STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	02/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 30, 31 and February 3, 4 and 5, 2025. Facility number: 012285 Provider number: 155777 AIM number: 201006770 Census Bed Type: SNF/NF: 16 SNF: 46 Residential: 48 Total: 110 Census Payor Type: Medicare: 29 Medicaid: 16 Other: 17 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 12, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights 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)	F 0550	**1 Resident 26 was affected. No adverse effects noted.** **2 All residents who require feeding assistance have the potential to be affected.**	02/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Isaac Zull	Administrator	03/05/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Findings include: 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. 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. 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. 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. 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 intimated. 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...."		**Education immediately provided to all licensed clinical staff to ensure they are sitting while feeding.** **3 All clinical staff were educated on resident rights and ensuring they are sitting while feeding. The DHS/designee will round during 5 meal services to ensure we are following the resident rights. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	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..." 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...." 3.1-3(t)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir 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) Findings include: 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.	F 0578	**1 Residents 160 and 152 were affected. Upon discovery, the code status order was immediately changed as well as the status on the resident banner in the electronic medical record to reflect accurate code status.** **2 All residents have the potential to be affected. A house wide audit was conducted to ensure that all residents had matching code status orders to the most updated signed code status and were updated timely. Education was provided to**	02/27/2025

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	An Indiana advance directive form, signed on 1/13/25, indicated the resident wished to not have life prolonging measures. An Indiana Physician Orders for Scope of Treatment (POST) form, signed on 1/13/25, indicated the resident chose to be a DNR. A physician's order, dated 1/23/25 at 2:32 p.m., indicated full code status. 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 1/23/25. A physician's order, dated 1/24/25, indicated DNR code status. 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. 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		**Licensed nurses on Advance Directives.** **3 As a measure of ongoing compliance, all new admissions, re-admissions and residents with scheduled quarterly care plan meetings will be audited to ensure no discrepancies in advanced directives. Audits will be conducted weekly x 4 weeks, then every other week x 8 weeks then monthly x 3 months.** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	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. A physician's order, dated 1/7/25, indicated the resident was a full code. 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. 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. A current care plan, dated 1/13/25, indicated the resident had chosen an advance directive of DNR. A physician's order, dated 1/17/25, indicated the resident's code status was DNR. 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. 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			

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	the attending physician for the desired code status...." 3.1-4(f)(5)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments 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) Findings include: 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. 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. A physician's order, dated 1/6/25, indicated to give trazodone (an antidepressant medication) 50 milligram (mg) daily. A physician's order, dated 1/7/25, indicated to give sertraline (an antidepressant medication) 25 mg daily. A physician's order, dated 1/7/25, indicated to give buspirone (an anxiety medication) 5 mg daily. There was no PASARR level I completed to reflect	F 0644	**1 Resident 18 was affected. PASARR Level II has been completed and reviewed by OBRA coordinators. No adverse effects noted.** **2 All residents have the potential to be affected. All have been reviewed for completion of PASRR assessment. Education to occur with the Social Service Director (SSD) on the PASRR completion process. All in-house residents have been reviewed to ensure PASRR was completed and accurate, if indicated.** **3 As a measure of ongoing compliance, the SSD or designee will audit 5 resident PASRRs, weekly x4 weeks, then every other week x2 months, then monthly x3 months.** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance**	02/27/2025

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	the resident's orders for sertraline, trazodone, and buspirone and the resident's mental health diagnoses. 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. 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 regiment from a MD...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		**Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care 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) Findings include: 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	F 0684	**1 Resident 4 was affected. Resident's provider was made aware of the hold and call orders as well as vital results. None of the residents (4) had adverse effects from medication received or lack of provider notification.** **2 All residents with hold or call parameters have the potential to be affected. A house wide audit was**	02/27/2025

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	disease with stage 1 through stage 4 chronic kidney disease, and type 2 diabetes mellitus. 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. 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. 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. 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. 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. A care plan, dated 1/28/25, indicated Resident 4 had CKD (chronic kidney disease) with an intervention to administer medications as ordered. 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. A current facility policy, titled "Preparation and		**conducted to ensure no other residents had vital signs outside of hold parameters or call parameters without proper action from licensed nurses. The provider reviewed the residents with hold parameters for medications and made changes as warranted. Education was provided to Qualified medication aides as well as licensed nurses on call parameters, hold parameters and following physician orders.** **3 As a measure of ongoing compliance, DHS or designee will review 5 residents with vital parameters with orders to ensure that all out of range readings are communicated to medical providers and medications are held/given per parameter orders. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	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...." 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...." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning 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) Findings include: 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. 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,	F 0695	**1 Resident 156 and 150 were affected. No adverse effects noted.** **2 All residents who require the use of oxygen have the potential to be affected. A house wide audit was conducted to ensure no other residents had oxygen therapy without proper orders.** **3 All licensed nursing staff were re-educated on Oxygen Therapy Policy. DHS/designee will complete audits on 5 residents to ensure oxygen**	02/27/2025

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	metabolic encephalopathy, chronic obstructive pulmonary disease, atelectasis, hypertensive heart and chronic kidney disease with heart failure, pulmonary hypertension, atrial fibrillation, and peripheral vascular disease. 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. 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. 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. 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. 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. 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%. 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. 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		**orders are in place for those who receive oxygen therapy. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	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. 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%. 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. 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. A nursing progress note, dated 1/27/25 at 11:05 p.m., indicated the resident was on oxygen. A nursing progress note, dated 1/28/25 at 10:31 p.m., indicated the resident was on oxygen. 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%. 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. During an interview, on 2/5/25 at 2:43 p.m., RN 2			

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	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. 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...." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs 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) Findings include: During an interview, on 1/31/25 at 10:32 a.m., the resident indicated she had been sick and coughing with pneumonia. 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.	F 0757	**1 Resident 156 was affected. No adverse effects noted.** **2 All residents have the potential to be affected. Education provided to all licensed nurses and the IDT team on duplicate medication orders and verified residents were not receiving duplicate therapy** **3 All licensed nurses educated on duplicate medication orders. To assure ongoing compliance , the DON/Designee will complete audits on 5 residents to ensure no duplicate medication orders. Audits will occur weekly x4 weeks, then every other week x8 weeks, then monthly x3 months.** **4 As a quality measure, the DHS or designee will review**	02/27/2025

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	155777	A. BUILDING 00 B. WING	02/05/2025

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

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	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. 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. 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. 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. 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. 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		**any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	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. 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. 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. "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			

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	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...." 3.1-48(a)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals 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) Findings include: 1. During an observation, on 2/3/25 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. 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. The medication card indicated the lorazepam 0.5 mg tablets had expired on 6/2/24. There was no current order for the lorazepam 0.5 mg tablets in the Electronic Health Record (EHR). During an interview, on 2/3/25 at 1:20 p.m.,	F 0761	**1 Resident 250 and 26 was affected by alleged deficient practice. Residents did not experience any adverse effects related to alleged deficient practice.** **2 All nurses educated on medication storage. All medication carts were immediately reviewed with all medications dated and stored appropriately per policy.** **3 As a measure of ongoing compliance, the Director of Health Services or designee to check 4 medication carts for appropriate medication storage. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement**	02/27/2025

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	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. During an interview, on 2/3/25 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. 2. During an observation, on 2/3/25 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. The clinical record for Resident 250 was reviewed on 2/3/25 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. A physician's order, dated 2/2/25, indicated to inject Humalog 100 unit/ml insulin subcutaneous before meals and to use according to the sliding scale. During an interview, on 2/3/25 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. During an interview, on 2/3/25 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.		**meetings. The plan will be reviewed and updated as warranted.**	

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	3. During an observation, on 2/3/25 at 1:25 p.m., the 200-medication room had two sleeves of drinking cups stored under the sink. During an interview, on 2/3/25 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. A current policy, titled "Guidelines for Disposal of Controlled Drugs," dated as revised 12/17/24 and received by the DON on 2/3/25 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...." A current policy, titled "Medication Storage in the Facility," dated as revised 11/2018 and received by the DON on 2/3/25 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			

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	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...." 3.1-25(m) 3.1-25(o)			
F 0808 SS=D Bldg. 00	483.60(e)(1)(2) Therapeutic Diet Prescribed by Physician 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). Findings include: 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	F 0808	**1 Resident 151 & 156 were affected. No adverse effects noted.** **2 All residents had the potential to be affected. Education provided to all dietary and clinical staff on Diet Order Formulary and Translation Guide. All residents diets were reviewed to ensure the correct diet was ordered and updated as needed.** **3 All Clinical and dietary staff were educated on following Diet Order Formulary and Translation Guide prescribed by the physician. A house wide audit was completed to ensure all residents have the correct diet initiated upon admission and to provide the meal tray in the correct consistency. As a measure of ongoing compliance DON/Designee will audit 5 residents diets orders to**	02/27/2025

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	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. 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. 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. A hospital discharge summary, dated 1/27/25, indicated a discharge diet of "Level 5 Minced and Moist". 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.		**meals served weekly x4 weeks, then every other week x8weeks, then monthly x3 months.** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted**	

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A physician's order, dated 1/27/25 and discontinued 1/28/25 at 10:08 a.m., indicated a regular consistency diet.

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.

A current care plan, dated 1/28/25, indicated a regular diet and to provide a diet as ordered.

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.

A physician's order, dated 1/29/25, indicated to give a mechanical soft diet with pureed meat.

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.

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.

During an interview, on 2/5/25 at 11:07 a.m., QMA

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	3 indicated diet modifications and any cueing or swallowing assistance needed by residents were easy to find and on the resident's profile sheet. 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. 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 "Minced and Moist" from the hospital. 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. 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. A hospital after visit summary, dated 1/4/25, indicated a discharge diet order of "Level 6 Soft and Bite-Sized" consistency.			

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	A physician's order, dated 1/4/25, indicated to give a regular consistency diet. A dietitian note, dated 1/8/25 at 9:44 p.m., indicated the Resident 156 was on a regular consistency diet. 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. A physician's order, dated 1/14/25, indicated a diet of regular consistency was ordered. 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. 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. 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. 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. 3.1-21(a)(3)			

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F 0880 SS=D Bldg. 00	3.1-21(b) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control 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) Findings include: 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. 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. A physician's order, dated 1/20/25, indicated give hydrocodone-acetaminophen 7.5-325 mg three times a day as needed for pain. During an interview, on 1/31/25 at 11:01 a.m., QMA 3 indicated she should not have touched	F 0880	**1 Resident 31 was affected. Resident had no adverse effects from alleged deficiency** **2 All residents have the potential to be affected. Education was provided to Qualified medication aides as well as licensed nurses on taking care to avoid touching the tablet or capsule, unless wearing gloves.** **3 To prevent recurrence, all clinical staff were educated on medication handling. To assure ongoing compliance, the DON/Designee will audit 5 medication passes weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as**	02/27/2025

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	the pill with her bare hands and should have worn gloves when handling the medication. 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...." 3.1-18(b)(5)		**warranted.**	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program 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) Findings include: During an interview, on 1/31/25 at 10:32 a.m., Resident 156 indicated she had been sick and coughing with pneumonia 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.	F 0881	**1 Resident 156 was affected. No adverse effects noted.** **2 All residents who require antibiotic therapy have the potential to be affected. Education to occur with Infection Preventionist to ensure the antibiotic stewardship program includes a system to monitor duplicate dosing of antibiotics.** **3 As measure of ongoing compliance the Infection preventionist will audit 5 resident Antibiotic orders weekly x4 weeks, then every other week x8 weeks, then monthly x3 months.** **4 As a quality measure, the DHS or designee will review any findings and**	02/27/2025

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	155777	A. BUILDING 00 B. WING	02/05/2025

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

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	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. 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. 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. 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. 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. 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. 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.		**corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

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	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. 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. 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. 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.			

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	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. 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...." 3.1-18(b)(1)(A)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations 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) Findings include: 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	F 0883	**1 Resident 13 was affected. No adverse effects noted.** **2 All residents who consent to vaccines have the potential to be affected. Education immediately provided to all licensed nurses and the IDT team on the Immunization Policy and to ensure all residents were up-to-date on immunizations, if the resident consented.** **3 All licensed nurses and the IDT team were educated on the Immunization Policy. A house wide audit was**	02/27/2025

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	dependence on supplemental oxygen. 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. 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. 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. 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. 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." 3.1-18(b)(5)		**completed to ensure any resident who consented to the flu, pneumonia vaccine received it. As a measure of ongoing compliance, DHS or designee will review 5 residents to ensure that all residents who have consented to receive vaccines have received them. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on interview and record review, the facility	F 0887	**1 Resident 13 was**	02/27/2025

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	failed to provide a Covid-19 vaccination when requested with a signed consent form for 1 of 5 residents reviewed for immunizations. (Resident 13) Findings include: 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. 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. 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. 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. 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.		**affected. No adverse effects noted.** **2 All residents who consent to vaccines have the potential to be affected. Education immediately provided to all licensed nurses and the IDT team on the Immunization Policy and to ensure all residents were up-to-date on immunizations, if the resident consented.** **3 All licensed nurses and the IDT team were educated on the Immunization Policy. A house wide audit was completed to ensure any resident who consented to the Covid vaccine received it. As a measure of ongoing compliance, DHS or designee will review 5 residents to ensure that all residents who have consented to receive vaccines have received them. Audits will occur weekly x 4 weeks, then every other week x 8 weeks then monthly x3 months** **4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as**	

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	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." 3.1-18(b)(5)		**warranted.**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 30, 31 and February 3, 4 and 5, 2025 Facility number: 012285 Residential Census: 48 Creasy Springs Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on February 12, 2025.	R 0000		