PRINTED: 07/01/2025
FORM APPROVED
OMP NO. 0028 030

CENTERS FOI	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155312	A. BUILDING <u>00</u> B. WING		COMPLETED 06/13/2025	
		100012		ADDRESS CITY STATE ZID COD	00/10/2020	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
INDIAN (CREEK HEALTHC	ARE CENTER		DON, IN 47112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
-1.3, 55	This visit was for the Investigation of Complaint		F 0000	Preparation or execution of		
	IN00459799.	-		this plan of correction does	not	
				constitute admission or		
	_	59799 - Federal/State deficiency		agreement of provider of the	!	
	related to the alleg	ations is cited at F656.		truth of the facts alleged or		
		12 2025		conclusions set forth on the		
	Survey date: June 13, 2025			State of Deficiencies. The Plant of Correction is prepared an		
	Facility number: (000206		of Correction is prepared an executed solely because it is		
	Provider number: 155312 AIM number: 100284940			required by the position of	'	
				Federal and State Law.		
				The Plan of Correction is		
	Census Bed Type:			submitted in order to respon	ıd	
	SNF/NF: 125 Total: 125			to the allegation of		
				noncompliance cited during		
	Census Payor Tyn	۹۰		the complaint survey conducted on June 13, 2025.		
	Census Payor Type: Medicare: 2 Medicaid: 96			Please accept this plan of	·	
				correction as the provider's		
	Other: 27			credible allegation of		
	Total: 125			compliance.		
				The facility would like to		
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.			respectfully request a desk		
				review.		
	Quality review con	mpleted on June 17, 2025.		Rodney Jackson HFA		
F 0656	483.21(b)(1)(3)					
SS=D		ent Comprehensive Care Plan				
Bldg. 00	Bovolop, implom	one Comprehensive Care Flan				
	Based on observat	ion, interview and record	F 0656		06/23/2025	
	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)			1) Residents B was not harm		
				by the alleged deficient practic	ce.	
				Residents B was part of a		
				confidential survey and will no	t be	
				identified.		
1	mici ventions. (Res	sident Dj				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Jennifer Chambers RN/DNS 06/20/2025

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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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155312	·		06/13/	06/13/2025	
			1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ECHMONT DR		
INDIAN CREEK HEALTHCARE CENTER					DON, IN 47112		
II ADIMIN		ALL OLIVILIA	_	JONIL	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		-	TAG	DEFICIENCY)	DATE	
					2) All residents who have a be		
	Findings include:				alarm could be affected by the		
					alleged deficient practice. A		
	_	ion, on 6/13/25 at 10:13 a.m., a			_	ay lookback of all alarms was pleted to ensure all have order	
		rved in place on Resident B's		I	1 · · · · · · · · · · · · · · · · · · ·		
	bed.				to monitor for placement and		
					functioning. Any identified		
		for Resident B was reviewed	concerns were immediately				
		n.m. The resident's diagnoses			addressed.		
		not limited to, epilepsy and			0.71 5110/5		
	convulsions.				3) The DNS/Designee held an		
					in-service for all nurses to pro		
		ated on 5/16/25 and revised on		education and expectations as it			
		e resident was at risk for falls		relates to alarms including			
		and the resident was to have a		ensuring an order is placed to			
	bed alarm in place for safety.				monitor resident alarm for pro		
					placement and function each	shift	
	The Internal Dispute Resolution note, dated				while alarm is in place.		
	5/19/25 at 10:36 a.m., indicated Resident B had an				() TI DNO/I		
	unwitnessed fall. The resident was found ly the floor next to the bed. The resident's bed		4) The DNS/designee will audit all				
					residents with alarms weekly f	or	
		m the alarm. The resident's	no less than 3 months and				
	care plan was updated with a new cordless alarm			compliance is maintained to			
	placed on resident's bed.			ensure an order is placed to			
	The physician's order, dated 6/13/25, indicated the				monitor resident alarm for proplacement and function each		
					while alarm is in place.	DIIIIL	
	resident had a bed alarm in place and staff were to check the placement and verify functioning every shift.				wille alaitii is iii piace.		
					The Administrator/Designee w	<i>i</i> ill	
	offit.			present the results of these audits			
	The clinical record lacked documentation of an			monthly to the QAPI committee			
	order for staff to check the placement and			for no less than 3 months. Any			
	function of the bed alarm every shift prior to			patterns that are identified will		-	
	6/13/25.			have an Action Plan initiated. The			
	During an interview, on 6/13/25 at 11:15 a.m., the				QAPI committee will determine		
					when 100% compliance is	_	
Regional Director of Clinical Operations indicated the facility did not have a policy on bed alarms.				achieved or if ongoing monitor	rina		
				is required.	9		
				io roquirou.			
	During an interview	y, on 6/13/25 at 11:25 a.m., the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/13/2025		
NAME OF PROVIDER OR SUPPLIER INDIAN CREEK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 240 BEECHMONT DR CORYDON, IN 47112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	checking the placen every shift.	indicated staff should be nent and function of the alarm s to Complaint IN00459799					

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