

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint # IN00129671.</p> <p>Complaint # IN00129671 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 22, 23, 24, 25, 26, & 29, 2013</p> <p>Survey team: Bobette Messman, RN, TC Michelle Carter, RN Rita Mullen, RN (7/22, 23, 24, 25, 26, 2013) Maria Panteleo, RN Sandra Nolder, RN (7/23, 24, 26, 2013)</p> <p>Facility number: 012285 Provider number: 155777 AIM number: 201006770</p> <p>Census bed type: SNF: 44 SNF/NF:19 Residential: 58 Total: 121</p> <p>Census payor type:</p>	F000000	<p>The submission of this plan of correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the Residents of Creasy Springs Health Campus. The facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This plan of correction will serve as the credible allegation of compliance with all federal and state requirements governing the management of this facility. Creasy Springs Health Campus respectfully requests a desk review with paper compliance to be considered in establishing that Creasy Springs Health Campus is in substantial compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Medicare: 25 Medicaid: 9 Other: 87 Total: 121</p> <p>Residential Sample : 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 1, 2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician order's were received to hold a medication, before withholding the medication from the resident, and failed to follow physician's orders related to blood pressure medications for 2 of 10 reviewed for following physician's orders, in a sample of 10. (Resident's #23 and #83)</p> <p>Findings include:</p> <p>1. The record for Resident #23 was reviewed on 7/26/13 at 1:35 p.m.</p> <p>Diagnoses included, but were not limited to, anxiety disorder, diabetes, gouty arthropathy, pneumonia, functional disturbances following cardiology surgery, polyneuropathy in diabetes, dehydration, insomnia, diabetes with peripheral circulatory disorders, extrinsic asthma, depressive disorder, chronic kidney disease, high blood pressure, coronary artery disease, and obesity.</p> <p>(a). A "Post-It" note stuck on the July</p>	F000282	<p>1. On 7/26/2013 Resident 23's order for Celexa was discontinued by her Physician and Remeron 15mg by mouth every day at bedtime was ordered. On 8/2/2013, the nursing staff began documenting Resident number 23's blood pressure and heart rate on the medication administration record in accordance with the order for metoprolol. On 8/2/13, the nursing staff began documenting Resident number 83's blood pressure on the medication administration record in accordance with the order for Lisinopril.2. All Residents have the ability to be affected by these deficient practices. All Residents medication administration records were audited for blood pressure and heart rate documentation if ordered by the Physician and for any medications being held to ensure a Physicians order is in place. No other Resident's medications were found to be on hold without a Physician's order. All other Residents with ordered blood pressure and heart rate checks were found to be documented on the medication administration record.3. Starting on 8/9/2013, Lisenced nurses are</p>	08/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2013 Medication Administration Record (MAR), stated "Please hold Celexa. Level 1 drug interaction with Amiodorone. Fax out to Doc." No date or time was indicated on the note.</p> <p>A physician's order to hold the Celexa was not in the chart.</p> <p>During an interview with LPN # 1, on 7/26/13 at 1:50 p.m., she indicated she was not aware of the information documented on the "Post-It" note. She indicated she did not know if the physician ordered to hold the Celexa, for Resident #23.</p> <p>The Director of Nursing (DON) indicated, during an interview, at 2:45 p.m., on 7/26/13, a concern was received from the pharmacy regarding an interaction between Celexa (anti-depressant) and amiodorone (antiarrhythmic), on 7/19/13. Therefore, hold Celexa.</p> <p>A Change of Condition form, dated 7/19/13, indicated the pharmacy notified the facility, on 7/19/13, regarding a possible interaction with Celexa and amiodorone. The pharmacy recommended to hold the Celexa. The facility notified the physician on 7/19/13, via fax. The</p>		<p>being in-serviced on the importance of documenting the Physician ordered blood pressure and heart rates for all Residents with these orders and the facility policy of obtaining an order to hold any medication for any reason. Lisenced nurses are also being in-serviced on following up with the Physician on a pharmacy recommendation to hold a medication the same day the recommendation was made by the Pharmacy.4.The director of Health Services or designee will audit Resident's medication administration records for compliance with documentation of ordered blood pressure and heart rate results.In addition, all Resident's medication administration records will be audited to ensure any medication that is held has an order for it to be held. These audits will be done five times per week for four weeks, then three times per week for four weeks then one time per week for four weeks then monthly there after. The findings of both audits will be presented to the QA&A committee monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>physician returned the fax, requesting further details, on 7/19/13.</p> <p>Celexa was held 7/20, 21, 22, 23, 24, 25, and 26, 2013. During an interview with the DON, on 7/26/13, at 3:00 p.m., she indicated this issue needed resolved and no one followed up with the pharmacy and physician. She indicated a physician's order was required to hold a medication.</p> <p>(b). The July 2013 MAR indicated an order for Metoprolol, 25 mg (milligrams) 1 tablet, orally, twice daily, hold for SBP (systolic blood pressure) below 110 or HR (heart rate) below 60.</p> <p>During an interview with LPN #1, on 7/26/13 at 1:50 p.m., she indicated the blood pressure and heart rates were not documented in accordance with the order for Metoprolol.</p> <p>During an interview with the DON, on 7/26/13 at 3:00 p.m., she indicated the blood pressure and heart rates were not documented, as expected.</p> <p>2. The clinical record for Resident #83 was reviewed on 7/26/13 at 9:24 a.m.</p> <p>Diagnoses included, but were not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>limited to, high blood pressure, depressive disorder, embolic cerebrovascular accident, atrial fibrillation, dementia, gastroesophageal reflux disease, bradycardia, dysphagia, anxiety, anorexia, malnutrition, dementia with behavioral symptoms, history of gastrointestinal bleed, and s/p (status post) hip fracture repair.</p> <p>A physician's order, dated 1/4/13, indicated Lisinopril, 10 mg, give 1 tablet, by mouth, at every bedtime for high blood pressure, hold for SBP (systolic blood pressure) less than 110.</p> <p>Blood pressure's were not documented or evident on the July 2013 MAR.</p> <p>During an interview with LPN #2, on 7/26/13, at 10:48 a.m., she indicated blood pressure's were usually documented with the corresponding medicine. However, Resident #83's blood pressure's were not documented.</p> <p>The DON indicated, during an interview on 7/26/13, at 1:36 p.m., Resident #83's blood pressure's were not documented, as expected.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-35(g)(2)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure pharmacy concerns were followed up with the attending physician for 1 of 10 reviewed for pharmacy recommendation follow up, in a sample of 10. (Resident #23)</p> <p>Findings include:</p> <p>The record for Resident #23 was reviewed on 7/26/13 at 1:35 p.m.</p> <p>Diagnoses included, but were not limited to, anxiety disorder, diabetes, gouty arthropathy, pneumonia, functional disturbances following cardiology surgery, polyneuropathy in diabetes, dehydration, insomnia, diabetes with peripheral circulatory disorders, extrinsic asthma, depressive disorder, chronic kidney disease, high blood pressure, coronary artery disease, and obesity.</p> <p>A "Post-It" note stuck on the July</p>	F000428	<p>1. On 7/26/2013 Resident 23's order for Celexa was discontinued by her Physician and Remeron 15mg by mouth every day at bedtime was ordered. 2. All Residents have the ability to be affected by this deficient practice. All Residents medication administration records were audited for any medications being held to ensure a Physicians order is in place. No Resident's medications were found to be on hold without a Physician's order. 3. Starting on 8/9/2013, Lisenced nurses are being in-serviced on the importance of obtaining a Physicians order to hold any medication for any reason. Lisenced nurses are also being in-serviced on following up with the Physician on a pharmacy recommendation to hold a medication the same day the recommendation was made by the Pharmacy.4.The director of Health Services or designee will audit all Resident's medication administration records to ensure any medication that is held has an order for it to be held. When A</p>	08/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2013 Medication Administration Record (MAR), stated "Please hold Celexa. Level 1 drug interaction with Amiodorone. Fax out to Doc." No date or time was indicated on the note. A physician's order to hold the Celexa was not in the chart.</p> <p>During an interview with LPN # 1, on 7/26/13 at 1:50 p.m., she indicated she was not aware of the information documented on the "Post-It" note. She indicated she did not know if the physician ordered to hold the Celexa, for Resident #23.</p> <p>The Director of Nursing (DON), during an interview, at 2:45 p.m., on 7/26/13, indicated a concern was received from the pharmacy regarding an interaction between Celexa (anti-depressant) and amiodorone (antiarrhythmic). Therefore, hold the Celexa.</p> <p>A Change of Condition form, dated 7/19/13, indicated the pharmacy notified the facility, on 7/19/13, regarding a possible interaction with Celexa and amiodorone. The pharmacy recommended to hold the Celexa. The facility notified the physician on 7/19/13, via fax. The physician returned the fax, requesting further details, on 7/19/13.</p>		Resident is identified as having a medication on hold, the auditor will ensure that the Physician has received all information requested to resolve any Pharmacy concerns. These audits will be done five times per week for four weeks, then three times per week for four weeks then one time per week for four weeks then monthly there after. The findings of both audits will be presented to the QA&A committee monthly.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>Celexa was held 7/20, 21, 22, 23, 24, 25, and 26, 2013. During an interview with the DON, on 7/26/13, at 3:00 p.m., she indicated this issue needed resolved and no one followed up with the pharmacy and physician. She indicated a physician's order was required to hold a medication.</p> <p>3.1-25(i)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	The submission of this plan of correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the Residents of Creasy Springs Health Campus. The facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This plan of correction will serve as the credible allegation of compliance with all federal and state requirements governing the management of this facility. Creasy Springs Health Campus respectfully requests a desk review with paper compliance to be considered in establishing that Creasy Springs Health Campus is in substantial compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on record review and interview, the facility failed to ensure all employees had the tuberculin skin test appropriately administered for 2 of 20 employee records reviewed for tuberculin skin testing. (Employee # 3 & 4)</p> <p>Findings include:</p> <p>During the review of employee records on 7/25/13, Employee #3 and Employee # 4 were not administered the second step tuberculin test.</p> <p>During an interview with the DON, on 7/29/13 at 12:45 p.m., she indicated Employee # 3 and Employee #4 did not have the second step tuberculin test administered.</p>	R000121	<p>1. On 8/11/2013 both employee numbers three and four had their 1st step PPDs repeated with their 2nd step PPD expected to be completed by 8/28/2013. 2. On 8/9/2013 all current employees medical files were audited to ensure first and second step PPDs were administered and read. Employees identified as lacking documentation of a first and second step PPD, will have the first and second step PPD completed and documented by 8/28/13. 3. The business office will track all PPDs due dates via an excel spread sheet. All new hires will have their first step PPD completed upon hire. The business office will then notify the employee via a typed letter with the due date for the second step PPD. 4. The Business office will audit monthly all new hires medical file for the previous month to ensure the new employees have both first and second step PPDs completed. Results of the monthly audit will be presented to the QA&A committee monthly.</p>	08/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure a PRN (as needed) medication was authorized by a nurse prior to administration by a qualified medical assistant (QMA), for 1 of 5 residents reviewed for authorized PRN medications. (Resident F)</p> <p>Findings include:</p> <p>The record for Resident F was reviewed on 7/24/13 at 10:40 a.m.</p> <p>Diagnoses for Resident F included, but were not limited to, syncope/collapse, muscle weakness, difficulty walking, dysphagia/oropharyngeal phase, and anemia.</p> <p>The April 2013 Medication Administration Record (MAR) indicated a physician's order, dated 2/25/11, Diazepam (anti-anxiety) 5 mg (milligrams), give 2 half tablets orally every 6 hours as needed for</p>	R000241	<p>1. Resident F's Diazepam was ordered to be given routine on 6/24/2013. No other PRN medications for Resident F were administered without prior nurse authorization.2. All Residents that reside at Creasy Springs Health Campus are at risk of being affected by this deficient practice. On 8/12/2013, an audit of all Resident's PRN medication administration records and the PRN tracking form for the month of August was completed. No further Residents were identified as being affected by this deficient practice.3. Starting on 8/9/2013, Licensed nurses and QMAs were in-serviced on the rule that a licensed nurse must give authorization to the QMA to administer any PRN medication. The nurse must give the authorization by signing the PRN tracking form.4. The Director of Health Services or designee will audit every Resident's PRN record for a nurses signature/initials five times per week for four weeks then three times per week for four weeks then once a week for four weeks</p>	08/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>anxiety.</p> <p>The April 2013 Medication Administration Record (MAR) indicated on 4/28/13, at 3:30 p.m., Diazepam was given to Resident F by QMA # 5 without prior nurse authorization.</p> <p>During an interview with the DON, on 7/29/13 at 12:50 p.m., she indicated QMA # 5 failed to obtain the proper authorization prior to administering an "as needed" medication.</p>		<p>then monthly. The findings of the audits will be submitted to the QA&A committee monthly.</p>		