative when being sent to the hospital. A copy was made and kept for the facility. During an interview, on 2/11/26 at 10:52 a.m., the Clinical Support Nurse indicated there were no bed hold policies completed for either of Resident 3's hospitalizations. During an interview, on 2/11/26 at 10:56 a.m., the Director of Nursing (DON) indicated a bed hold policy should be completed when a resident went to the hospital. The residents should be given the bed hold policy. During an interview, on 2/11/26 at 10:57 a.m., the Administrator indicated a bed hold policy should be completed, signed, and given to the resident or the resident's representative. The bed hold policy should be mailed by certified mail if indicated. A current facility policy, titled Bed Hold Policy, dated as last revised 11/18/16 and received from the Executive Director on 2/9/26 at 1:56 p.m., indicated .To establish a policy and procedure following state and federal guidelines as it pertains to a resident notification and billing procedures for hospital therapeutic leave bed-hold. 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded accurately for 2 of 2 residents reviewed for MDS accuracy. (Resident 9 and 2)Findings include: 1. The clinical record for Resident 9 was reviewed on 2/6/26 at 1:24 p.m. The diagnoses included, but were not limited to, congestive heart failure, edema, fluid overload, and hypertensive chronic kidney disease. A physician's order, dated 12/10/25, indicated to administer furosemide (a diuretic medication) 80 milligrams (mg) twice a day. During an interview, on 2/9/26 at 3:49 p.m., the MDS Coordinator indicated the congestive heart failure diagnosis was not included in the resident's quarterly MDS assessment on 12/12/25. 2. The clinical record for Resident 2 was reviewed 2/9/26 at 9:00 am. The diagnosis included, but were not limited to, dementia, depression, anxiety, and post-traumatic stress disorder. The clinical record review did not include post-traumatic stress disorder under Resident 2's diagnoses list. The social history observation, dated 1/26/26, indicated Resident 2 had no traumatic history. The Minimum Data Set (MDS) assessment did not indicate Resident 2 had a diagnosis of post-traumatic stress disorder. There was no care plan located related to post-traumatic stress disorder. During an interview, on 2/10/26 at 2:38 p.m., Licensed Practical Nurse 6 indicated Resident 2 had a diagnosis of post-traumatic stress disorder related to being in a war. Resident 2 did not have a care plan in place for post-traumatic stress disorder. During an interview, on 2/10/26 at 2:42 p.m., the Dementia Care Director indicated Resident 2 did have a diagnosis of post-traumatic stress disorder and there was no care plan in place. During an interview, on 2/11/26 at 11:04 a.m., the Director of Nursing (DON) indicated Resident 2 was admitted with the diagnosis of post-traumatic stress disorder. The DON indicated the MDS assessment should have listed the diagnosis of post-traumatic stress disorder, and a care plan should have been in place. During an interview, on 2/9/26 at 3:55 p.m., Clinical Support Nurse indicated there was not a facility policy for MDS accuracy. The facility followed the Resident Assessment Instrument (RAI) manual. 3.1-31(a) 3.1-31(c)(1) 3.1-31(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure comprehensive person-centered care plans were developed and implemented for 2 of 2 residents reviewed for care plans. (Resident 9 and 2)Findings include:1. The clinical record for Resident 9 was reviewed on 2/6/26 at 1:24 p.m. The diagnoses included, but were not limited to, congestive heart failure, edema, fluid overload, and hypertensive chronic kidney disease. A physician's order, dated 12/10/25, indicated to administer furosemide (a diuretic medication) 80 milligrams (mg) twice a day. A physician's order, dated 12/13/25, indicated to administer metolazone (a diuretic medication) 5 mg tablet daily. A comprehensive person-centered care plan related to congestive heart failure and the use of multiple diuretic medications was not initiated until 2/9/26, after the start of the survey. 2. The clinical record for Resident 2 was reviewed on 2/9/26 at 9:00 am. The diagnosis included, but were not limited to, dementia, depression, anxiety, and post-traumatic stress disorder. The social history observation, dated 1/26/26 at 3:08 p.m., indicated Resident 2 had no traumatic history. The clinical record did not contain a comprehensive person-centered care plan related to post-traumatic stress disorder. During an interview, on 2/10/26 at 2:38 p.m., Licensed Practical Nurse 6 indicated Resident 2 had a diagnosis of post-traumatic stress disorder related to being in a war and Resident 2 did not have a care plan in place related to the post-traumatic stress disorder. During an interview, on 2/10/26 at 2:42 p.m., the Dementia Care Director indicated Resident 2 had a diagnosis of post-traumatic stress disorder and did not have a care plan. A current facility policy, titled Comprehensive Care Plan Guidelines, dated as last reviewed 12/10/25 and received from the Clinical Support Nurse on 2/11/26 at 10:02 a.m., indicated .to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines .A comprehensive care plan will be developed within 7 days of the admission comprehensive assessment.Comprehensive care plans need to remain accurate and current 3.1-35(a) 3.1-35(b)(1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure staff administered medications as ordered and followed the physician ordered medication parameters for 2 of 2 residents reviewed for quality of care. (Resident 64 and 8)Findings include:1. The clinical record for Resident 64 was reviewed on 2/5/26 at 2:33 p.m. The diagnoses included, but were not limited to, right distal femur fracture, depression, paraplegia, spinal cord injury, congestive heart failure, edema, fluid overload, hypertensive chronic kidney disease, depression, and dementia.A care plan, dated 9/16/25, indicated the resident had chronic pain. The interventions included, but were not limited to, administer medications and opioids as ordered.a. A physician's order, dated 10/11/25, indicated to administer two (2) capsules of pregabalin (a medication used to treat neuropathic pain) 50 milligrams three times a day. A controlled drug record indicated Resident 64 received one (1) capsule of pregabalin 50 mg on 10/11/25 at 1:15 p.m., and one (1) capsule on 10/13/25 at 8:30 a.m. Resident 64 should have received two (2) capsules at each administration. b. A physician's order, dated 12/10/25, indicated to administer morphine sulfate (a narcotic pain medication) ER (extended release) 15 milligram tablet every 8 hours. A nursing progress note, dated 10/11/25 at 6:29 a.m., indicated Resident 64 refused to take his evening medications. RN 8 offered the resident the medication prepared by the evening shift nurse at 12:30 a.m. The resident indicated he would take the medication prepared by the previous nurse. The morning dose of morphine was not given due to being too close to the previous dose.A controlled drug record indicated the morphine 15 mg tablet was signed out on 10/11/25 for the 9:00 p.m. dose. There was no documentation Resident 64 had refused the 9:00 p.m. dose by the evening shift nurse.The midnight shift nurse administered Resident 64 the evening medications prepared by the previously scheduled nurse at 12:30 a.m., which resulted in Resident 64 missing his morning dose of morphine and another dose was not administered until 1:15 p.m., on 10/12/25. During an interview, on 2/6/26 at 11:35 a.m., the Clinical Support Nurse 3 indicated Resident 64 missed his morning dose of morphine and could have been in pain before his next scheduled dose. During an interview, on 2/10/26 at 2:21 p.m., RN 3 indicated she administered the medications the evening shift nurse prepared. The medication administered included morphine and pregabalin. She then did not administer Resident 64's 6:00 a.m. dose. The resident missed his morning dose and could have been hurting before his next dose was due. 2. The clinical record for Resident 8 was reviewed on 2/6/26 at 12:28 p.m. The diagnoses included, but were not limited to, congestive heart failure, osteomyelitis (a serious bone infection) of the left ankle and foot, diabetes mellitus, and chronic kidney disease. A physician's order, dated 8/21/25, indicated to administer spironolactone (a diuretic medication which helps treat high blood pressure) 12.5 milligrams (mg) daily and hold the medication for a systolic blood pressure less than 105.The spironolactone 12.5 milligrams was administered when the following systolic blood pressures were less than 105:a. On 11/2/25, the blood pressure was 98/62.b. On 11/5/25, the blood pressure was 82/49.c. On 11/6/25, the blood pressure was 99/64.d. On 11/10/25, the blood pressure was 99/61.e. On 11/18/25, the blood pressure was 103/62.f. On 11/25/25, the blood pressure was 82/52.g. On 12/15/25, the blood pressure was 98/62.h. On 2/1/26, the blood pressure was 103/65.The clinical record also did not contain documentation that the low blood pressures were re-checked after the medication was administered until the resident's next dose.During an interview, on 2/10/26 at 11:30 a.m., Clinical Support Nurse 3 indicated the medication was supposed to be held and not given when the systolic blood pressure was less than 105. The staff should follow the physician's order and hold the medication when needed.During an interview, on 2/11/26 at 11:02 a.m., QMA 10 indicated if the blood pressure was out of range and the medication had a hold parameter, it should be documented in the Medication Administration Record (MAR) and the medication held.A current facility policy, titled Medication Administration - General Guidelines, dated as revised 1/2018 and received from the Clinical Support Nurse on 2/6/26 at 11:35 a.m., indicated .The person who prepares the dose for administration is the person who administers the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose.Medications are administered within 60 minutes of scheduled time.The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off=duty without first recording the administration of any medication.If a dose of regularly scheduled medication is withheld, refused.it is documented on MAR or n the EHR. An explanatory note is also entered.3.1-37(a)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an enteral feeding bag was labeled with the product name, date, and time for 1 of 1 resident reviewed for enteral feeding. (Resident 3)Findings include:During an observation, on 2/4/26 at 12:22 p.m., Resident 3 had two clear bags hanging on a feeding pump, which was turned off, and not connected to the resident. One bag was half full of a clear liquid without a label with the date, time or substance and the other bag was half full of a tan colored liquid without a label with the date, time or substance.During an interview, on 2/4/26 at 12:22 p.m., Registered Nurse 5 indicated the bags should have been labeled with a date, time, rate and what the substance was in the bag. During an interview, on 2/10/26 at 10:49 a.m., the Clinical Support Nurse indicated the enteral feeding bags should have had a label with the date, time and name of substance in bag.The clinical record for Resident 3 was reviewed on 2/10/26 11:24 a.m. The diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, influenza, dysphagia, gastrostomy status, irritable bowel syndrome, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, acute and chronic respiratory failure, and pneumonia.A physician's order, dated 1/28/26, indicated to administer the enteral feeding formula [NAME] Farms 1.4 at a flow rate of 60ml/hour for 14 hours, on at 6 p.m. and off at 8 a.m.A physician's order, dated 1/14/26, indicated to administer a free water flush of 120 milliliters (ml) every 4 hours.A physician's order, dated 1/8/26, indicated to change the enteral feeding bag every day.Durning an observation, on 2/11/26 at 9:57 a.m., an unopened 325 ml container of [NAME] Farms enteral feeding indicated once opened it must be used within 24 hours in a healthcare setting.During an interview, on 2/11/26 at 10:59 a.m., the Director of Nursing (DON) indicated the enteral feeding bags should have been labeled with a date, time, and name of the substance.A current facility policy, titled Tube Feedings, dated as revised 5/10/24 and received from the Clinical Support Nurse on 2/10/26 at 10:49 a.m., indicated .TF recommendations should include product.3.1-44(a)(2)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure the nursing staff administered medications in a safe and competent manner for 1 of 1 resident reviewed for competent nurse staffing. (Resident 64)Findings include:The clinical record for Resident 64 was reviewed on 2/5/26 at 2:33 p.m. The diagnoses included, but were not limited to, right distal femur fracture, depression, paraplegia, spinal cord injury, congestive heart failure, edema, fluid overload, hypertensive chronic kidney disease, depression, and dementia.A care plan, dated 9/16/25, indicated the resident had chronic pain. The interventions included, but were not limited to, administer medications and opioids as ordered.A nursing progress note, dated 10/11/25 at 6:29 a.m., indicated Resident 64 refused to take his evening medications. RN 8 offered the resident the medication prepared by the evening shift nurse at 12:30 a.m. The resident indicated he would take the medication prepared by the previous nurse. The morning dose of morphine was not given due to being too close to the previous dose.A controlled drug record indicated the morphine 15 mg tablet was signed out on 10/11/25 for the 9:00 p.m. dose. There was no documentation Resident 64 had refused the 9:00 p.m. dose by the evening shift nurse.The midnight shift nurse administered Resident 64 the evening medications prepared by the previously scheduled nurse at 12:30 a.m., which resulted in Resident 64 missing his morning dose of morphine and another dose was not administered until 1:15 p.m., on 10/12/25. During an interview, on 2/6/26 at 11:35 a.m., the Clinical Support Nurse 3 indicated RN 3 should not have administered pills prepared by another nurse on a previous shift. During an interview, on 2/10/26 at 2:21 p.m., RN 3 indicated she administered the medications the evening shift nurse prepared. The medication should have been destroyed. Medications prepared by another nurse should not be administered and she should not have administered the medications another nurse or QMA had prepared.During an interview, on 2/11/26 at 12:30 p.m., the Clinical Support Nurse 3 indicated the nurses should only administer medication they prepared. A current facility policy, titled Medication Administration - General Guidelines, dated as revised 1/2018 and received from the Clinical Support Nurse 4 on 2/6/26 at 11:35 a.m., indicated .Five Rights - Right resident, right dose, right route and right time, are applied for each medication being administrated.The person who prepares the dose for administration is the person who administers the dose.Medications are administered within 60 minutes of scheduled time, except for, with or after meal orders.In no case should the individual who administered the medication report off=duty without first recording the administration of any medication.If a dose of regularly scheduled medication is withheld, refused.it is documented on MAR or in the EHR. An explanatory note is also entered.3.1-17(a)

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	02/11/2026

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 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, interview and record review, the facility failed to ensure enhanced barrier precaution infection control practices were implemented and followed for 1 of 1 resident reviewed for infection control. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 2/10/26 at 11:24 a.m. The diagnoses included, but were not limited to, gastrostomy status and irritable bowel syndrome.A care plan, dated 12/12/25, indicated Resident 3 required enhanced barrier precautions (EBP) during high contact care related to the presence of a feeding tube. Interventions included, but were not limited to, utilize a gown and gloves according to the enhanced barrier precautions policy.A physician's order, dated 1/7/26, indicated Resident 3 required enhanced barrier precautions due to the gastrostomy tube.During an observation, on 2/4/26 at 12:22 p.m., no personal protective equipment (PPE) was placed outside or inside Resident 3's room and an enhanced barrier precautions (EBP) sign was not displayed inside or outside Resident 3's room or on the door.During an observation, on 2/4/26 at 12:49 p.m., an EBP sign was taped to the exterior side of Resident 3's door. The Administrator was observed in the hall with a tape dispenser and EBP signs.During an interview, on 2/4/26 at 12:49 p.m., the Administrator indicated he did not tape the EBP sign outside of Resident 3's room, a certified nursing assistant did. He did hang the EBP signs on the other doors and the signs should have been placed on the doors prior. During an observation, on 2/6/25 at 11:43 a.m., RN 5 administered medications through Resident 3's gastrostomy tube with only gloves and no other personal protective equipment.During an interview, on 2/6/26 at 12:47 p.m., the Clinical Support Nurse indicated PPE should be worn for any care provided to a resident with a gastrostomy tube.During an interview, on 2/9/26 at 9:38 a.m., QMA 10 indicated PPE should be worn when administering medications or feeding to someone with a gastrostomy tube.During an interview, on 2/11/26 at 9:50 a.m., RN 5 indicated if a resident had a gastrostomy tube an EBP sign should be displayed at the entrance of the room with PPE close by. When administering medications via gastrostomy tube, hand hygiene should be performed and PPE should be worn. During an interview, on 2/11/26 at 10:54 a.m., the Director of Nursing (DON) indicated staff should wear PPE, as indicated for EBP, when administering medication through a gastrostomy tube.A current facility policy, titled Enhanced Barrier Precautions Standard Operating Procedure, dated as last reviewed 12/3/25 and provided by the Clinical Support on 2/6/26 at 12:47 p.m., indicated .EBP will be in place during high-contact care activities for residents with the following condition.All Residents with indwelling medical devices.feeding tubes.At minimum, staff shall wear gloves and gowns during high-contact care activities.3.1-18(b)(2)

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	02/11/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to ensure a call light was accessible to a resident while at her bathroom sink for 1 of 1 resident reviewed for call light accessibility. (Resident 4)Findings include:During an interview, on 2/5/26 at 12:30 p.m., Resident 4 indicated she could not reach her call light while she was sitting at the sink in her wheelchair. She indicated the staff positioned her at the sink to finish her personal hygiene and would leave the room. Her right arm was weakened due to a stroke, and the call light was on her right side and out of reach when she sat at the sink. Due to her arm weakness, she could not maneuver her wheelchair away from the sink.The clinical record for Resident 4 was reviewed on 2/6/26 at 11:16 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, muscle wasting and atrophy, lack of coordination, and weakness.A care plan, dated 10/22/25, indicated Resident 4 was at risk for falling related to weakness, incontinence, and medications. Interventions included, but were not limited to, keeping the call light within reach.During an interview, on 2/6/26 at 10:50 a.m., the Clinical Support Nurse indicated the call light should always be in reach of the residents.During an interview, on 2/6/26 at 10:55 a.m., the Administrator indicated the call light in the bathroom was too short to reach the resident if she was sitting at the sink.During an interview, on 2/10/26 at 3:24 p.m., CNA 2 indicated a resident should not be left alone if they could not reach their call light.A current facility policy, titled Guidelines for Answering Call Lights, dated as last revised 5/11/16 and provided by the Administrator on 2/9/26 at 1:56 a.m., indicated .Ensure the call light is plugged in securely to the outlet and in reach of the resident.After the requested service has been provided.return the call light to within reach of the resident.3.1-19(u)(1)3.1-19(u)(2)