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	12/20/2023

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: December 13, 14, 18, 19 and 20, 2023 Facility number: 012285 Provider number: 155777 AIM number: 201006770 Census Bed Type: SNF/NF: 28 SNF: 30 Residential: 47 Total: 105 Census Payor Type: Medicare: 22 Medicaid: 21 Other: 15 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed January 3, 2024.	F 0000	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, true representation of the quality of care provided, and the living environment provided to the residents of Creasy Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Rife	Executive Director	01/15/2024

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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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a resident with a Brief Interview for Mental Status (BIMS) which showed intact cognition was invited to participate in the care plan meetings for 1 of 3 residents reviewed for care plan meetings. (Resident 57) Finding includes: During an interview, on 12/13/23 at 3:41 p.m., Resident 57 indicated she was not aware of care plan meetings. The record for Resident 57 was reviewed on 12/18/23 at 3:41 p.m. Diagnosis included, but were not limited to, bipolar II disorder, frontotemporal neurocognitive disorder, anxiety, and degenerative disease of the basal ganglia.	F 0657	**1)**Resident #57 was affected. Resident First meetings have been scheduled for resident #57. No adverse effects noted. **2)** All residents have the potential to be affected. All residents are to be invited to their Resident First meetings. Resident first meetings will be scheduled if indicated. Legacy Lane Coordinator has been educated on ensuring resident's are invited to their Resident First Meeting. **3)** As a measure of ongoing compliance, the DHS/MDS or designee will complete an audit of up to 5 residents based on the	01/15/2024

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	A Minimum Data Set (MDS) assessment, dated 7/28/23, indicated the resident had a BIMS score of 14 which indicated intact cognition. A Resident First Meeting (care plan meeting), dated 7/27/23 at 5:32 p.m., indicated the resident's representative attended the meeting. The attendees included the Social Services Director (SSD), Licensed Practical Nurse (LPN), the facility Administrator, the Assistant Director of Health Services (ADHS) and the resident's spouse. The Resident First Meeting, dated 7/27/23, did not include the resident as being invited to the meeting and did not include the resident as attending the meeting. A Resident First Meeting, dated 10/23/23 at 2:24 p.m., indicated the resident's representative attended the meeting. The attendees also included an LPN. The Resident First Meeting, dated 10/23/23, did not include the resident as being invited to the meeting and did not include the resident as attending the meeting. During an interview, on 12/18/23 at 5:10 p.m., the Legacy Neighborhood Director indicated the resident would defer to her husband for "everything". The Legacy Neighborhood Director did not have documentation to show the resident was invited to the care plan meetings or documentation to show the resident chose not to attend. The resident was not aware of the care plan meetings. The resident was able to make choices about her day-to-day life. A current policy, titled "Resident's First Meeting Guidelines," dated as revised on 4/25/2022 and		MDS schedule weekly x4 weeks, then every other week x2 months, then monthly x3 months. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	received from the Clinical Support Nurse on 12/19/23 at 3:52 p.m., indicated "...Resident First Meeting Guidelines...To facilitate communication and participation regarding the resident's plan of care, medical condition and care needs between the resident, family, resident representative and care givers...A Resident First meeting should be scheduled and held within 5 business days of admission...Director of Social Services or designee should send invitations to the resident and/or representative notifying them of the date and time of the conference as far in advance as possible...Solicit input from the resident and/or representative regarding care choices and changes to their routine...Add any input from the resident and/or representative into the narrative notes sections on the observation form...The Resident First Meeting is a time to communicate information related to care needs and medical condition and seek input from the resident or representative...Review the resident goals and discuss with the team, family, and resident...." 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			

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	Based on observation, interview and record review, the facility failed to ensure a resident who was on the memory care unit was provided with preferred activities while in isolation for Covid-19 for 1 of 1 resident reviewed for activities. (Resident 59) Finding includes: During an observation, on 12/13/23 at 1:09 p.m., staff were in the room to assist the resident. He was sitting up in his wheelchair. There was no reading material, no television on, and no music playing in the room. During an observation, on 12/14/23 at 11:30 a.m., the resident was sitting up in his room on the side of the bed. The television was not on, there was no music playing, and no books or other activity material observed in the room. During an observation, on 12/14/23 at 12:30 p.m., QMA 11 went into the resident's room, she indicated he did not watch the television, did not listen to music, usually just sat in his wheelchair in the room, and did not participate in any activities. During an interview, on 12/14/23 at 2:22 p.m., the resident's daughter indicated he used to watch old westerns on television and liked the newspaper. The resident could still read, and he usually watched television with a group of residents although not in his room. During an observation, on 12/18/23 at 3:58 p.m., the resident was sitting up in the wheelchair in his room, there was no music playing, the television was not on, and there was no reading material in his room.	F 0679	**1)** Resident #59 was affected. Care plans have been updated to match resident preferences **2)** All residents have the potential to be affected. Life enrichment staff educated on engaging residents for activities and documentation of participation or lack thereof. **3)** As a measure of ongoing compliance, the LED or designee will audit residents for participation, documentation of participation, and to ensure preferences match care plan and assessment data. Audit to consist of 5 residents weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. ="" p="">	01/15/2024

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	The record for Resident 59 was reviewed on 12/14/23 at 5:04 p.m. Diagnosis included, but were not limited to, old myocardial infarction, osteoarthritis, hearing loss, age related cataracts, and a history of malignant neoplasm of the large intestine. The resident resided on the memory care unit although he did not have a diagnosis of dementia. A care plan, dated 10/3/23, indicated it was important for the resident to have the opportunity to engage in activities and engage in activities which were meaningful to the resident. The goal was for the staff to take the necessary actions to accommodate the resident's routine and for the resident to indicate he was satisfied with the activities. The approaches included, but were not limited to, it was important for the resident to have the opportunity to listen to music, there was no favorite type of music and he just enjoyed listening to music, it was important for the resident to keep up with the news so ensure the resident had avenues such as the newspaper and television. The resident enjoyed watching the news channel and reading the newspaper. The staff was to provide independent activity supplies such as playing cards, the daily chronicles, and music listening equipment. During an interview, on 12/19/23 at 2:30 p.m., Activity Staff 12 indicated the resident was in his room due to having Covid-19. He did like to listen to music. There was not much the activity staff could do when a resident was in their room due to Covid-19. The Legacy Neighborhood Director was the one completing the one-to-one activities in the resident's room.			

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	During an interview, on 12/19/23 at 2:33 p.m., the Legacy Neighborhood Director indicated she had not charted any one-to-one activities for the last two days for the resident. The resident did like country music and music from the 50's and 60's. The resident did not receive the newspaper and she had not read the newspaper to the resident. During an interview, on 12/19/23 at 2:38 p.m., CNA 5 indicated the resident liked to roam around and he sometimes would get agitated while listening to music. The resident did not have books or other reading material in his room. During an interview, on 12/19/23 at 3:41 p.m., the Clinical Support Nurse indicated she talked to the resident's daughter, and she indicated the resident loved church and religious music and maybe the agitation came from playing the wrong music. The resident liked looking through the newspaper and liked reading the Bible with large print. A current policy, titled "Resident Choice," dated as effective 6/2/16 and received from the Clinical Support Nurse on 12/19/23 at 4:20 p.m., indicated "...Residents are encouraged to participate in the life enrichment program (activity program)...It is the resident's choice to participate in the activities of their choosing...Residents will be invited to attend activities and will be provided the opportunity to participate in structured and individual programs...Resident who prefer not to participate in structured programs will be offered alternatives for meaningful pursuit of leisure interests...." 3.1-33(a)			
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to reweigh a resident with a weight loss and to notify the provider of a weight loss for 1 of 3 residents reviewed for nutrition. (Resident 55) Finding includes: The record for Resident 55 was reviewed on 12/18/23 at 11:03 a.m. Diagnoses included, but were not limited to, unspecified dementia, chronic kidney disease stage 3, age related physical debility, and altered mental status. A weight log indicated the following weights: a. On 8/5/23, the weight was 207.2 pounds. b. On 8/14/23, the weight was 212.6 pounds. c. On 8/21/23, the weight was 209 pounds. d. On 8/28/23, the weight was 199.2 pounds.	F 0692	**1)** Physician and family notified of weight loss for resident #55. Physician assessed and resident had no ill effects. Dietician reassessed. Resident was re-weighed. **2)** Review all residents to monitor for any weight loss and proper MD notification if weight loss noted. **3) A**ll licensed Nursing staff were educated on process of weight loss monitoring and proper notification/process when identified with a resident. CCM staff were educated to observe for weight triggers and process if identified. All open nutrition/weight	01/15/2024

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	There was a 6.3% weight loss from 8/21/23 to 8/28/23 (14 days). During an interview, on 12/19/23 at 10:57 a.m., the Clinical Support Nurse indicated their Electronic Health Record (EHR) did not trigger for a significant weight loss. There should have been a reweight completed to confirm the resident's weight. During an interview, on 12/19/23 at 2:23 p.m., the Clinical Support Nurse indicated there was no provider notification about the weight loss. A current policy, titled "Guidelines for Weight Tracking," dated as last reviewed on 12/31/23 and received from the Clinical Support Nurse on 12/18/23, indicated "...Residents who have a weight that seems out of normal range shall be re-weighed to determine the accuracy of the original weight...the physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days...." 3.1-46(a)(1)		events pulled daily in CCM and any weight loss triggers to be reviewed daily by CCM team times 3 months. DHS or designee to audit daily times 4 weeks to ensure any concerns are followed up on and brought to QA team for review and any recommendations. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. /p> ="" p="">	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's			

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	clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on interview and record review, the facility failed to clear a clogged feeding tube (gastric tube) using an approved procedure for 1 of 3 residents reviewed for feeding tubes. (Resident 18) Finding includes: The record for Resident 18 was reviewed on 12/14/23 at 5:10 p.m. Diagnoses included, but were not limited to, unspecified protein-calorie malnutrition, dysphagia, oropharyngeal phase, and artificial openings of gastrointestinal tract status. A progress note, dated 11/27/23 at 12:33 p.m., indicated the resident had a clogged feeding tube (gastric tube). The nurse tried "coke" (soda) to unclog the feeding tube after another nurse tried, without success. The nurse received an order to send the resident to the emergency room. There was no physician's order to use "coke" to unclog the feeding tube. During an interview, on 12/20/23 at 5:06 p.m., the Clinical Support Nurse indicated the policy did not include to put "coke" in the feeding tube to	F 0693	**1)** Resident #18 was affected. All clogged gastric tubes to be unclogged per facility SOP. All nurses have been educated on proper procedure for unclogging gastric tubes. **2)** All residents with a gastric tube had the potential to be affected residents have functioning gastric tubes. **3)** As a measure of ongoing compliance the DHS/designee will audit all residents that have a gastric tube for proper functioning and procedure for unclogging if indicated. Audit to consist of all in house gastric tubes will be assessed weekly x 4 weeks, 2 times weekly every other week and then 1 a week monthly x 3 months. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure	01/15/2024

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	unclog it. A current policy, titled "Administering Gastric/Jejunostomy Tube Medications," dated as reviewed 12/31/23 and received from the Clinical Support Nurse on 12/20/23 at 5:37 p.m., indicated "...if the stomach contents cannot be aspirated, pull back slightly on the tube and reposition...if the tube is still not patent, withhold medication and notify the physician...." 3.1-44(a)(2)		substantial compliance is maintained or 100% compliance is met.	
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to hold insulin according to the physician ordered parameters for 1 of 1 resident reviewed for insulin administration. (Resident 29) Resident 29 had hypoglycemia which resulted in an emergency room visit and hospitalization. Finding includes: During an interview, on 12/14/23 at 10:36 a.m., RN 6 indicated Resident 29 became unresponsive, on 12/13/23 at 9:00 p.m., and was sent to the emergency room. The resident had a blood sugar of 18 (mg) milligram/(dL)deciliter (a normal fasting blood sugar level was between 70 mg/dL and 100 mg/dL). The record for Resident 29 was reviewed on 12/18/23 at 4:13 p.m. Diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, and hypertension.	F 0760	**1)** Resident #29 was affected. Resident was sent to the hospital. **2)** All diabetic residents had the potential to be affected by this practice. **3) L**icensed nursing staff were re-educated on the policy titled “Medication Administration” by The Director of Health Services or designee. The Director of Health Services or designee will Audit medication passes 4 times a week for 5 weeks to ensure compliance with current nursing standards. Also, As a measure of ongoing compliance, the DHS or designee will audit for appropriate orders on 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. **4)** The results of the audit observations will be reported,	01/15/2024

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	A care plan, dated 11/12/21, indicated the resident had a risk for hypoglycemia and hyperglycemia related to diabetes mellitus. The interventions included, but were not limited to, give medication per orders, monitor blood sugars per physician orders, and to observe for hypoglycemia such as sweating, cold, clammy skin, numbness of the fingers, toes, mouth, rapid heartbeat, tremors, and dizziness. A current physician's order, dated 9/21/22, indicated to give Novolog (a fast-acting insulin) 100 unit/ml subcutaneous (SQ). Give insulin before meals and at bedtime per the following sliding scale: a. If blood sugar was 141 to 150, give 2 units. b. If blood sugar was 151 to 200, give 3 units. c. If blood sugar was 201 to 250, give 5 units. d. If blood sugar was 251 to 300, give 9 units. e. If blood sugar was 301 to 350, give 11 units. f. If blood sugar was 351 to 400, give 13 units. g. If blood sugar was 401 to 450, give 15 units. h. If blood sugar was greater than 450, call MD. A current physician's order, dated 11/18/23, indicated Novolog 100 unit/ml, give 6 units SQ before meals and at bedtime. If the blood glucose was less than 201 hold the insulin. A Medication Administration Record (MAR) indicated the blood sugar level on 12/13/23 at 7:12 p.m., was 197. The resident received 6 units of Novolog. The resident should not have received the insulin, on 12/13/23 since the blood glucose was less than 201. A progress note, dated 12/13/2023 at 9:11 p.m.,		reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. ="" span="">	

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	155777	A. BUILDING 00 B. WING	12/20/2023

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	indicated the resident was found unresponsive to verbal and physical stimuli, eyes glazed, very sweaty, and coarse lung sounds with auditory gurgle. The resident was sent to the emergency department for evaluation and treatment. A hospital document, dated 12/13/23 at 9:34 p.m., indicated the resident presented to the emergency room from the facility and was unresponsive and diaphoretic. The resident's glucose level was less than 20 per emergency physician on call. A hospital document, dated 12/14/23 at 12:52 a.m., indicated the resident had symptomatic hypoglycemia with a history of diabetes mellitus. The emergency blood sugar level was 18. The resident was started on dextrose (used to provide extra water and carbohydrates), intravenous (IV) fluids, and the insulin would be on hold. The resident received an additional or inaccurate insulin dose at the facility. During an interview, on 12/19/23 at 10:45 a.m., the Clinical Support Nurse indicated the resident was sent to the ER for evaluation and treatment. RN 7 found the resident unresponsive. The resident received dextrose in the ER and her blood sugar level did not go up. They started the resident on IV dextrose and when she got to the hospital her blood glucose level was 18. During an interview, on 12/20/23 at 3:11p.m., RN 7 indicated a Certified Resident Care Assistant (CRCA) came to her and said the resident did not look right. When RN 7 entered the resident's room, she was unresponsive. The resident was sweaty, and her lungs sounded course. RN 7 was not sure when she gave insulin to the resident or what time the resident was sent to the hospital.			

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	During an interview, on 12/20/23 at 10:54 a.m., the Clinical Support Nurse indicated the resident was given 6 units of insulin when the blood sugar level was 197 at 7:10 p.m. The resident had a hold order for a blood sugar level of less than 201. The nurse gave the 6 units of Novolog with the 3 units. The resident became unresponsive and was sent out to the ER. A current policy, titled "Guidelines for Medication Error Reporting," dated as revised 5/10/2017 and received by the Clinical Support Nurse on 12/20/23 at 5:15 p.m., indicated "...To identify medications given in error and expedite correction actions...In the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare. Notify the attending physician promptly of the error. Implement physician's orders. Notify the resident or responsible party. Initiate the appropriate Event form. Monitor the resident closely for 72 hours or as directed. Document the following in the resident's clinical record: A description of the error (brief). Name of physician and time notified. Physician's subsequent orders. Medication errors will be reviewed by the Quality Assurance Committee to identify trends and/or actions for implementations...." A current policy, titled "Guidelines for Medication Orders," dated as reviewed on 12/31/2022 and received by the Clinical Support Nurse on 12/20/23 at 12:00 p.m., indicated "...Each resident shall be under the care of a licensed physician authorized to practice medicine in the state where care is provided and shall be seen by the physician in accordance with regulations and as resident condition warrants...."			

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	A document, titled "Understanding Your Daily Insulin Needs," https://www.healthline.com/health/how-much-insulin-to-take-chart, dated May 10, 2023, indicated "...Calculating how much insulin to take is usually based on two considerations: Basal insulin dose. A basal insulin dose is an amount that you give yourself daily regardless of the foods you eat. Bolus insulin dose. A bolus insulin dose helps correct or anticipate the carbohydrates you eat throughout the day. You will usually correct this with a bolus dose of rapid-acting insulin...you are estimating how many units of insulin it will take to process the carbohydrates you eat...as a general rule, 1 unit of rapid-acting insulin will process anywhere from 12 to 15 grams of carbohydrates...1 unit of insulin lowers your blood sugar by about 50 milligrams per deciliter (mg/dL)...not all people will process insulin the same way...Insulin has a narrow therapeutic index, which means there is a fine line between a beneficial dose and a harmful one. It's possible to overdose on insulin...Another factor to keep in mind is the 1:50 correction ratio. In general, correcting high blood sugar by 50 mg/dL uses 1 unit of insulin...This correction ratio - also known as the insulin sensitivity factor - can vary for different people or in different situations...." 3.1-48(c)(2)			
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility-			

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	§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.			
	Based on observation, interview and record review, the facility failed to accurately assess a resident's mouth for teeth and dentures and to show documentation of the dental status and the need for a dental appointment had been documented for 1 of 2 residents reviewed for dental. (Resident 59)	F 0790	**1)** Resident #59 was affected. No adverse effects were noted. **2)** All like residents had the potential to be affected. All like residents assessed for proper dental assessment to ensure residents receive the proper plan	01/15/2024

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	Finding includes: During an interview, on 12/14/23 at 2:28 p.m., the resident's daughter indicated the resident's dentures did not fit well and the staff indicated the dentist would come to the facility. The resident did not chew well because of the fit of the dentures. The record for Resident 59 was reviewed on 12/14/23 at 5:04 p.m. Diagnosis included, but were not limited to, old myocardial infarction, osteoarthritis, hearing loss, age related cataracts, and a history of malignant neoplasm of the large intestine. A physician's order, dated 9/29/23, indicated the resident may see the dentist as needed. An admission observation, dated 9/29/23 at 5:53 p.m., indicated the resident had full dentures which included upper and lower dentures. A care plan, dated 10/12/23, indicated the resident was at a risk for malnutrition related to the resident had no natural teeth and had upper and lower dentures. The care plan did not include the resident's dentures did not fit well and did not include the resident ate without the dentures in place. During an interview, on 12/19/23 at 2:30 p.m., the Legacy Neighborhood Director indicated the resident had not been seen by the dentist. The Director had talked to the family, on 12/19/23, about the resident seeing the dentist. There was no documentation prior to this date the dentist had been discussed with the resident's family. She		of care. **3)** DHS or designee will re-educate nurses on accuracy of nursing assessment. DHS or designee will audit 5 residents nursing observation assessments weekly x 4 weeks, then every other week x2 months and then monthly x 3 months. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	did not know if the resident's dentures fit well or not and indicated she was not a clinical staff. During an observation and interview, on 12/19/23 at 2:38 p.m., CNA 5 indicated the resident's top dentures would fall when the resident's mouth was open. The resident only had upper dentures and there were no lower dentures in the resident's room. The resident was observed, and he had 4 or 5 natural teeth on the bottom. CNA 5 could not locate the resident's upper dentures and looked all over the room. During an interview, on 12/19/23 at 3:41 p.m., the Clinical Support Nurse indicated the resident's daughter was called and thought his upper dentures were in the bathroom. If the facility could not locate the dentures, they would fill out a resident concern form. The daughter indicated the resident never had lower dentures. The admission observation and care plan were not correct. The documentation did not include the resident's dental status had been discussed with the family prior to 12/19/23. A current policy, titled "Dental Services Including Repair, Replacement," dated as reviewed on 12/31/22 and received from the Clinical Support Nurse on 12/19/23 at 4:20 p.m., indicated "...to assist residents in obtaining routine and emergency dental care, per the resident request. The facility will assist by making appointments and/or by arranging for transportation to and from the dental services location...Clinical staff will assess teeth and gums upon admission, with each comprehensive assessment and as needed to identify pain, lost or broken teeth, visible signs of tooth decay and other chewing and swallowing problems...If through assessment of a resident's teeth and gums, a dental need is identified the			

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	nurse will contact social services or their designee who will follow through with making an appointment for the resident to consult with a Dentist...Social Services or their designee will assist with making the dental appointments and arranging transportation, if necessary...Social Services or their designee will assist with making the referral to a Dentist within 3 business days or less from the time a dental problem or concern is identified...If there is a delay in the actual treatment by a dental professional, an assessment of the resident's ability to eat and drink adequately will be completed...The facility will promptly, within 3 business days, refer residents with lost or damaged dentures for Dental services. If there is a delay with repair or replacement of dentures, the facility will document what was done to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay...." 3.1-24(a)(1) 3.1-24(a)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following			

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	elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be			

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	followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the staff failed to wear the required PPE (Personal Protective Equipment) into an isolation room and to follow the PPE protocol for 1 of 4 hallways reviewed for transmission-based precautions (the Legacy hallway) and to ensure a catheter bag was not touching the ground for 1 of 2 residents reviewed for urinary catheter. (Resident 269) Findings include: 1a. During an observation, on 12/13/23 at 1:03 p.m., LPN 13 had on a N95 mask and put a face shield over the mask. She entered Resident 59's room to provide care. When LPN 13 came out of Resident 59's room, she took off her face shield and did not remove the N95 mask. She wore the same N95 into the hallway. During an interview, on 12/13/23 at 1:22 p.m., LPN 13 indicated she should have removed her N95 mask when leaving the resident's room.	F 0880	**1)** No specific residents were affected. All residents on Legacy Lane have been assessed with routine infection control monitoring and no adverse effects noted. Employees were immediately educated on the use of appropriate PPE in isolation rooms when providing resident care, with return demonstration and follow proper PPE in hallway with TBP. **2)** All residents have the potential to be affected. All staff to be educated, by the DHS, ED, or designee on appropriate eye protection, with return demonstration, per CDC and facility policy. The Executive Director (ED), DHS, Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same	01/15/2024

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	1b. During an observation, on 12/19/23 at 2:43 p.m., CRCA 5 and CRCA 6 entered an isolation room on the Legacy unit. Both wore a surgical mask with face shield, and both were not wearing N95 masks. During an interview, on 12/19/23 at 2:44 p.m., LPN 7 indicated she thought the CRCAs needed a surgical mask when going into Covid positive rooms. During an interview, on 12/19/23 at 3:41 p.m., the Clinical Support Nurse indicated when entering a Covid positive room, a N95 mask should be worn. During an interview, on 12/19/23 at 3:55 p.m., the Clinical Support Nurse indicated the 200 hall and the Legacy unit were considered to be in a Covid outbreak and the staff were required to wear proper PPE while in Covid positive rooms. During an interview, on 12/20/23 at 2:55 p.m., the Clinical Support Nurse indicated the facility had 21 residents and 11 staff testing positive for Covid-19 from 12/1/23 to 12/20/23. During an interview, on 12/20/23 at 3:02 p.m., RN 10 indicated PPE must be worn while providing care in the resident's room.2. During an observation, on 12/14/23 at 10:09 a.m., Resident 269's catheter bag was touching the ground. During an observation, on 12/14/23 at 10:17 a.m., CRCA 2 went into Resident 269's room to check on the resident. During an observation, on 12/14/23 at 10:23 a.m., CRCA 2 had come out of the resident's room and the catheter bag was still touching the ground.		team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. **3)** As a measure of ongoing compliance, the DHS or designee, will complete audits of appropriate PPE in isolation rooms and in hallways with TBP on 5 staff members weekly x4 weeks, then every other week x2 months, then monthly x3 months while recording incidents identified under the campuses IPCP and any corrective actions taken **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. The systemic changes will be completed by January 15, 2024 Catheter: **1)** Residents had no ill effects from alleged deficiency **2)** All other residents with an indwelling catheter had the potential to be affected. A whole house Audit was completed by DON/Designee on all residents	

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	During an observation, on 12/14/23 at 2:27 p.m., Resident 269's catheter bag was still touching the ground. The record for Resident 269 was reviewed on 12/18/23 at 10:47 a.m. Diagnoses included, but were not limited to, urinary tract infection, benign prostatic hyperplasia (BPH), overactive bladder, and retention of urine. A current physician's order, dated 12/14/23, indicated the resident had an indwelling urinary catheter. During an interview, on 12/14/23 at 2:36 p.m., RN 2 indicated the catheter bag was touching the ground and it should not be touching the ground. A current policy, titled "Urinary Catheter Care," dated as last reviewed on 12/21/22 and received from the Clinical Support Nurse on 12/20/23 at 5:15 p.m., indicated "...Be sure the catheter tubing and drainage bag are kept off the floor...." A current policy, titled "COVID-19 Identification and Management," dated as revised on 6/5/23 and received from the Clinical Support Nurse on 12/20/23 at 5:15 p.m., indicated "...When Caring for a COVID-19 Positive Resident or Resident in Transmission Based Precautions...Personal Protective Equipment (PPE) is required when caring for or entering the room of a person in TBP. Required PPE: N95 mask, gown, eye protection, and gloves...Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) are to be worn during all resident care encounters...PPE must be removed and discarded after each resident care encounter...."		with catheters not touching the ground. This audit was completed. **3)** To prevent recurrence, all staff were educated by the DON/Designee on catheter bag storage. To assure ongoing compliance, the DON/Designee will audit all residents with catheters to ensure proper storage is being completed 2 times a week X4 weeks, 2 times a week biweekly, then 2x monthly times 3 months. **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. ="" p=""> ="" span<="" p="">	

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	A document, titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated May 8, 2023, indicated "The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency...Personal Protective Equipment: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing, and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134) ...." 3.1-18(b)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to follow an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use for 6 of 12	F 0881	**1)** No specific residents were affected. **2)** All residents with antibiotics	01/15/2024

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	155777	A. BUILDING 00 B. WING	12/20/2023

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	months reviewed for antibiotic stewardship. (July 2023-December 2023) Findings include: During a record review, on 12/20/23 at 2:45 p.m., the Antibiotic Stewardship binder had antibiotic monitoring starting January 2023 to June 2023. There was no documentation, tracking of infections, and antibiotic monitoring from July 2023 to December 2023. During an interview, on 12/20/23 at 2:45 p.m., the Clinical Support Nurse indicated the Infection Preventionist (IP) would make sure the antibiotics were monitored and met the McGeer (an infection surveillance for long-term care facilities) criteria. The IP would map the trends of infections and depending on the infections the facility would in-service staff. During an interview, on 12/20/23 at 2:53 p.m., the Clinical Support Nurse indicated the Antibiotic Stewardship binder did not contain information of tracking infections past June 2023. A current policy, titled "Antibiotic Stewardship Guideline," dated as reviewed 11/10/17 and received from the Executive Director on entrance, indicated "Review infections and monitor antibiotic usage patterns. New orders for antibiotic usage will be reviewed during the campus Clinical Care Meeting on regular business days. Obtain and review laboratory reports for campus trends of resistance. Monitor antibiotic resistance patterns (MRSA, VRE...) infections. Include a separate report for the number of residents on antibiotics that did not meet criteria (McGreer Criteria) for active infection. Pharmacy provider will assist in review of all antibiotic usage		prescribed have the potential to be affected. All current antibiotic use was reviewed, and infection control binder updated and ongoing monitoring to continue. IP Nurse has been educated on using the McGeer Criteria to ensure appropriate antibiotic justification. **3)** As a measure of ongoing compliance, the DHS, or designee, will complete audits of the infection control binder to ensure the antibiotic stewardship program is being completed/followed per policy weekly x4 week, weekly every other week and then monthly for 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. The systemic changes will be completed by January 15, 2024.	

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	for appropriateness...." 3.1-18(b)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 13, 14, 18, 19 and 20, 2023 Facility number: 012285 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed January 3, 2024.	R 0000	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, true representation of the quality of care provided, and the living environment provided to the residents of Creasy Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual			

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	resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 6 of 7 residents reviewed for signed service plans. (Resident 52, 53, 7, 34, 3 and 29) Findings include: 1. The record for Resident 52 was reviewed on 12/13/2023 at 2:45 p.m. Diagnoses included, but were not limited to, hypertension and atrial fibrillation. A service plan was not signed by the resident or resident's representative for 2023.	R 0217	1)Residents 52, 53, 7, 34, 3 and 29 were affected. No adverse effects noted. **2)** All like resident's service plans reviewed to ensure they are signed by the resident or POA. **3)** DHS/Designee will audit 5 residents weekly x4 weeks, then every other week x2 months and then monthly x 3 months to ensure all services plans are signed. Education provided to nurses on the Service Plan policy and ensuring it is signed by resident or POA.	01/15/2024

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	2. The record for Resident 53 was reviewed on 12/13/2023 at 4:20 p.m. Diagnoses included, but were not limited to, congestive heart failure. A service plan was not signed by the resident or resident's representative for 2023. 3. The record for Resident 7 was reviewed on 12/13/2023 at 2:38 p.m. Diagnoses included, but were not limited to, dementia. A service plan was not signed by the resident or resident's representative for 2023. 4. The record for Resident 34 was reviewed on 12/13/2023 at 4:10 p.m. Diagnoses included, but were not limited to, dementia. A service plan was not signed by the resident or resident's representative for 2023. 5. The record for Resident 3 was reviewed on 12/13/2023 at 4:30 p.m. Diagnoses included, but were not limited to, dementia. A service plan was not signed by the resident or resident's representative for 2023. 6. The record for Resident 29 was reviewed on 12/13/2023 at 2:55 p.m. Diagnoses included, but were not limited to, congestive obstructive pulmonary disease. A service plan was not signed by the resident or resident's representative for 2023. During an interview, on 12/14/2023 at 5:15 p.m., the Executive Director indicated the residents did have a service plan, but it was not signed. The resident signed the service plan when it was		**4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. ="" p="">	

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	discussed with him and his family. He indicated the form should have been signed when discussed. A current facility policy, titled "AL- Evaluation and Service Plan Guidelines," with an effective date of 12/11/2017 and received from the Executive Director on 12/18/2023 at 11:10 a.m., indicated "...The resident and/or responsible party should be notified and documented in the EHR...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to maintain an infection control practice to help prevent the development and transmission of diseases and infection in 1 of 2 assisted living units reviewed for infection control. (the memory care unit) Finding includes: During a tour of the memory care unit, on 12/13/2023 at 12:52 p.m., one (1) of the eight (8) residents with Covid did not have Personnel Protective Equipment (PPE) available for staff utilization.	R 0407	**1)** PPE equipment was made available for staff utilization on memory care unit. Resident 11 was immediately offered a mask and redirected to room. Staff education on memory care participating in activities that are COVID +. Staff educated on appropriate use of PPE. Staff immediately educated on proper donning and doffing techniques. **2)**All memory care residents had the potential to be affected. **3) Education provided to**	01/15/2024

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	During an observation, on 12/13/2023 at 1:01 p.m., Resident 20 wandered into Resident 11's room which was considered a Covid infected room. The door was open and not closed. Resident 20 wandered into Resident 11's bathroom and bedroom. Resident 11 was not in her room and was found in activities without any PPE. During an observation, on 12/13/2023 at 12:56 p.m., Resident 12 was wandering in a hallway of the memory care unit without any PPE. Resident 12 was known to have active Covid. Resident 12 was observed to be escorted by staff member 2 to her room which had an open door. Staff member 2 did not wear the appropriate PPE when returning the resident to her room. No gown, N95 mask, or shield was worn. When staff member 2 exited the resident's room, she did not take off the contaminated PPE she was wearing (gloves and a surgical mask). Staff member 2 did not discard her contaminated PPE and proceeded to attend activities with other memory care residents. During an interview, on 12/13/2023 at 1:20 p.m., with staff member 2 indicated she should have worn the required PPE and discarded her contaminated PPE before doing an activity with other residents. During an interview, on 12/13/2023 at 2:03 p.m., the Memory Care Director indicated resident doors should have been closed, residents were encouraged to wear PPE and stay in their rooms. The staff were aware of the proper infection control procedures and practices for Covid. Staff member 2 did not act appropriately and follow the infection control practice and procedure. A current facility policy, titled "Infection		**memory care director on PPE usage, activities and donning and doffing PPE. All staff that work memory care unit educated on the following: list out.** DHS/designee to round on memory care unit utilizing the following tool weekly **4)** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. ="" p="">	

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	Prevention and Control Program," dated as effective 11/10/2017 and received from the Executive Director on 12/13/2023 at 2:00 p.m., indicated "...The campus has a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases that...Follows accepted national standards...." A document, titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated May 8, 2023, indicated "The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency...Personal Protective Equipment: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing, and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134) ...."			