

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/19/2026
NAME OF PROVIDER OR SUPPLIER Indian Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure administered narcotic medications were documented on the controlled substance medication administration record for 6 of 6 residents reviewed for resident medical records. (Resident B, C, D, E, F and G) Findings include:1. The clinical record for Resident B was reviewed on 7/19/26 at 10:49 a.m. The resident's diagnoses included, but were not limited to, anxiety (the bodies natural response to stress) and malignant neoplasm of the tonsil (a type of head and neck cancer).The physician's order, dated 7/10/26, indicated the resident was to receive Clonazepam (medication for anxiety) 0.5 mg (milligrams) in the morning and evening for anxiety.The physician's order, dated 6/30/26, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg six times a day for pain at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with Licensed Practical Nurse (LPN) 5. The controlled substance administration record did not reflect the administration of the resident's Clonazepam or Hydrocodone-Acetaminophen 8:00 a.m. dose. The controlled substance record count of medication was off by one dose.2. The clinical record for Resident C was reviewed on 7/19/26 at 11:04 a.m. The resident's diagnoses included, but were not limited to, polyneuropathy and chronic ulcer of the left lower leg with necrosis.The physician's order, dated 7/8/26, indicated the resident was to receive Hydrocodone-Acetaminophen 10-325 mg every 6 hours as needed for pain.The July 2026 Medication Administration Record indicated the resident received the medication at 8:32 a.m.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with Licensed Practical Nurse (LPN) 5. The controlled substance administration record did not reflect the administration of the resident's as needed Hydrocodone-Acetaminophen dose administered. The controlled substance record count of medication was off by one dose. 3. The clinical record for Resident D was reviewed on 7/19/26 at 11:12 a.m. The resident's diagnosis included, but was not limited to, diabetes and major depressive disorder.The physician's order, dated 7/10/26, indicated the resident was to receive Hydrocodone-Acetaminophen, 10-325 mg three times a day in the morning, afternoon and at bedtime.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with LPN 5. The controlled substance administration record did not reflect the administration of the resident's morning administration of the Hydrocodone-Acetaminophen. The controlled substance record count of medication was off by one dose.4. The clinical record for Resident E was reviewed on 7/19/26 at 11:20 a.m. The resident's diagnoses included, but were not limited to, osteoarthritis and left arm pain.The physician's order, dated 7/17/26, indicated the resident was to receive Oxycodone-Acetaminophen, 10-325 mg every 4 hours as needed for pain.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with LPN 5. The controlled substance administration record did not reflect the administration of the resident's as needed administration of the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155312 If continuation sheet Page 1 of 2

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone-Acetaminophen. The controlled substance record count of medication was off by one dose.5. The clinical record for Resident F was reviewed on 7/19/26 at 11:30 a.m. The resident's diagnoses included, but were not limited to, osteoarthritis and depression.The physician's order, dated 7/10/26, indicated the resident was to receive Tramadol (narcotic pain medication), 50 mg every 6 hours as needed for pain.The July 2026 medication administration record indicated the resident received the pain medication on 7/19/26 at 8:25 a.m.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with LPN 5. The controlled substance administration record did not reflect the administration of the resident's as needed administration of the Tramadol. The controlled substance record count of medication was off by one dose.6. The clinical record for Resident G was reviewed on 7/19/26 at 11:45 a.m. The resident's diagnoses included, but were not limited to, neuropathy and chronic pain.The physician's order, dated 7/8/25, indicated the resident was to receive Morphine Sulfate (narcotic pain medication), 15 mg twice a day for chronic pain.On 7/19/26 at 9:00 a.m., a narcotic medication count was completed with LPN 5. The controlled substance administration record did not reflect the administration of the resident's morning administration of the Morphine Sulfate. The controlled substance record count of medication was off by one dose.During an interview and observation, on 7/19/26 at 9:02 a.m., LPN 5 indicated she had administered the residents' narcotic medications, but had not signed the medication out on the controlled substance administration record at the time of administration. The Narcotic medications should be signed out on the Controlled Substance Administration record at the time of administrations. During the interview LPN 5 was observed to sign out all the controlled medications she had administered prior to the Narcotic count observation. On 7/19/26 at 10:32 a.m., the Executive Director provided a current, undated copy of the document titled Medication Administration. It included, but was not limited to, Procedure.Narcotics will be signed out when given. 410 IAC (Indiana Authorization Code) 16.1-3.1-50(a)(2)		