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	03/10/2023

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 Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00403245. Complaint IN00403245 - Federal/State deficiencies related to the allegations are cited at F921. Survey dates: March 6, 7, 8, 9, and 10, 2023 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 73 SNF: 12 Total: 85 Census Payor Type: Medicare: 7 Medicaid: 58 Other: 20 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 15, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State Law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey conducted on March 6-10, 2023. Please accept this plan of correction as the provider's credible allegation of compliance as of April 8, 2023. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Executive Director	03/31/2023

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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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility protect the residents right to be free from physical and verbal abuse by another resident for 1 of 1 allegations of abuse reviewed. (Resident 9, Resident 24) Findings include: On 3/6/23 at 9:22 a.m., a facility reported incident was reviewed. The incident, dated 2/22/23, indicated Resident 24 resided in the room across the hall from Resident 9. Resident 24 heard Resident 9 yelling from her room and went to her room and cursed at her and threw items from Resident 9's room at Resident 9. The area around Resident 9's left eye was reddened. Resident 24 was upset because resident 9 was yelling. On 3/8/23 at 9:33 a.m., the clinical record of Resident 9 was reviewed. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. A skin assessment, dated 2/22/23, indicated "Marks and swollen right eye from altercation from other resident [Resident 24]." On 3/8/23 at 10:40 a.m., the clinical record of Resident 24 was reviewed. The diagnoses	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The incident with resident 9&24 was immediately responded to by nursing staff. Both residents were assessed by nursing and resident 9 was placed on 1-1 until he was sent to a geriatric psychological facility for further evaluation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Executive Director/designee will interview residents monthly for 3 months and then quarterly thereafter regarding any problems with other residents. Any issues brought up will be immediately addressed. What measures will be put into	04/08/2023

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	included, but were not limited to, paranoid schizophrenic, dementia, and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 3/10/23, indicated Resident 24 had no cognitive impairment. A Progress Note, dated 2/22/23 at 5:25 p.m., indicated writer was stopped by Nurse Aide In Training (NAIT) was requesting to come help with Resident 24. The resident was back in his room at that time. Resident 24 was being verbally aggressive towards floor staff. When asked what was going on Resident 24 stated "Do you hear that?" Staff educated resident on physical aggression and verbal aggression to other residents. Intervention was ineffective at this time. Resident 24 then stated "If I could get closer to her I will hurt her." Staff attempted to re-educate again on physical aggression. Intervention continues to be ineffective. Resident again stated "If I get close to her , I will hurt her." Attempted again to redirect. Resident stated "I don't care, call the f****** cops." A Progress Note, dated 2/22/23 at 5:12 p.m., indicated Resident 24 was being physically and verbally aggressive towards another resident across the hall from him. He threw cups and trash at her. When questioned he said she deserved it and would continue to do it if she did not be quiet. Nursing and the Social Serves Director (SSD) attempted to calm Resident 24, but Resident 24 still was insistent on harming Resident 9 if he had the opportunity. Currently on one-one with staff. On 3/8/23 at 8:47 a.m., observed Resident 24 in his room with his radio on with the volume on high. Resident 24's room mate, Resident 39, had his TV		place or what systemic changes will you make to ensure that the deficient practice does not reoccur? Facility staff will receive education by the DNS/designee on abuse education. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? The resident interviews will be reviewed in the Quality Assurance and Performance Improvement Committee X 3 months and then quarterly thereafter. This committee is overseen by the Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	on with very loud volume. During an interview, at that time, Resident 24 indicated he wanted to throw a can of shaving cream at Resident 39. "His [Resident 39] TV is way to loud, I [Resident 24] try to be nice, but if they are not nice, I don't have to be." On 3/8/23 at 9:42 a.m., the Administrator provided a policy titled Abuse Prohibition, Reporting, and Investigation, dated February 2010, and indicated it was the current policy being used by the facility. A review of the policy, indicated "Policy: It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse..., this includes but is not limited to verbal abuse and physical abuse..." 3.1-27(a)(1) 3.1-27(b)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure emergency tracheostomy (trach) supplies were available at bedside for 1 of 1 residents reviewed for respiratory care. (Resident 131) Findings include:	F 0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 131 emergency tracheostomy supplies were	04/08/2023

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	On 3/6/23 at 9:00 a.m., a family interview was conducted at Resident 116's bedside. The resident's family member was at bedside and indicated "this place is not set up for this (trach care)." During an observation at that time, a small bedside table with emergency tracheostomy supplies inside the drawers was observed. The drawer contained a size 6 tracheostomy tube. The drawer lacked a smaller size in the event the resident would accidentally or intentionally pull out the current size 6 tracheostomy tube. No other tube was visible in the residents drawer. On 3/6/23 at 10:10 a.m., Resident 131's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure and tracheostomy status. An Admission Minimum Data Set (MDS) assessment, dated 3/5/23, indicated Resident 131's cognitive status was moderately impaired. The Physicians orders for March 2023, included, but were not limited to: "Trach orders, Ambu bag, small trach and same size trach at beside every shift. Type/size of trach 6.0 Bivona uncuffed." During an interview on 3/6/23 at 9:16 a.m., the Director of Nursing (DON) indicated the smaller trach was supposed to be available in the drawer next to the resident. . During an interview on 3/10/23 at 8:45 a.m., Licensed Practical Nurse 5, indicated emergency trach supplies are stored at bedside. If she pulls it out and the smaller size is not available, she would		placed at bedside. There were no other residents in the facility with a Tracheostomy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? There are no other residents within the facility that have a Tracheostomy. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? DNS/designee will conduct an inservice for nursing staff related to the proper placement of emergency tracheostomy supplies. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance program will be put into place? When the facility has a tracheostomy resident in the facility the DNS/designee will verify placement of the emergency tracheostomy supplies daily. These audit tools will be reviewed monthly X 3 months in the Quality Assurance and Performance	

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	use the currant size in the drawer. During an interview on 3/10/23 at 9:00 a.m., Registered Nurse 6 indicated the trach supplies are always kept at bedside. A care plan, dated 3/7/23 and current through 6/7/23, the resident requires a tracheostomy. The interventions included, but were not limited to, trach care as ordered. During an interview on 3/9/23 at 11:22 a.m., the Director of Nursing indicated a policy for trach supply storage was not available. 3.1-47(a)(4)		Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive			

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	Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication and treatment carts were locked for 2 of 2 treatment carts and 1 of 4 medication carts observed. (100 hall treatment cart, 200 hall treatment cart, 100 hall medication cart) Findings include: 1. During a random continuous observation on 3/8/23 from 8:45 a.m. until 9:03 a.m., a treatment cart on the 100 hall next to the nurses station was observed to be unlocked and unsupervised. During that time, from 8:50 am. until 9:25, no staff were observed near the cart. Several residents in wheel chairs were observed ambulating past the unlocked cart. The unlocked cart contained, but was not limited, to the following prescribed medicated treatments. a. 1 - thirty-gram tube ketoconazole (a medicated cream to treat skin infections caused by fungus) 2% cream b. 1 - thirty-gram tube containing collagenase santyl (a medicated ointment that removes dead tissue from wounds to promote healing) ointment 250 units c. 4 - 1/2 - one hundred gram tubes of diclofenac (a medicated ointment used to treat pain) 1% gel d. 2- bottles of Gentiam Violet (a medication used to treat fungus infections of the skin) 2% During an interview on 3/8/23 at 9:03 a.m.,	F 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medication and treatment carts were locked and immediate education was provided to nursing staff. 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 receiving medications have the potential to be affected by the alleged deficient practice. DNS/designee will conduct an inservice with nursing and QMA staff related to the proper procedures to ensure the Medication and treatment carts are locked when not in use. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur?	04/08/2023

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	Certified Nursing Aide (CNA) 2, indicated the treatment cart should have been locked. During an interview on 3/8/23 at 9:08 a.m., Qualified Medicine Assistant (QMA) 3, indicated the treatment cart was supposed to be locked. QMA 3 was not observed to lock the cart at that time. 2. During a random continuous observation on 3/8/23 from 1:35 p.m. until 2:10 p.m., the treatment cart located on the 200 hall across from the mechanical room, was observed to be unlocked. No staff was observed to be in view of the cart. The unlocked treatment cart contained, but was not limited to the following prescribed medicated treatments: a. 1 - one ounce bottle of skin integrity hydrogel. b. 2 - bottles of Gentiam Violot 2%. c. 3- one hundred gram tubes of diclofenac 1% gel d. 2 - tubes of ketoconazole 2% cream During an interview on 3/8/23 at 2:00 p.m., CNA 7 indicated she was not sure where the nurse was, and indicated "this is the time they all usually go on break." During an interview on 3/8/23 at 2:15 p.m., the Unit Manager, indicated the treatment cart should have been locked. During in interview on 3/8/23 at 11:09 a.m., the Administrator indicated 17 of 69 residents are cognitively impaired and self-mobile, that do not reside in memory care or moving forward (locked unit). 3. On 3/8/23 from 8:12 a.m. until 8: 15 a.m., observed LPN 4 (Licensed Practical Nurse)		DNS/designee will do random cart audits five days a week to ensure compliance. Any non-compliance will be immediately addressed thru education. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance program will be put into place? The random cart audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee overseen by the Executive Director monthly for 3 months and then quarterly thereafter. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	administering medications on the 100 hall. LPN 4 was observed to leave the medication cart unlocked with the medication drawers facing out toward the hallway. LPN 4 left the medication cart unattended while assisting residents with their medications in their rooms. At that time, multiple self-mobile residents were observed to pass by the medication cart. There were no other staff members observed in the area at that time. During an interview on 3/8/23 at 1:43 p.m., the Administrator indicated that the medication carts should have been locked when there were no licensed personnel with direct visual contact of the medication cart. During an interview on 3/8/23 at 1:43 p.m., the DON (Director of Nursing) indicated the medication carts should have been locked when there were no licensed personnel with direct visual contact of the medication cart. During an interview on 3/8/23 at 1:43 p.m., the DON indicated there are 8 self-mobile cognitively impaired residents residing on the 100 hall. On 3/8/23 at 1:43 p.m., the DON provided a copy of the medication storage policy, revision dated 1/1/13, and titled: General Dose Preparation and Medication Administration, and indicated it was the current policy followed by the facility. The policy indicated, " ...7. Facility should ensure that medication carts are always locked when out of sight or unattended." 3.1-25(m)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a resident's room was free of spills, was in good sanitary condition, and presented a comfortable living condition for 1 of 24 residents rooms observed. (Resident J) Findings include: On 3/6/23 at 12:04 p.m., observed Resident J resting in bed. The following was observed at his bedside: - Jevity 1.5 cal was being administered at 60 milliliter (ml) per hour through Resident J's gastrostomy tube (g-tube - a tube inserted through the wall of the abdomen directly into stomach). The Jevity bag was hanging on a medication pole and the tubing was connected from the bag to Resident J's g-tube site located on his abdomen. The medication pole had multiple splashes of a dried tan residue adhered to the lower fourth of the pole and on the legs. - Oxygen (O2) was being administered at 2 liters per nasal cannula from the concentrator (a machine that takes in air from the room and filters out nitrogen; the process provides higher amounts of oxygen needed for oxygen therapy). The concentrator was located next to a medication pole. The concentrator had multiple splashes of a dried tan residue adhered to the machine. - On the floor near Resident J's bed, next to the concentrator machine, and around the medication pole were multiple dried splashes of a dried tan	F 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident J equipment and floor were immediately cleaned. 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 resident rooms with medication poles and oxygen concentrators were immediately assessed for cleanliness. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? Executive Director/designee will educate nursing and housekeeping staff on cleaning of medical equipment to include medication poles and oxygen concentrators. Random weekly audits of room cleanliness will be initiated by the Executive Director/designee to ensure equipment is being	04/08/2023

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	residue adhered to the floor. On 3/6/23 at 1:05 p.m., the same was observed. On 3/7/23 at 11:13 a.m., the same was observed. On 3/8/23 at 2:10 p.m., the same was observed. During an observation with the Unit Manager, on 3/8/23 at 2:18 p.m., the same was observed. During an interview at that time, the Unit Manager indicated "that's nasty." The Unit Manager indicated she was aware of the "mess" as she saw it "earlier that morning" and was unsure whose responsibility it was to keep the area clean. During an interview on 3/9/23 at 9:05 a.m., the Administrator indicated Resident J's floor and medical equipment should have been kept clean. On 3/10/23 at 9:45 a.m., the Administrator provided a copy of the Daily Cleaning Procedure document, dated 12/2021 and indicated it was the current procedure used by the facility. A review of the document indicated, "...mop flooring to include under beds, corners, edging and under chairs/equipment...conduct final inspection..." This Federal tag is related to Complaint IN00403245. 3.1-19(f)		cleaned appropriately. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? The random weekly audits will be reviewed in the Quality Assurance and Performance Improvement Committee over seen by the Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	