STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155312	A. BUILDING 00 B. WING	06/13/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00459799. Complaint IN00459799 - Federal/State deficiency related to the allegations is cited at F656. Survey date: June 13, 2025 Facility number: 000206 Provider number: 155312 AIM number: 100284940 Census Bed Type: SNF/NF: 125 Total: 125 Census Payor Type: Medicare: 2 Medicaid: 96 Other: 27 Total: 125 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2025.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on June 13, 2025.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Rodney Jackson HFA**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview and record review, the facility failed to ensure an intervention was in place related to staff monitoring the placement and functionality of a resident's bed alarm for 1 of 3 residents reviewed for development and implementation of a care plan interventions. (Resident B)	F 0656	1) Residents B was not harmed by the alleged deficient practice. Residents B was part of a confidential survey and will not be identified.	06/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Chambers	RN/DNS	06/20/2025

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	Findings include: During an observation, on 6/13/25 at 10:13 a.m., a bed alarm was observed in place on Resident B's bed. The clinical record for Resident B was reviewed on 6/13/25 at 9:17 a.m. The resident's diagnoses included, but were not limited to, epilepsy and convulsions. The care plan, initiated on 5/16/25 and revised on 6/8/19, indicated the resident was at risk for falls related to seizures and the resident was to have a bed alarm in place for safety. The Internal Dispute Resolution note, dated 5/19/25 at 10:36 a.m., indicated Resident B had an unwitnessed fall. The resident was found lying on the floor next to the bed. The resident's bed alarm cord was ripped from the alarm. The resident's care plan was updated with a new cordless alarm placed on resident's bed. The physician's order, dated 6/13/25, indicated the resident had a bed alarm in place and staff were to check the placement and verify functioning every shift. The clinical record lacked documentation of an order for staff to check the placement and function of the bed alarm every shift prior to 6/13/25. During an interview, on 6/13/25 at 11:15 a.m., the Regional Director of Clinical Operations indicated the facility did not have a policy on bed alarms. During an interview, on 6/13/25 at 11:25 a.m., the		2) All residents who have a bed alarm could be affected by the alleged deficient practice. A 30-day lookback of all alarms was completed to ensure all have order to monitor for placement and functioning. Any identified concerns were immediately addressed. 3) The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to alarms including ensuring an order is placed to monitor resident alarm for proper placement and function each shift while alarm is in place. 4) The DNS/designee will audit all residents with alarms weekly for no less than 3 months and compliance is maintained to ensure an order is placed to monitor resident alarm for proper placement and function each shift while alarm is in place. The Administrator/Designee will present 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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	Director of Nursing indicated staff should be checking the placement and function of the alarm every shift. This Citation relates to Complaint IN00459799 3.1-35(b)(1)			