CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155312	B. WING		03/28/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 240 BEECHMONT DR CORYDON, IN 47112				
(X4) ID	SHWWARV	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	Billion,		DATE	
Bldg			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			
	Quality Review con	mpleted on 04/02/25		you have any questions, feel f to contact me at (812) 738-81 Sincerely, Rodney Jackson, Administrator.			
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State was conducted by the Indiana Ith in accordance with 42 CFR	K 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/o	or		
	483.90(a). Survey Date: 03/28 Facility Number: 0 Provider Number: AIM Number: 100	8/25 000206 155312		execution of this plan of corre- does not constitute admission agreement by the provider of 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	ction of the		

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

(X6) DATE

TITLE

Jill McCarty LPN/Administrator in Training 04/14/2025

Any defiency statement 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 disclodays 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) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 240 BEECHMONT DR CORYDON, IN 47112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	At this Life Safety On Healthcare Center with Requirements Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one story facility basements was detected to construction and was facility has a fire all smoke detectors on corridors, spaces op resident sleeping rocapacity of 135 and time of this survey.	Code survey, Indian Creek vas found not in compliance for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Ity with two separate rmined to be of Type V (000) as fully sprinklered. The arm system with hard wired both levels including the en to the corridors, and all toms. The facility has a had a census of 119 at the dents have customary access d all areas providing facility etered.			is required by the provisions of federal and state law. We requite that our plan of correction, monitoring tools and review of systemic changes we have make considered for a paper compliance desk review. Show you have any questions, feel fit to contact me at (812) 738-812 Sincerely, Rodney Jackson, Administrator.	ade ald ree	
K 0226 SS=E Bldg. 01	failed to ensure 1 of sets were arranged t latch. LSC section assemblies in horizo or automatic-closing Standard for Fire Do Protectives, section doors shall swing ea	on and interview, the facility fover 3 horizontal exit fire door o automatically close and 7.2.4.3.10 requires all fire door ontal exits shall be self-closing g. In addition NFPA 80, the bors and Other Opening 6.1.4.2.1 states self-closing asily and freely and shall be	K 0.	226	="" b=""> ="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">		04/14/2025
	to close and latch ea	sing device to cause the door ach time it is opened. This ct 24 residents in 2 smoke			="" p=""> ="" b="">		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2025	
	PROVIDER OR SUPPLIE		240 BE	ADDRESS, CITY, STATE, ZIP COD EECHMONT DR DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION n occupied.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ="" p=""> -"" p="">	(X5) COMPLETION DATE
	Findings include: Based on observation of the facility (MD) on 03/28/25 set near Resident Finding horizontal exit and tested the doors fait to the door latching properly. The MD consistently operation of records rev	ions and interview during a with the Maintenance Director at 11:50 a.m., the rated fire door doom # 124 was used as a as a smoke barrier. When led to latch into the frame due g hardware not functioning agreed the door would not		="" p=""> ="" p=""> ="" p="""> ="" p="""> ="" b="""> ="" b="""> ="" b="""> Corrective action for the residents found have been affected by the def practice: No residents were affected by alleged deficient practice. Corrective action taken for the residents having the potential be affected by the same defic practice: All residents near fire door ne room 124 has the potential to affected. Maintenance adjuste the hardware on fire door to o proper working order. Measures/systemic changes p into place to ensure the defici practice does not recur: RDO provided education to E and Maintenance Director on requirements NFPA 80, The Standard for Fire Doors and C Opening Protectives on 04/14/2025. Corrective actions to be monitored to ensure the defici practice will not recur: Maintenance Director comple work order on 03/28/2025 to ensure that the hardware was adjusted to obtain working ord ensure compliance. The Administrator/Designee	ficient the pse to ient ar be ed btain put ent D Other ient deted
1				observe the fire door for	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155312		A. BUILDING <u>01</u> B. WING			COMPLETED 03/28/2025	
				_	ADDRESS OF A STATE THE SOR	00/20/		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ECHMONT DR			
INDIAN (CREEK HEALTHC	ARE CENTER			OON, IN 47112			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
					appropriate closure 5 times pe			
					week to ensure adequate clos			
					x 4 weeks, 2 times per week			
					weeks, then weekly ongoing.			
					results of these audits monthly the QAPI committee for no les	-		
					than 3 months. Any patterns			
					are identified will have an Acti			
					Plan initiated. The QAPI			
					committee will determine whe	n		
					100% compliance is achieved	or if		
					ongoing monitoring is required	d.		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2025		
	PROVIDER OR SUPPLIER CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0321	NFPA 101		="" p=""> ="" p=""> ="" p="">			
SS=E Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 18 residents, as well as staff and visitors in the kitchen/dining area. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 03/28/25 at 12:25 p.m., the Kitchen Door into the serving area, equipped with a self/closing device, failed to self/close and latch into the door frame. The kitchen area contained large 30 gallon plus trash receptacles. This finding was acknowledged by the MD at the time of records review and again at the exit conference with the MD and Administrator in Training present. 3.1-19(b)	K 0321	="" b=""> ="" p=""> ="" span="">Corrective action the residents found to have be affected by the deficient practi No residents were affected by alleged deficient practice. Corrective action taken for tho residents having the potential be affected by the same defici practice: All residents have the potential be affected. Maintenance adjut the hardware on fire door to of proper working order. Measures/systemic changes p into place to ensure the deficie practice does not recur:	een ce: the sse to ent al to asted btain		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 03/28/2025	
	PROVIDER OR SUPPLIE		24	TREET ADDRESS, CITY, STATE, ZIP 40 BEECHMONT DR ORYDON, IN 47112	COD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		FROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE AG DEFICIENCY)	SHOULD BE COMPLETION DATE
				RDO provided educa and Maintenance Dirrequirements NFPA 8 Standard for Fire Doc Opening Protectives 04/14/2025. Corrective actions to to ensure the deficier not recur: Maintenance Director work order on 03/28/3 ensure that the hardwadjusted to obtain work ensure compliance. The Administrator/De observe the fire door appropriate closure 5 week to ensure adeq x 4 weeks, 2 times per weeks, then weekly or results of these audit the QAPI committee than 3 months. Any pare identified will have Plan initiated. The QAC committee will detern 100% compliance is a ongoing monitoring is """ span=""> ="" span="">	ation to ED ector on 30, The ors and Other on be monitored at practice will or completed 2025 to vare was orking order to esignee will for it times per uate closure er week x 4 ongoing. The s monthly to for no less patterns that e an Action API nine when achieved or if

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO			COMPL	LETED
		155312	B. WING 03/28/2025			/2025	
			<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	S.					
INDIANIC	CREEK HEALTHCA	DE CENTED	240 BEECHMONT DR CORYDON, IN 47112				
INDIAN	REEN HEALTHUA	RE CENTER		CORTL	JON, IN 47112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
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					="" b="">		
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					="" p="">		
K 0351	NFPA 101						
SS=F		Installation					
Bldg. 01	Sprinkler System	- installation					
Diag. 01	Rased on observation	on and interview, the facility	I V O	251	="" b="">		04/16/2025
		lug or caps for 1 of 1 fire	K 0	331	="" p="">		04/16/2023
	_	ion (FDC). NFPA 25, Standard			- p- > ="" p="">		
	_	Festing, and Maintenance of			- p- >		
	_	rotection Systems, 2011			="" p="">		
		Department Connections. 13.7.1			="" p="">		
		nnections shall be inspected			="" p="">		
	quarterly to verify t				="" b="">		
		nent connections are visible			="" p="">		
	and accessible.				="" p="">		
	(2) Couplings or sw	rivels are not damaged and			Corrective action for the resid	lents	
	rotate smoothly.	S			found to have been affected b		
		e in place and undamaged.			deficient practice:		
		lace and in good condition.			No residents were affected by	the	
	(5) Identification sign	_			alleged deficient practice.		
	(6) The check valve				· '		
		rain valve is in place and			Corrective action taken for the	se	
	operating properly.	-			residents having the potential	to	
		nent connection clapper(s) is in			be affected by the same defici		
	place and operating				practice:		
		ice could affect all residents.			[
	_				All residents have the potentia	al to	
	Findings include:				be affected. Fire cap will be		

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replaced by SafeCare on 4/16/25.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155312	B. WING 03/28/		2025			
				CTDEET 4	ADDRESS SITE STATE SID COD			
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
INIDIANI		DE CENTED	240 BEECHMONT DR					
INDIAN	CREEK HEALTHCA	ARE CENTER		CORYL	OON, IN 47112			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		T.C.	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
		on and interview during a tour						
		the Maintenance Director (MD)			Measures/systemic changes p	nut		
		p.m., the FDC was not			into place to ensure the deficie			
		that were functional. 1 of 2			practice does not recur:) I I C		
		broken into pieces which were			practice does not recur.			
	1	OC line. Based on interview at			RDO provided education to EI	,		
	1				and Maintenance Director on	,		
	the time of observation, the Maintenance Director stated perhaps a recent hail storm had broken the					ord		
	plastic cover cap.	ent nan Storm nau bloken the			requirements NFPA 25, Stand			
	piasue cover cap.				for the Inspection, Testing and			
	This find:	drawaydadaad by the MD -44b-			Maintenance of Water Based			
	This finding was acknowledged by the MD at the time of records review and again at the exit				Protection Systems 2011 edition			
					13.7 Fire department connecti	ons		
	conference with the MD and Administrator in				on 4/14/2025.			
	Training present.				Fire cap will be replaced by			
	21 104)				SafeCare on 4/16/25 to ensure	Э		
	3.1-19(b)				compliance.			
					The Administrator/Designee w	'Ill		
					inspect fire department			
					connections 5 times per week			
					ensure they are in place and r			
					broken 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 F	Plan		
					initiated. The QAPI committee	will		
					determine when 100% complia	ance		
					is achieved or if ongoing			
					monitoring is required.			
					="" p="">			
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					="" p="">			
					="" p="">			
K 0353	NFPA 101							
SS=E	Sprinkler System	- Maintenance and Testing						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155312	B. W	B. WING 03/28/2025			/2025
				CERTE	A DODDEGG CHEV CHARE THE COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
INIBIANI		A DE OENTED			ECHMONT DR		
INDIAN	CREEK HEALTHC	ARE CENTER		CORYL	DON, IN 47112		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		BROWDENG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
ĺ	Based on observati	ion and interview, the facility	K 0	353	="" b="">		04/16/2025
		the ceiling construction in a	120		="" p="">		0 11 10/2020
		er in accordance with NFPA 13,			="" p="">		
		stallation of Sprinkler Systems.			="" b="">		
		ition, Section 6.2.7.1 states			="" p="">		
		s, or other devices used to			="" p="">		
	_	space around a sprinkler shall			="" p="">		
		ll be listed for use around a			="" b="">		
		icient practice could affect staff			="" p="">		
	and up to 5 staff ar				="" p="">		
	und up to 3 starr ar	id visitors.			Corrective action for the reside	ents	
	Findings include:				found to have been affected b		
	i mamga merade.				deficient practice:	y tile	
	Based on observati	ion and interview during a tour			No residents were affected by	tho	
		the Maintenance Director (MD)			alleged deficient practice.	uic	
	-	50 p.m., in the basement stair			alleged delicient practice.		
		missing sprinkler head			Corrective action taken for the	000	
		ng in the sprinkler head not			residents having the potential		
		ng the hole around the sprinkler			be affected by the same defici		
		erview at the time of			practice:	EIIL	
		aintenance Director agreed the			practice.		
		ea was missing the escutcheon.			All residents have the netentic	al to	
	alorementioned are	ea was missing the escutcheon.			All residents have the potentia		
	This finding was a	almost doed by the MD at the			be affected. Fire escutcheon p		
		cknowledged by the MD at the riew and again at the exit		will be replaced by SafeCare on		JII	
		e MD and Administrator in			4/16/25.		
					N4	4	
	Training present.				Measures/systemic changes p		
	2.1.10(1)				into place to ensure the deficie	ent	
	3.1-19(b)				practice does not recur:		
						_	
					RDO provided education to El	J	
					and Maintenance Director on	ll	
					requirements NFPA 13, Stand		
					for the Installation of Sprinkler	•	
					Systems 4/14/2025.		
					Fire escutcheon plate ordered	and	
					will be put in by Safe Care on		
					4/16/25 to ensure compliance		
					The Administrator/Designee w	/ill	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		A. BUILDING 01 B. WING		COMPLETED 03/28/2025			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 240 BEECHMONT DR CORYDON, IN 47112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0761 SS=E Bldg. 01	Based on observation interview, the facility inspection and testing assemblies were considered in the same of the	ection & Testing - Doors on, records review, and by failed to ensure annual ag of at least 1 fire door inpleted in accordance of LSC inicating openings in dividing a by 19.1.1.4.1 shall be irridors and shall be protected using fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table ected by approved, listed, emblies and fire window accompanying hardware, colosing devices, anchorage, ince with the requirements of for Fire Doors and Other accompt as otherwise	K 0761	inspect sprinklers 5 times per week to ensure all state plates escutcheons or other devices used to cover the annular spataround a sprinkler are in place weeks, 2 times per week x 4 weeks, then weekly ongoing. results of these audits monthly the QAPI committee for no less than 3 months. Any patterns than 3 months. Any patterns than 3 months are identified will have an Activation of the plan initiated. The QAPI committee will determine when 100% compliance is achieved ongoing monitoring is required entry the permit of the permit	ce 2 x 4 The 7 to 2s chat on or if		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155312		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/28/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 240 BEECHMONT DR CORYDON, IN 47112			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	specified in this Codor assemblies shall be shan annually, a inspection shall be shy the AHJ. NFPA assemblies shall be sides to assess the cassembly. NFPA 80 the following items (1) No open holes ceither the door or fr (2) Glazing, vision are intact and secure equipped. (3) The door, frame noncombustible thr and in working orded damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open process before the active shadow (8) Latching hardwards.	r breaks exist in surfaces of ame. light frames, and glazing beads ely fastened in place, if so , hinges, hardware, and eshold are secured, aligned, er with no visible signs of sing or broken. do not exceed clearances .3.1.7. device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the	TAG	="" p=""> Corrective action for the residund to have been affected by deficient practice: No residents were affected by alleged deficient practice. Corrective action taken for the residents having the potential be affected by the same deficient practice: All residents have the potential be affected. Annual Inspection the Transfilling room complet by Maintenance Director on 4/14/2025. Measures/systemic changes into place to ensure the deficient	dents by the y the ose to cient al to n for ed	
	prohibit operation a frame.	rare items that interfere or re not installed on the door or		practice does not recur: RDO provided education to E and Maintenance Director on		
	have been performe (11) Gasketing and inspected to verify	ications to the door assembly d that void the label. edge seals, where required, are heir presence and integrity. ice could affect 15 residents.		requirements NFPA 80, Stanfor Fire Doors and Other Ope Protectives. Sprinkler System 4/14/2025.	ning	
	Findings include: Based on records re	view and interview with the		Annual Inspection for the Transfilling room completed by Maintenance Director on 4/14	-	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155312	(X2) MULTIPLE COM A. BUILDING B. WING		ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/28/2025	
NAME OF PROVIDER OR SUPPLIER INDIAN CREEK HEALTHCARE CENTER				240 BE	ADDRESS, CITY, STATE, ZIP COD ECHMONT DR DON, IN 47112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	Maintenance Direct a.m. no documental the fire door asseming room was available observation during Transfilling room h assembly. Based or records review and the annual fire door the Oxygen Room listed fire door insp individual sheets w Oxygen Room being This finding was actime of records review	tor (MD) on 03/28/25 at 11:40 tion of an annual inspection for bly at the Oxygen Transfilling for review. Based on the tour the Oxygen had a 90-minute fire door interview at the time of observation, the MD stated rinspection documentation for was not available. There were 9 hections on the map, only 8 here available for review, the high the missing sheet. Eknowledged by the MD at the hew and again at the exit had and Administrator in			to ensure compliance. The Administrator/Designee wobserve the transfilling oxyger room 5 times per week to ensure compliance in place x 4 weeks times per week x 4 weeks, the weekly ongoing. The results of these audits monthly to the Quantities for no less than 3 months. Any patterns that are identified will have an Action Finitiated. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required. ="" p=""> ="" p="""> ="" p="""> ="" p="""> ="" p=""">	n ure s, 2 en f API e Plan	

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