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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Creek Healthcare Center	240 Beechmont Dr Corydon, IN 47112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B)Findings include:The review of the Incident Report, dated 10/29/25, indicated that an unnamed Certified Nurse Aide (CNA) did not like how Housekeeper 5 spoke to Resident B. The resident was removed from the interaction. The Director of Nursing (DON) was notified, and the housekeeper was removed from the floor. The resident was immediately asked and did not recall hearing what the housekeeper said. The physician, family, and Executive Director (ED) were notified. The care plan was updated. A psychosocial follow-up would be conducted daily for 3 days. The investigation was completed and abuse was unsubstantiated. The record for Resident B was reviewed on 11/19/25 at 9:10 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hallucinations, psychosis, atherosclerotic heart disease, hypertensive heart disease, hyperlipidemia, type 2 diabetes mellitus, disorientation, anxiety disorder, dementia with behavioral disturbance, hyperglycemia, hypertension, delirium, and post-traumatic stress disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 7/18/25, indicated the resident was severely cognitively impaired. The care plan, dated 8/8/25 and revised 10/25/25, indicated the resident wandered aimlessly from place to place. The interventions, included, but were not limited to, assess for hunger, thirst, ambulation, toileting needs, to complete a wandering evaluation, upon admission or re-admission, quarterly, and as needed (PRN), to notify staff of the wandering risk, to provide diversionary tactics or activities as needed, to redirect the resident when appropriate, to provide structured activities at times of increased wandering, diversional tasks, redirection of ambulation pattern, and utilization of safe wandering areas.The behavior note, dated 10/26/25 at 3:13 p.m., indicated the resident was awake all day. He was cooperative with staff and took his medications without difficulty. He was sitting in the north lounge with peers having snacks at times. The behavior note, dated 10/28/25 at 1:31 p.m., indicated the resident had no behaviors this shift. The resident was sitting in the common area eating with other residents at this time. The DON note, dated 10/29/25 at 1:55 p.m., indicated a full assessment was completed of the resident, status post staff discussion of not liking how the resident was talked to. The resident did not hear the allegations indicated and had no recall of the incident. The resident was at his psychosocial baseline status without distress, complaints of pain or discomfort, and was without any new findings upon assessment. The resident carried out his daily activities as usual. Family was notified of the incident and the plan, and they were agreeable without questions or comments. The local police department was notified of the incident as reported to the Indiana State Department of Health by the Executive Directo r. The case number was 25C3906 by Officer 8. No date was documented.The Skin-Shower and Wound Assessment sheet was completed on the resident on 10/29/25. No skin areas were documented. During the investigation by the facility of the incident on 10/29/25, the following staff were interviewed with the following statements:CNA 3 was with CNA 6, assisting a resident to their room when the Housekeeper 5 turned to Resident B and said, Stop f*****g following me. CNA 3 then went to Resident B to remove him from the interaction while CNA 6 continued assisting the other resident to their room. CNA 3 then called the nurse to notify her of the interaction.CNA 6 was with (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 3, assisting a resident to their room when Housekeeper 6 turned to Resident B and said, Stop f*****g following me. CNA 3 went to remove Resident B from the conversation while CNA 6 continued to assist another resident to their room.During the investigation by the facility, 62 residents were interviewed as to whether they felt safe and if abuse had occurred. No complaints were identified. The Abuse Education, dated 10/29/25, indicated the names of staff in attendance by their signature. The Housekeeping Schedule, dated 9/21/25 through 11/1/25, indicated Housekeeper 5 worked an eight-hour shift from 6:30 a.m. to 2:30 p.m., on 10/28/25 and an eight-hour shift from 6:30 a.m. to 2:30 p.m., on 10/29/25.The Social Service Designee Admissions note, dated 10/30/25 at 9:06 a.m., indicated the resident remained at psychosocial baseline. The resident remained in his room per his choice.The Social Services Admissions note, dated 10/30/25 at 9:09 a.m., indicated the resident remained at psychosocial baseline. The resident was awake in his room. He ate breakfast in his room per his choice and ate a decent amount of his meal. The resident indicated he enjoyed breakfast. The resident requested his television be turned on to a classic channel. Activities were provided with a truck magazine and cookies per his request. The resident remained in his room per his choice.The Social Service Designee Admissions note, dated 10/31/25 at 12:59 p.m., indicated the resident remained at psychosocial baseline. The resident woke and watched television in his room per his choice. The resident continued to socialize well with staff and his peers.The Social Services Admissions note, dated 10/31/25 at 1:22 p.m., indicated the resident remained at psychosocial baseline. He slept for most of the morning, woke and watched television in his room per his choice. The resident was in a pleasant mood with a relaxed demeanor. The resident was in the dining room eating lunch with his peers. The resident continued to socialize well with staff and peers. The resident had no concerns.The DON note, dated 11/1/25 at 1:49 p.m., indicated the resident remained at psychosocial baseline. The resident had no behaviors this shift. He was ambulating in the common areas and was interacting appropriately with staff and peers.The behavior note, dated 11/11/25 at 1:20 a.m., indicated the resident had been pacing in the hallway and toward rooms, but was easily redirected. The resident was encouraged to lay down and give his legs a break. He had been in bed since 1:00 a.m., with no behaviors since laying down. The Alert Charting Observation note, dated 11/14/25 at 2:55 p.m., indicated the resident had been cooperative with care this shift. The resident was wandering on the unit and was redirected and provided snacks and drinks. The redirection was effective for short periods of time. The resident was currently resting in his recliner with his call light within reach. The sensor alarm was in place and working properly.During an interview, on 11/19/25 at 9:14 a.m., Resident D indicated that staff would speak rudely at times but didn't want to say anything about it. During an interview, on 11/19/25 at 9:39 a.m., the Social Service Designee indicated she didn't witness the incident between Housekeeper 5 and Resident B, but she did monitor the resident afterwards. The resident didn't recall anything about the housekeeper or what had happened. The resident was severely cognitively impaired. The resident liked to socialize. After the incident, the Social Service Designee interviewed other residents about their treatment by staff, but no one indicated any issues. Housekeeper 5 admitted to saying something inappropriate to Resident B. The housekeeper did have a deep tone to his voice when speaking. Housekeeper 5 had already been removed from the facility. CNA 3 stayed with the resident after the occurrence. The Social Service Designee followed the resident once, daily due to her being back on the 100 Hall unit. During an interview, on 11/19/25 at 9:53 a.m., the DON indicated Housekeeper 5 told Resident B, Stop f*****g following me. The resident was removed from the situation. Housekeeper 5 had been let go, after the incident. Resident B liked to wander and have something to do. No other occurrences of verbal abuse occurred at the facility.During an interview, on 11/19/25 at 10:00 a.m., the Housekeeping Director indicated CNAs 3 and 6 came to her and told her what the housekeeper had said to Resident B. Housekeeper 5 said, Stop f*****g following me. The housekeeper was in the housekeeping closet when Resident B followed him to it. Resident B had been in the military and could look intimidating to staff, until they got to know him. Resident B liked to keep tabs on staff and be with them. After CNAs (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 and 6 told the Housekeeping Director what Housekeeper 5 said, the Housekeeping Director immediately removed Housekeeper 5 from the floor. Housekeeper 5 would not give her his statement regarding the events initially but did so a few days later and admitted to what he said. He didn't normally work over there on the 100 Hall unit, but no other issues had been identified regarding him, his work or his language. He had a deep tone to his voice when he spoke. He had since been terminated. An in-service on Abuse was given to staff after the incident.During an interview, on 11/19/25 at 10:06 a.m., CNA 3 indicated she was walking with CNA 6 assisting another resident. They both heard Housekeeper 5 say, Stop f*****g following me, I'm not the one to follow. Housekeeper 5 indicated this in a whisper yell. He could be heard by them, even though they were walking another resident on the hall. Housekeeper 5 had worked on the 100 Hall unit multiple times. CNA 3 left the other resident with CNA 6, to remove Resident B from the situation and to an activity. She reported the incident to the nurse, unit manager, and DON. CNA 6 walked the other resident back to their room. An abuse in-service was conducted after the incident occurred. Housekeeper 5 was removed from the building.During an interview, on 11/19/25 at 10:48 a.m., the ED indicated she was out of town when the incident occurred. CNA 3 heard Housekeeper 5 make the remark to Resident B. The resident didn't hear it. The resident was removed, and staff were notified of the situation. The resident could not recall anything. Other residents were interviewed during the investigation. Housekeeper 5 had never done this before. The housekeeper had worked at the facility for several years. He was suspended and then would not answer the phone. It was more of a whisper, but the CNAs could hear it. The staff were in-serviced on abuse that day. The current Abuse and Neglect and Misappropriation policy, included, but was not limited to, . Will: In Indiana, the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Mental Abuse: In Indiana, verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotion suffering; this may include staff to resident, any episode, or resident to resident, if it is willfully directed towards a specific resident.The Past noncompliance began on 10/29/25 and the deficient practice corrected by 11/18/25 after the facility implemented a systemic plan that included the following actions: The facility completed staff education on abuse (10/29/25), physician and police notification completed on (10/29/25), facility wide resident interviews completed related to abuse (10/30/25), psychosocial follow-up 3 day follow-up completed by Social Service Designee and DON (11/1/25), and ongoing abuse audits with residents (11/18/25).3.1-27(a)(1)3.1-27(b)