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	03/01/2023

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: 03/01/23 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 121. Quality Review completed on 03/06/23	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 requests 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, Executive Director.	
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: 03/01/23 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	Executive Director	03/20/2023

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 121 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 03/06/23		is required by the provisions of federal and state law. We requests 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, Executive Director.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 38 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10. NFPA 10, Standard for	K 0355	**1. Safecare was immediately contacted to request inspection of fire extinguisher identified on the survey. Attached is letter from Safecare identifying work completed in regards to**	03/27/2023

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	155312	A. BUILDING 01 B. WING	03/01/2023

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	Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect at least 10 residents, staff, and visitors while in the and around the 200-hall lounge/dining room. Findings include: Based on observations on 03/01/23 between 11:45 a.m. and 1:45 a.m. during a tour of the facility with the Maintenance Director and Administrator-in-Training (AIT), the ABC type portable fire extinguisher in the 200-hall lounge/dining room had affixed maintenance tags documenting the date the most recent annual maintenance was performed as October of 2021. All other fire extinguishers in the facility had affixed maintenance tags documenting the date the most recent annual maintenance was performed as October 2022. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve-month period. This finding was reviewed with the Executive Director, Maintenance Director, and AIT during the exit conference. 3-1.19(b)		**200-Hall lounge/dining room fire extinguisher.** **2. This alleged deficient practice could affect staff or residents in the 200-hall lounge/dining room. All other fire extinguishers were observed to ensure timely inspection and tags were in place.** **3. Maintenance Director and Maintenance Assistant were in-serviced on importance of fire extinguishers in compliance with K-355 on 3/15/2023.** **4. Fire extinguishers will be inspected on a monthly basis by Maintenance Director or designee to schedule and ensure compliance with annual Safecare inspection. Executive Director to review process and assure it is followed. Process presented to QAPI for review and additional recommendations when issues arise. Executive Director will review with maintenance fire extinguisher inspection reports, any issues will be immediately corrected.**	

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	2. Based on observation and interview, the facility failed to inspect 1 of 38 portable fire extinguishers each month during the past 12-month period. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect at least 10 residents, staff,			

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	and visitors while in and around the 200-hall lounge/dining room. Findings include: Based on observations on 03/01/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director and Administrator-in-Training (AIT), the fire extinguisher in the 200-hall lounge/dining room had not been inspected monthly since September of 2022. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned portable fire extinguisher had not been inspected monthly since September of 2022. This finding was reviewed with the Executive Director, Maintenance Director, and AIT during the exit conference. 3.1-19(b)			
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 5 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire	K 0500	**1. FM Global was immediately contacted to request inspection of boilers identified on the survey. Attached is inspection from FM identifying work completed in regards to boiler**	03/27/2023

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	emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations on 03/01/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director and Administrator-in-Training (AIT), the three of five fuel-fired water heaters in the facility had certificates with expiration dates of 10/19/22. Based on interview at the time of observation, the Maintenance Director confirmed the expiration dates of the three fuel-fired water heaters. This finding was reviewed with the Executive Director, Maintenance Director, and AIT during the exit conference. 3.1-19(b)		**inspections.** **2. This alleged deficient practice could affect all staff, residents, and visitors in the facility. All other fuel-filled water heaters had current inspection certificates.** **3. Maintenance Director and Maintenance Assistant were in-serviced on importance of fuel-fired water heaters inspection certificates in compliance with K-500 on 3/15/2023.** **4. The fuel-fired water heaters inspection certificates will be observed on a monthly basis by Maintenance Director or designee to schedule and ensure compliance with routine fuel-fired water heater inspections. Executive Director to review process and assure it is followed. Process presented to QAPI for review and additional recommendations when issues arise. Executive Director will review fuel-fired water heater inspection reports and any issues will be immediately corrected.**	