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	04/15/2025

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00455414 completed on March 14, 2025. This visit was in conjunction with the Investigation of Complaints IN00455992 and IN00457336. Complaint IN00455414 - Not corrected. Complaint IN00455992 - No deficiencies related to the allegations are cited. Complaint IN00457336 - No deficiencies related to the allegations are cited. Survey dates: April 15, 2025 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 87 SNF: 2 Total: 89 Census Payor Type: Medicare: 2 Medicaid: 72 Other: 15 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 21, 2025.	F 0000	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 April 18, 2025.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Craig	Executive Director	04/25/2025

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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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure insulin vials (medication used to treat high blood sugar) were dated after they were opened for 1 of 4 medication carts reviewed for medication storage. (North Unit Medication Cart 1) Findings include: On 4/15/25 at 7:55 a.m., observed the North Unit Medication Cart 1. The following was observed: - One vial of insulin lispro (rapid acting insulin that starts to lower blood sugar within 15 minutes) 100 units/milliliter (ml) with the cap removed and half empty. The vial lacked a date that indicated the date the vial was opened. - One vial of Humalog (rapid acting insulin that starts to lower blood sugar within 15 minutes) 100 units/ml with the cap removed. The vial lacked a date that indicated the date the vial was opened. - Two vials of Novolin R (short acting insulin that starts to lower blood sugar within 30 minutes) 100 units/ml with the caps removed. The vials lacked a date that indicated the date the vials were opened. During an interview on 4/15/25 at 8:05 a.m., LPN 1 indicated all of the insulin vials should have been dated for the date they were opened. On 4/15/25 at 10:08 a.m., the Director of Nursing provided a copy of a facility policy, titled Medication Storage and Expiration Policy, dated 11/20/24, and indicated this was the current policy used by the facility. A review of the policy	F 0761	F761 Label/Store Drugs and Biologicals What corrective action(s) will be 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 April 18, 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 April 18, 2025. Medication carts will be audited daily by nurse	04/18/2025

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	indicated staff should record the date opened on the primary vial. This deficiency was cited on 3/14/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(j)		managers/designee to ensure all 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 ensure staff wore personal protective equipment (PPE) while repositioning a resident who required enhanced barrier precautions for 1 of 3 residents reviewed for infection control. (Resident B) Findings include:	F 0880	F880 Infection Prevention and Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? DON and RN 1 for Resident B was immediately in serviced about Enhanced Barrier	04/18/2025

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	On 4/15/25 at 8:14 a.m., inside Resident B's room, observed an Enhanced Barrier Precaution sign and personal protective equipment hanging on the bathroom door. At that time, Resident B indicated she wanted to be repositioned. During an observation on 4/15/25 at 8:25 a.m., Resident B was lying in bed with a pillow under both hips. The Director of Nursing (DON) stood on Resident B's left side and another nurse stood to Resident B's right side. The nurse shifted Resident B to the right side and the DON assisted Resident B to raise her right arm and hold the side rail to her left side. Then, the DON and the nurse turned Resident B to her left side. At that time, observed a bandage, dated 4/14/25, to sacral area. The nurse placed a pillow under Resident B's right side and Resident B was lowered back to a lying position and made comfortable. Neither the nurse nor the DON donned (put on) gloves nor gown before they repositioned Resident B. During an interview on 4/15/25 at 8:36 a.m., RN 1 indicated the nurse and DON should have donned gloves and a gown to reposition Resident B. The clinical record for Resident B was reviewed on 4/15/25 at 9:40 a.m. The diagnoses included, but were not limited to, pressure ulcer to sacral region, heart failure, and dementia. A care plan, dated 4/11/25, indicated Resident B was at risk of transferring or becoming colonized with a multidrug-resistant organism (MDRO) and required enhanced barrier precautions due to a chronic wound that required a dressing. Interventions included, but were not limited to, wear gown and gloves prior to high contact resident care activities.		Precautions to include use of PPE while repositioning a resident How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents on Enhanced Barrier Precautions have the potential to be affected by the alleged deficient practice. An in-service will be completed by SDC/designee for all staff regarding proper infection control practice regarding PPE for residents on Enhanced Barrier Precautions during high contact resident care activities by 4/18/25 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An in-service will be completed by SDC/designee for all staff regarding proper infection control practice regarding PPE for residents on Enhanced Barrier Precautions during high contact resident care activities by 4/18/25 Observational rounds will be completed daily by CEN/designee to ensure that PPE is worn for residents on Enhanced Barrier Precautions during high contact resident care activities. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	On 4/15/25 at 10:08 a.m., the DON provided a copy of a facility policy, titled Enhanced Barrier Precautions, dated 3/2025, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will use the proper infection control and prevention measures as outlined by the Centers for Disease Control (CDC) and local health departments when dealing with a resident on Enhanced Barrier Precautions. This deficient practices was cited on 3/14/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)(1)		The DNS/designee will be responsible for the completion of the Enhanced Barrier Precautions PPE QA Tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Enhanced Barrier Precautions PPE QA Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee	