STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155312	A. BUILDING -- B. WING	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIAN CREEK HEALTHCARE CENTER	240 BEECHMONT DR CORYDON, IN 47112

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/07/24 Facility Number: 000206 Provider Number: 155312 AIM Number: 100284940 At this Emergency Preparedness survey, Indian Creek Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 135 certified beds, with a current census of 124. Quality Review completed on 02/08/24	E 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We request that our plan of correction, monitoring tools and review of systemic changes we have made be considered for a paper compliance desk review. Should you have any questions, feel free to contact me at (812) 738-8127. Sincerely, Samantha Lawson, Regional Director of Operations.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/07/24 Facility Number: 000206 Provider Number: 155312 AIM Number: 100284940	K 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Lawson	RDO	02/26/2024

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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	At this Life Safety Code survey, Indian Creek Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with two separate basements was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on both levels including the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 135 and had a census of 124 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/08/24		is required by the provisions of federal and state law. We request that our plan of correction, monitoring tools and review of systemic changes we have made be considered for a paper compliance desk review. Should you have any questions, feel free to contact me at (812) 738-8127. Sincerely, Samantha Lawson, Regional Director of Operations.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under			

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	18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing system would provide complete coverage over the entire cooking area. Section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. This deficient practice could affect mostly kitchen staff, plus any residents while in the main dining room which was adjacent to and in the same smoke compartment as the kitchen. Findings include: Based on observations on 02/07/24 between 12:00 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, there were no extinguishing nozzles provided directly over the cook top stove and grill under the kitchen range hood. Based on interview at the time of observation, the Maintenance Director agreed there were no extinguishing nozzles provided directly over the cook top stove and grill under the kitchen range hood, and further said the stove and grill were flip flopped with the oven several months ago and that's why the stove and grill were not provided with extinguishing nozzle	K 0324	**K324** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents utilize dining room have potential to be affected. Safe Care immediately contacted to place work order. **Measures/systemic changes put into place to ensure the deficient practice does not recur:**	02/22/2024

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	coverage. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		RDO provided education to ED and Maintenance Director on requirements for Cookie Facilities in accordance with NFPA 96, Standard for Commercial Cooking Operations on 2.22.2024. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Safe Care completed work order on 2/12/2024 to ensure that all piping and nozzles are properly covering the 6B range and griddle to ensure compliance. The Administrator/Designee will observe the range and griddle 5 times per week to ensure adequate coverage x 4 weeks, 2 times per week x 4 weeks, then weekly ongoing. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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