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	03/28/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/28/25 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 119. Quality Review completed on 04/02/25	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, Rodney Jackson, Administrator.	
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: 03/28/25 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
Jill McCarty	LPN/Administrator in Training	04/14/2025

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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	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 119 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 04/02/25		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, Rodney Jackson, Administrator.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Based on observation and interview, the facility failed to ensure 1 of over 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 24 residents in 2 smoke	K 0226	=" b=""> =" p=""> =" p=""> =" b=""> =" p=""> =" p=""> =" p=""> =" b=""> =" p=""> =" p=""> =" b=""> =" p=""	04/14/2025

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	compartments when occupied. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 03/28/25 at 11:50 a.m., the rated fire door set near Resident Room # 124 was used as a horizontal exit and as a smoke barrier. When tested the doors failed to latch into the frame due to the door latching hardware not functioning properly. The MD agreed the door would not consistently operate as engineered. 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)		=”” p=””> =”” p=””> =”” p=””> =”” b=””>=”” b=””>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 near fire door near room 124 has the potential to be affected. Maintenance adjusted the hardware on fire door to obtain proper working order. Measures/systemic changes put into place to ensure the deficient practice does not recur: RDO provided education to ED and Maintenance Director on requirements NFPA 80, The Standard for Fire Doors and Other Opening Protectives on 04/14/2025. Corrective actions to be monitored to ensure the deficient practice will not recur: Maintenance Director completed work order on 03/28/2025 to ensure that the hardware was adjusted to obtain working order to ensure compliance. The Administrator/Designee will observe the fire door for	

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			appropriate closure 5 times per week to ensure adequate closure 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. ="" p="">="" p="">="" b="">="" p="">="" p="">="" p="">="" b="">="" p="">="" p="">="" b="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" b="">="" p="">="" p="">="" b=""	

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			=""> =""> =""> ="">	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 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	=""> =""> =""> =""> =""> =""> =""> =""> =""> =""> =""> =""> span="">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 have the potential to be affected. Maintenance adjusted the hardware on fire door to obtain proper working order. Measures/systemic changes put into place to ensure the deficient practice does not recur:	04/14/2025

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			RDO provided education to ED and Maintenance Director on requirements NFPA 80, The Standard for Fire Doors and Other Opening Protectives on 04/14/2025. Corrective actions to be monitored to ensure the deficient practice will not recur: Maintenance Director completed work order on 03/28/2025 to ensure that the hardware was adjusted to obtain working order to ensure compliance. The Administrator/Designee will observe the fire door for appropriate closure 5 times per week to ensure adequate closure 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. ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""	

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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 have the potential to be affected. Fire cap will be replaced by SafeCare on 4/16/25. | |
| K 0351 SS=F Bldg. 01 | NFPA 101
Sprinkler System - Installation

Based on observation and interview, the facility did not ensure the plug or caps for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following:
(1) The fire department connections are visible and accessible.
(2) Couplings or swivels are not damaged and rotate smoothly.
(3) Plugs or caps are in place and undamaged.
(4) Gaskets are in place and in good condition.
(5) Identification signs are in place.
(6) The check valve is not leaking.
(7) The automatic drain valve is in place and operating properly.
(8) The fire department connection clapper(s) is in place and operating properly.
This deficient practice could affect all residents.

Findings include: | K 0351 | | 04/16/2025 |

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	Based on observation and interview during a tour of the facility with the Maintenance Director (MD) on 03/28/25 at 1:30 p.m., the FDC was not provided with caps that were functional. 1 of 2 FDC line caps were broken into pieces which were laying inside the FDC line. Based on interview at the time of observation, the Maintenance Director stated perhaps a recent hail storm had broken the plastic cover cap. 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)		Measures/systemic changes put into place to ensure the deficient practice does not recur: RDO provided education to ED and Maintenance Director on requirements NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems 2011 edition, 13.7 Fire department connections on 4/14/2025. Fire cap will be replaced by SafeCare on 4/16/25 to ensure compliance. The Administrator/Designee will inspect fire department connections 5 times per week to ensure they are in place and not 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 Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. ="" p=""> ="" p=""> ="" p=""> ="" p="">	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Based on observation and interview, the facility failed to maintain the ceiling construction in a basement stair tower in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 5 staff and visitors. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) on 03/28/25 at 12:50 p.m., in the basement stair tower, there was a missing sprinkler head escutcheon resulting in the sprinkler head not completely covering the hole around the sprinkler head. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned area was missing the escutcheon. 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 0353	=”” b=”“> =”” p=”“> =”” p=”“> =”” b=”“> =”” p=”“> =”” p=”“> =”” p=”“> =”” b=”“> =”” p=”“> =”” p=”“> 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 have the potential to be affected. Fire escutcheon plate will be replaced by SafeCare on 4/16/25. Measures/systemic changes put into place to ensure the deficient practice does not recur: RDO provided education to ED and Maintenance Director on requirements NFPA 13, Standard 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 will	04/16/2025

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			inspect sprinklers 5 times per week to ensure all state plates, escutcheons or other devices used to cover the annular space around a sprinkler are in place 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. ="" p="">=""> ="" p="">="">	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise	K 0761	="" b="">="" p="">="" p="">="" b="">="" p="">="" p="">="" p="">="" p="">="" b="">="" p="">="" p="">="" p="">="" b="">="" p="">="" p="">="" b="">="" p=""	04/14/2025

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	specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 15 residents. Findings include: Based on records review and interview with the		=”” p=””> =”” p=””> =”” p=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> 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 have the potential to be affected. Annual Inspection for the Transfilling room completed by Maintenance Director on 4/14/2025. Measures/systemic changes put into place to ensure the deficient practice does not recur: RDO provided education to ED and Maintenance Director on requirements NFPA 80, Standard for Fire Doors and Other Opening Protectives. Sprinkler Systems 4/14/2025. Annual Inspection for the Transfilling room completed by Maintenance Director on 4/14/25	

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	Maintenance Director (MD) on 03/28/25 at 11:40 a.m. no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room had a 90-minute fire door assembly. Based on interview at the time of records review and observation, the MD stated the annual fire door inspection documentation for the Oxygen Room was not available. There were 9 listed fire door inspections on the map, only 8 individual sheets were available for review, the Oxygen Room being the missing sheet. 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)		to ensure compliance. The Administrator/Designee will observe the transfilling oxygen room 5 times per week to ensure compliance in place 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. ="" p=""> ="" p=""> ="" p="">	