John Craig

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

03/27/2025

l f ´		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155241	(X2) MULTIPLE CO A. BUILDING B. WING				
	PROVIDER OR SUPPLIER	<u>I</u>	STREET ADDRESS, CITY, STATE, ZIP COD  525 E THOMPSON RD INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE		
F 0000	REGELATORT OF	CESC IDENTIFY THAT HAT ORGANIZATION	1710		DATE		
F 0000 Bldg. 00	IN00454385 and IN Complaint IN00454 the allegations are of Complaint IN00455 related to the allegal F761, and F880.  Survey date: March Facility number: 00 Provider number: 1 AIM number: 1002  Census Bed Type: SNF/NF: 86 SNF: 7 Total: 93  Census Payor Type Medicare: 7 Medicaid: 73 Other: 13 Total: 93  These deficiencies is accordance with 41	1385 - No deficiencies related to cited.  13414 - Federal/State deficiencies tions are cited at F554, F759,  14, 2025  10145 155241 175110	F 0000	F000 The creation and submission this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. provider respectfully requests the 2567 plan of correction be considered the letter of credib allegation and requests desk review (paper compliance) on after March 28, 2025.	ot s t forth es, or This that e		
SS=D Bldg. 00	Resident Self-Adn	nin Meds-Clinically Approp	F 0554	F554 Resident Self-Administ Medications-Clinically	o3/28/2025		
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE		

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 disclosed 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1K8V11 Facility ID: 000145 If continuation sheet Page 1 of 9

**Executive Director** 

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155241			03/14/	2025	
		<u> </u>		CTREET (	ADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
FOREST	CDEEK VIII I ACE		525 E THOMPSON RD				
FUREST	CREEK VILLAGE			INDIAN	IAPOLIS, IN 46227		
(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 OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	review, the facility				Appropriate		
		medication assessments were			What corrective action(s) will be	эе	
	•	residents observed with			accomplished for those reside		
	medications at the b	pedside. (Resident E).			found to have been affected b	y the	
			1		deficient practice?		
	Findings include:				Resident E's medications		
					were immediately removed fro	om	
		a.m., observed a small purple			bedside.		
		oill, and a yellow capsule sitting			How other residents having th		
	-	c medication cup on Resident	1		potential to be affected by the		
		here was no staff in Resident			same deficient practice will be	:	
	E's room.				identified and what corrective		
					action(s) will be taken;		
	_	y on 3/14/25 at 8:25 a.m., LPN 1			All residents have the pote	ntial	
		pills that were left in the plastic			to be affected by the alleged		
	-	bedside table should not			deficient practice.		
	have been left in his	s room.			A 1x audit has been		
					completed to ensure no		
		a.m. Resident E's clinical record			medications are left at the bes	side	
		diagnoses included, but were			without a self – administer		
		etes and thyroid disorder. The			medication agreement		
		ed a self-administration			All licensed nursing staff		
	medication assessm	ent.			be in-serviced by DNS/design		
	0 2/14/25 / 12 1/	1 5011 1 1			on the appropriate process for		
		p.m., the DON indicated			medication storage by March	28,	
		have a self-administration			2025		
		ent and the medications en left at the bedside.			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	_	
	should not have bee	on left at the bedside.			What measures will be put into		
	On 3/14/25 at 0.15	om the Director of Number of			place or what systemic change		
		a.m., the Director of Nursing			will be made to ensure that the		
	(DON) provided a copy of a facility policy, titled Medication Storage and Expiration Policy, dated				deficient practice does not rec		
		ted this was the current policy			All licensed nursing staff		
		A review of the policy	1		be in-serviced by DNS/design on the appropriate medication		
		n should be stored in a locked			storage policy by March 28,20		
		ed medication room that is			Daily observational roun		
	inaccessible by resi				will be completed by	us	
	maccessione by test	demo and visituis.	1		DNS/designee to ensure no		
	This citation relates	to Complaint IN00455414.			medications are left at residen	ite	
	This challon relates	10 Complaint 11100433414.				ເເວ	
			1		bedside that do not have a		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155241		A. BUILDING  B. WING	00	COMPLETED 03/14/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227					
(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			
F 0759	3.1-11(a) 483.45(f)(1)			self-administer medication agreement.  Any resident that chose have medications in their room have a self-administer medical observation reviewed by the II quarterly or with significant charterly or condition.  How the corrective action(s) we monitored to ensure the deficing practice will not recur, what quassurance program will be put place;  The DNS/designee will be responsible for the completion the Medication Storage QA Toweekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure complian Deficiency in this practice will result in disciplinary action up and including termination of the responsible employee.	n will tion DT ange will be ent tality into  pe of pol by  the not e ce.			
SS=E Bldg. 00	Based on observation review, the facility free of a medication	on, interview, and record failed to ensure residents were error rate greater than 5	F 0759	F759 Free of Medication Erro				
	percent for 4 of 25 c	opportunities, resulting in a		What corrective action(s) will b	oe			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1K8V11

Facility ID: 000145

If continuation sheet

Page 3 of 9

03/31/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 03/14/2025 155241 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medication error rate of 16 percent. Resident B, accomplished for those residents Resident C) found to have affected by the deficient practice? Findings include: No resident identified has been affected by this practice. 1. On 3/14/25 at 7:23 a.m., observed RN 1 Skills check off for administer Wixela 250/50 micrograms (mcg) medication administration (prescription metered dose inhaler used to treat completed for RN 1 asthma and chronic obstructive pulmonary disease) and Incruse Ellipta 62.5 mcg (prescription How other residents having the metered dose inhaler used to treat chronic potential to be affected by the obstructive pulmonary disease) to Resident B. RN same deficient practice will be 1 did not ask Resident B to rinse her mouth with identified and what corrective water and spit the water out before RN 1 left action will be taken? Resident B's room. At that time, RN 1 indicated he All residents have the had finished administering Resident B's potential to be affected by the medications. RN 1 didn't need to have Resident B alleged deficient practice. rinse her mouth and spit after he administered SDC/designee will complete Wixela nor Incruse. a medication administration skills check off with all licensed nursing The instructions for use for Wixela 250/50 mcg staff by March 28, 2025. were reviewed on 3/14/25 at 9:00 a.m. A review of DNS/designee will conduct the instructions indicated rinse mouth with water an in-service with all licensed after breathing in the medicine. Spit out the water. nurses on medication Do not swallow. administration by March 28, 2025 On 3/14/25 at 11:52 a.m., the Director of Nursing What measures will be put into (DON) provided a copy of a skills competency, place or what systemic changes titled Meter Dose Inhaler Delivery, dated 9/2023, will be made to ensure that the and indicated this was the current skills deficient practice does not recur? competency used by the facility. A review of the DNS/designee will conduct skills competency indicated once the medication an in-service with all licensed is administered, have the resident wash their nurses on medication mouth out with water or mouthwash and spit it administration by March 28, 2025 out. Daily observational rounds will be completed by 2. On 3/14/25 at 7:45 a.m., observed RN 1 SDC/designee for medication administer 34 units of Lantus Solostar 100 units/ml administration compliance (milliliter) (prescription long acting insulin How the corrective actions will be

FORM CMS-2567(02-99) Previous Versions Obsolete

administered from an insulin pen) and 21 units of

Event ID:

1K8V11

Facility ID: 000145

If continuation sheet

monitored to ensure the deficient

Page 4 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155241	B. W	ING		03/14/	/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			THOMPSON RD		
FOREST	CREEK VILLAGE		INDIANAPOLIS, IN 46227				
					T		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	200 units/ml (prescription fast			practice will not recur, i.e., who		
	_	nistered from an insulin pen) to			quality assurance program wil	l be	
		priming either insulin pen. At			put into place?		
		icated he did not need to prime			The DNS/designee will b		
		insulin pen nor the Humalog			responsible for the completion		
	KwikPen before adi	ministering the insulin.			the medication administration	QA	
	The instructions for	use of Lantus Solostar were			Tool weekly times 4 weeks,		
		5 at 9:09 a.m. A review of the			monthly times 6 and then	ftc	
		ed dial a test dose of two units			quarterly to encompass all shi until continued compliance is	แร	
		tion button all the way in and			maintained for 2 consecutive		
					quarters. The results of these		
	check to see that insulin comes out of the needle.				audits will be reviewed by the		
	The instruction for	use of Humalog KwikPen were			QAPI committee overseen by	the	
		5 at 9:10 a.m. A review of the			ED. If the threshold of 95% is		
		ed prime before each injection.			achieved an action plan will be		
		ans removing the air from the			developed to ensure complian		
		e. If the pen is not primed the			Deficiency in this practice will		
		e too much or too little insulin.			result in disciplinary action up	to	
	j				and including termination of th		
	On 3/14/25 at 9:15	a.m., the DON provided a copy			responsible employee.		
	of a skills competer	ncy, titled Insulin Pen					
	Administration, dat	ed 10/2019, and indicated this					
	was the current skil	ls competency used by the					
	facility. A review of	f the competency indicated					
		aling two units and push the					
		ish out the two units. A small					
	drop of insulin shou	ıld be visible. If insulin does					
	not appear, repeat.						
	This citation relates	to Complaint IN00455414.					
	3.1-48(c)(1)						
E 0704							
F 0761	483.45(g)(h)(1)(2)						
SS=D	Label/Store Drugs	and Biologicals					
Bldg. 00	n 1 1		1	<b>-</b> < 1			02/20/2025
		on, interview, and record	F 0'	/61	F761 Label/Store Drugs and		03/28/2025
		ailed to ensure medications			Biologicals		
	were dated when op	pened for 1 of 3 medication			What corrective action(s) will be	oe -	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		NSTRUCTION (X3) I		3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE		
		155241	B. W	ING		03/14/	/2025	
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	R			HOMPSON RD			
FOREST	CREEK VILLAGE		INDIANAPOLIS, IN 46227					
(X4) ID	SIIMMADV	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		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
		medication storage. (200 Hall			accomplished for those reside	ents		
	Medication Cart)				found to have affected by the			
	Included Surry				deficient practice?			
	Findings include:				No resident identified ha	is		
	_				been affected by this practice			
	On 3/14/25 at 7:23	a.m., observed Wixela 250/50			Medications with no ope			
	mcg (micrograms)	(prescription inhaler used for			date were immediately remov			
	chronic obstructive	pulmonary disease) sitting			from the medication cart.			
	inside a clear baggy in the top drawer of the 200							
		t. The label on the Wixela			How other residents having th	ie		
		esident B, 60 doses were filled,			potential to be affected by the			
		doses remained. There was no			same deficient practice will be	)		
	opened date written anywhere on the inhaler				identified and what corrective			
		naler itself. A Lantus Solostar			action will be taken?			
	· ·	ter) insulin pen was observed			All residents taking			
		awer of the medication cart.			medications have the potentia	al to		
		n on the Lantus Solostar			be affected by the alleged			
	_	was no opened date written			practice.			
		antus Solostar label nor on the						
	insulin pen itself.				All medication carts were			
	D	2/14/25 4.7.47 DN			audited x1 to ensure all applic			
	_	v on 3/14/25 at 7:47 a.m., RN			open medications were labele	ea.		
		1 indicated the Lantus Solostar			DNC/docieres a will assess	at.		
	been dated when the	Wixela inhaler should have			DNS/designee will condu an in-service with all nurses o			
	been dated whell th	ey were opened.			medication storage and labeli	• •		
	On 3/14/25 at 0.15	a m the Director of Nursing			by March 28, 2025.	iig		
	On 3/14/25 at 9:15 a.m., the Director of Nursing provided a copy of a facility policy, titled				by Maion 20, 2023.			
		e and Expiration Policy, dated						
	_	-			What measures will be put int	0		
	11/2024, and indicated this was the current policy used by the facility. A review of the policy				place or what systemic chang			
	1	opened should be documented			will be made to ensure that th			
	on the primary medication container (vial, bottle,				deficient practice does not red			
	inhaler) when the medication had a shortened				DNS/designee will condu			
	expiration date onc				an in-service with all nurses o			
	1	•			medication storage and labeli			
	This citation relates	s to Complaint IN00455414.			by March 28, 2025.	5		
		•			Medication carts will be			
	3.1-25(j)				audited daily by nurse			
3.1. 2.5(1)				managers/designee to ensure	all			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1K8V11

Facility ID: 000145

If continuation sheet Page 6 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155241	B. WI	NG		03/14/	2025
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
FOREST	CREEK VILLAGE		525 E THOMPSON RD INDIANAPOLIS, IN 46227				
	T	OT A TEN JEWE OF DEPLOYED VOICE	1		I		975
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ļ	(X5) COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
					open medications are labeled	and	
					stored correctly. Any concerns	s will	
					be addressed immediately.		
					Llow the corrective action(a) w	الله م	
					How the corrective action(s) we monitored to ensure the defici		
					practice will not recur, what qu		
					assurance program will be put	•	
					place:		
					The DNS/designee will b		
					responsible for the completion		
					the medication storage QA To weekly times 4 weeks, monthl		
					times 6 and then quarterly to	у	
					encompass all shifts until		
					continued compliance is		
					maintained for 2 consecutive		
					quarters. The results of these		
					audits will be reviewed by the QAPI committee overseen by	the	
					ED. If the threshold of 95% is		
					achieved an action plan will be		
					developed to ensure compliar		
					Deficiency in this practice will		
					result in disciplinary action up		
					and including termination of th	ie	
					responsible employee		
F 0880	483.80(a)(1)(2)(4						
SS=D	Infection Preventi	on & Control					
Bldg. 00	Based on observati	on, interview, and record	F 08	280	F880 Infection prevention an	nd	03/28/2025
		failed to implement infection	r 08	000	control	u	03/20/2023
	-	or 1 of 1 random observations.			What corrective action(s) will I	ре	
	_	m hand hygiene prior to			accomplished for those reside		
		ng off gloves and did not			found to have affected by the		
		or to exiting the room. (Resident			deficient practice?		
	D, LPN 1)		1		No resident identified ha	S	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1K8V11

Facility ID: 000145

If continuation sheet

Page 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED	
AND ILAN	OF CORRECTION	155241	B. WING		03/14/2025	
		199241	b. WING		03/14/2023	
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD FHOMPSON RD		
FOREST	CREEK VILLAGE		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				been affected by this practice.		
	Findings include:			LPN 1 was immediately		
				educated on medication		
	On 3/14/25 at 7:58	a.m., observed LPN (Licensed		administration in regard to pro	per	
	Practical Nurse) 1 v	walk into Resident D's room		infection control practices		
	holding two insulin	pens. LPN 1 told Resident D				
	she was going to ad	lminister his insulin. LPN 1 put		How other residents having th	е	
	on a pair of clean g	loves and administered the		potential to be affected by the		
	insulin to Resident	D. No hand hygiene was		same deficient practice will be		
	observed. Then LP	N 1 walked out of Resident D's		identified and what corrective		
	room and removed	the dirty gloves. At that time,		action will be taken?		
	LPN 1 indicated sh	e should have performed hand		All residents have to		
	hygiene before she	put on the gloves and after		potential to be affected by the		
	she removed the glo	oves. LPN 1 should have		alleged deficient practice		
	removed the gloves	s before she left Resident D's		All licensed nurses will b	e	
	room.			educated by the DNS/Designe	ee on	
				Infection Control procedures for	or	
	On 3/14/25 at 9:15	a.m., the Director of Nursing		medication administration by		
	(DON) provided a	copy of a skills competency,		March 28, 2025.		
	titled Insulin Pen A	dministration, dated 10/2019,				
	and indicated this w	vas the current skills		What measures will be put into		
	competency used by	y the facility. A review of the		place or what systemic change	es	
	competency indicat	ted 4. perform hand hygiene, 5.		will be made to ensure that the	e	
	explain procedure,	6. put on gloves, 21. remove		deficient practice does not rec	ur?	
	gloves and perform	hand hygiene.		All licensed nurses will be	:	
				educated by the DNS/Designe	ee on	
	On 3/14/25 at 9:15	a.m., the DON provided a copy		Infection Control procedures for	or	
	of a facility policy,	titled Infection Prevention and		medication administration by		
	Control Program Po	olicy, dated 5/2023, and		March 28, 2025.		
	indicated this was the current policy used by the			Observational rounds will	be	
		f the policy indicated		completed daily by DNS/desig	nee	
	prevention of the sp	oread of infections is		to ensure that staff are utilizing	g	
		e core principles of infection		appropriate infection control		
		out not limited to, hand hygiene		procedures during medication		
	and standard precau	utions.		administration.		
				How the corrective action(s) w	rill be	
	This citation relates	s to Complaint IN00455414.		monitored to ensure the defici	ent	
				practice will not recur, what qu	ıality	
	3.1-18(b)(1)			assurance program will be put	into	
			place;			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155241			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL <b>03/14</b> /	ETED
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE			525 E 1	ADDRESS, CITY, STATE, ZIP COD FHOMPSON RD IAPOLIS, IN 46227		
(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 APPROPRIAL DEFICIENCY)  The DNS/designee will be responsible for the completion the infection control QA Tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the	oe of	(X5) COMPLETION DATE
				QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure complian Deficiency in this practice will result in disciplinary action up and including termination of th responsible employee.	not e ce. to	

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