STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155312	A. BUILDING 01 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIAN CREEK HEALTHCARE CENTER	240 BEECHMONT DR CORYDON, IN 47112

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K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/28/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/25/25 Facility Number: 000206 Provider Number: 155312 AIM Number: 100284940 At this PSR 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 PSR survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/01/25	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 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.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill McCarty	LPN/AIT	05/12/2025

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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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 compartments when occupied. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) And Interim Administrator (IAD) on 04/25/25 at 9:50 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 IAD and MD agreed the door would not consistently operate as engineered and failed several times to close and latch. The MD stated that he had tested the door daily and was surprised it wasn't operating properly. The MD and IAD agreed the door still needed attention. This finding was acknowledged by the MD and IAD at the time of discovery and again at the exit conference with the and IAD present. This deficiency was cited on 03/18/25. The facility failed to implement a systemic plan of correction	K 0226	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:	04/28/2025

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	to prevent recurrence. 3.1-19(b)		All residents near fire door near room 124 has the potential to be affected. Safe Care replaced internal push bar top latch. 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.	

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			Corrective actions to be monitored to ensure the deficient practice will not recur: New internal push bar top latch was replaced by Safe Care 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	

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			100% compliance is achieved or if ongoing monitoring is required.	

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