STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00454385 and IN00455414. Complaint IN00454385 - No deficiencies related to the allegations are cited. Complaint IN00455414 - Federal/State deficiencies related to the allegations are cited at F554, F759, F761, and F880. Survey date: March 14, 2025 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 86 SNF: 7 Total: 93 Census Payor Type: Medicare: 7 Medicaid: 73 Other: 13 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 17, 2025.	F 0000	**F000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after March 28, 2025.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record	F 0554	**F554 Resident Self-Administer Medications-Clinically**	03/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Craig	Executive Director	03/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	review, the facility failed to ensure self-administration medication assessments were complete for 1 of 1 residents observed with medications at the bedside. (Resident E). Findings include: On 3/14/25 at 8:09 a.m., observed a small purple pill, a small white pill, and a yellow capsule sitting inside a small plastic medication cup on Resident E's bedside table. There was no staff in Resident E's room. During an interview on 3/14/25 at 8:25 a.m., LPN 1 indicated the three pills that were left in the plastic cup on Resident E's bedside table should not have been left in his room. On 3/14/25 at 9:29 a.m. Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes and thyroid disorder. The clinical record lacked a self-administration medication assessment. On 3/14/25 at 12:10 p.m., the DON indicated Resident E did not have a self-administration medication assessment and the medications should not have been left at the bedside. On 3/14/25 at 9:15 a.m., the Director of Nursing (DON) provided a copy of a facility policy, titled Medication Storage and Expiration Policy, dated 11/2024, and indicated this was the current policy used by the facility. A review of the policy indicated medication should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. This citation relates to Complaint IN00455414.		**Appropriate** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident E's medications were immediately removed from bedside. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. A 1x audit has been completed to ensure no medications are left at the beside without a self – administer medication agreement All licensed nursing staff will be in-serviced by DNS/designee on the appropriate process for medication storage by March 28, 2025 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All licensed nursing staff will be in-serviced by DNS/designee on the appropriate medication storage policy by March 28,2025 Daily observational rounds will be completed by DNS/designee to ensure no medications are left at residents bedside that do not have a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	3.1-11(a)		self-administer medication agreement. Any resident that chose to have medications in their room will have a self-administer medication observation reviewed by the IDT quarterly or with significant change of condition. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The DNS/designee will be responsible for the completion of the Medication Storage 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 QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure residents were free of a medication error rate greater than 5 percent for 4 of 25 opportunities, resulting in a	F 0759	**F759 Free of Medication Errors Rts 5% or more** What corrective action(s) will be	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	medication error rate of 16 percent. Resident B , Resident C) Findings include: 1. On 3/14/25 at 7:23 a.m., observed RN 1 administer Wixela 250/50 micrograms (mcg) (prescription metered dose inhaler used to treat asthma and chronic obstructive pulmonary disease) and Incruse Ellipta 62.5 mcg (prescription metered dose inhaler used to treat chronic obstructive pulmonary disease) to Resident B. RN 1 did not ask Resident B to rinse her mouth with water and spit the water out before RN 1 left Resident B's room. At that time, RN 1 indicated he had finished administering Resident B's medications. RN 1 didn't need to have Resident B rinse her mouth and spit after he administered Wixela nor Incruse. The instructions for use for Wixela 250/50 mcg were reviewed on 3/14/25 at 9:00 a.m. A review of the instructions indicated rinse mouth with water after breathing in the medicine. Spit out the water. Do not swallow. On 3/14/25 at 11:52 a.m., the Director of Nursing (DON) provided a copy of a skills competency, titled Meter Dose Inhaler Delivery, dated 9/2023, and indicated this was the current skills competency used by the facility. A review of the skills competency indicated once the medication is administered, have the resident wash their mouth out with water or mouthwash and spit it out. 2. On 3/14/25 at 7:45 a.m., observed RN 1 administer 34 units of Lantus Solostar 100 units/ml (milliliter) (prescription long acting insulin administered from an insulin pen) and 21 units of		accomplished for those residents found to have affected by the deficient practice? No resident identified has been affected by this practice. Skills check off for medication administration completed for RN 1 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. SDC/designee will complete a medication administration skills check off with all licensed nursing staff by March 28, 2025. DNS/designee will conduct an in-service with all licensed nurses on medication administration by March 28, 2025 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/designee will conduct an in-service with all licensed nurses on medication administration by March 28, 2025 Daily observational rounds will be completed by SDC/designee for medication administration compliance How the corrective actions will be monitored to ensure the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	Humalog KwikPen 200 units/ml (prescription fast acting insulin administered from an insulin pen) to Resident C without priming either insulin pen. At that time, RN 1 indicated he did not need to prime the Lantus Solostar insulin pen nor the Humalog KwikPen before administering the insulin. The instructions for use of Lantus Solostar were reviewed on 3/14/25 at 9:09 a.m. A review of the instructions indicated dial a test dose of two units then press the injection button all the way in and check to see that insulin comes out of the needle. The instruction for use of Humalog KwikPen were reviewed on 3/14/25 at 9:10 a.m. A review of the instructions indicated prime before each injection. Priming the pen means removing the air from the needle and cartridge. If the pen is not primed the resident may receive too much or too little insulin. On 3/14/25 at 9:15 a.m., the DON provided a copy of a skills competency, titled Insulin Pen Administration, dated 10/2019, and indicated this was the current skills competency used by the facility. A review of the competency indicated prime the pen by dialing two units and push the end of the pen to push out the two units. A small drop of insulin should be visible. If insulin does not appear, repeat. This citation relates to Complaint IN00455414. 3.1-48(c)(1)		practice will not recur, i.e., what quality assurance program will be put into place? The DNS/designee will be responsible for the completion of the medication administration 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 QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review the facility failed to ensure medications were dated when opened for 1 of 3 medication	F 0761	**F761 Label/Store Drugs and Biologicals** What corrective action(s) will be	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	carts reviewed for medication storage. (200 Hall Medication Cart) Findings include: On 3/14/25 at 7:23 a.m., observed Wixela 250/50 mcg (micrograms) (prescription inhaler used for chronic obstructive pulmonary disease) sitting inside a clear baggy in the top drawer of the 200 hall medication cart. The label on the Wixela inhaler indicated Resident B, 60 doses were filled, on 1/22/25, and 47 doses remained. There was no opened date written anywhere on the inhaler package nor the inhaler itself. A Lantus Solostar 100 unit/ml (milliliter) insulin pen was observed sitting in the top drawer of the medication cart. The seal was broken on the Lantus Solostar insulin pen. There was no opened date written anywhere on the Lantus Solostar label nor on the insulin pen itself. During an interview on 3/14/25 at 7:47 a.m., RN (Registered Nurse) 1 indicated the Lantus Solostar insulin pen and the Wixela inhaler should have been dated when they were opened. On 3/14/25 at 9:15 a.m., the Director of Nursing provided a copy of a facility policy, titled Medication Storage and Expiration Policy, dated 11/2024, and indicated this was the current policy used by the facility. A review of the policy indicated the date opened should be documented on the primary medication container (vial, bottle, inhaler) when the medication had a shortened expiration date once opened. This citation relates to Complaint IN00455414. 3.1-25(j)		accomplished for those residents found to have affected by the deficient practice? No resident identified has been affected by this practice. Medications with no open date were immediately removed from the medication cart. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents taking medications have the potential to be affected by the alleged practice. All medication carts were audited x1 to ensure all applicable open medications were labeled. DNS/designee will conduct an in-service with all nurses on medication storage and labeling by March 28, 2025. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/designee will conduct an in-service with all nurses on medication storage and labeling by March 28, 2025. Medication carts will be audited daily by nurse managers/designee to ensure all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
			open medications are labeled and stored correctly. Any concerns will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The DNS/designee will be responsible for the completion of the medication storage 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 QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to implement infection control practices for 1 of 1 random observations. Staff did not perform hand hygiene prior to putting on and taking off gloves and did not remove gloves prior to exiting the room. (Resident D, LPN 1)	F 0880	**F880 Infection prevention and control** What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? No resident identified has	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	Findings include: On 3/14/25 at 7:58 a.m., observed LPN (Licensed Practical Nurse) 1 walk into Resident D's room holding two insulin pens. LPN 1 told Resident D she was going to administer his insulin. LPN 1 put on a pair of clean gloves and administered the insulin to Resident D. No hand hygiene was observed. Then LPN 1 walked out of Resident D's room and removed the dirty gloves. At that time, LPN 1 indicated she should have performed hand hygiene before she put on the gloves and after she removed the gloves. LPN 1 should have removed the gloves before she left Resident D's room. On 3/14/25 at 9:15 a.m., the Director of Nursing (DON) provided a copy of a skills competency, titled Insulin Pen Administration, dated 10/2019, and indicated this was the current skills competency used by the facility. A review of the competency indicated 4. perform hand hygiene, 5. explain procedure, 6. put on gloves, 21. remove gloves and perform hand hygiene. On 3/14/25 at 9:15 a.m., the DON provided a copy of a facility policy, titled Infection Prevention and Control Program Policy, dated 5/2023, and indicated this was the current policy used by the facility. A review of the policy indicated prevention of the spread of infections is accomplished by the core principles of infection control including, but not limited to, hand hygiene and standard precautions. This citation relates to Complaint IN00455414. 3.1-18(b)(1)		been affected by this practice. LPN 1 was immediately educated on medication administration in regard to proper infection control practices How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have to potential to be affected by the alleged deficient practice All licensed nurses will be educated by the DNS/Designee on Infection Control procedures for medication administration by March 28, 2025. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed nurses will be educated by the DNS/Designee on Infection Control procedures for medication administration by March 28, 2025. Observational rounds will be completed daily by DNS/designee to ensure that staff are utilizing appropriate infection control procedures during medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
			The DNS/designee will be responsible for the completion of 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 QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	