STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155241	A. BUILDING -- B. WING	03/27/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/27/23 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 At this Emergency Preparedness survey, Forest Creek Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 128 certified beds. At the time of the survey, the census was 83. Quality Review completed on 03/29/23	E 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 survey. Please accept this plan of correction as the provider's credible allegation of compliance as of April 25, 2023. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/27/23 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 At this Life Safety Code survey, Forest Creek	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Executive Director	04/13/2023

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	Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 83 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached wooden storage sheds. Quality Review completed on 03/29/23		cited during the survey. Please accept this plan of correction as the provider's credible allegation of compliance as of April 25, 2023. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			

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	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook tops in 1 of 1 dining/activities rooms was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 15 residents and staff while in the East 100 Wing Dining/Activities Room. Findings include: Based on observation on 03/27/23 from 1:40 p.m.	K 0324	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The cook top in the dining/activities room was immediately shut off at the switch. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The maintenance director/designee will make at least weekly documented rounds to ensure that the cook top is deactivated at the switch. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The maintenance director/designee will make at least weekly documented rounds	04/25/2023

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	to 3:00 p.m. during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor, there was a cooktop stove in the East 100 Wing Dining/Activities Room by resident room 132. When checked, and not in use, the stove top appliance was not deactivated from the individual cooktop power source. Based on interview at the time of observation, the Field Maintenance Supervisor confirmed the cooktop stove was not deactivated when not in use. The Field Maintenance Supervisor deactivated the power source to the cooktop at the breaker at the time of observation. This finding was reviewed with the Executive Director, Maintenance Director and Field Maintenance Supervisor during the exit conference. 3.1-19(b)		to ensure that the cook top is deactivated at the switch. 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? Rounds will be done weekly X 4 weeks, monthly X 2 months and quarterly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 66 resident room corridor door would close completely and latch into the door frame. This deficient practice could affect at least 15 residents and staff. Findings include: Based on observation on 03/27/23 between 1:40 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor, the corridor door to resident room two did not latch when tested several times. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to room two failed to close completely and latch	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Room 2 corridor door has been repaired so it will latch. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A monthly preventative	04/25/2023

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	into the frame when tested. This finding was reviewed with the Executive Director, Maintenance Director and Field Maintenance Supervisor during the exit conference. 3.1-19(b)		maintenance document will be used to ensure all resident room doors latch appropriately. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? A monthly preventative maintenance document will be used to ensure all resident room doors latch 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 monthly preventative maintenance document will be reviewed by the QAPI committee overseen by the Executive Director.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not			

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	require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1. Based on observation and interview, the facility failed to ensure 2 of 6 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect as many as 30 residents, as well as staff and visitors in Memory Care wing and the Activities Room. Findings include: Based on observations on 03/27/23 between 1:40 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor, the following was noted: a. the set of smoke barrier doors located near resident rooms # 11 and # 13 did not fully close. There was a six inch gap between the doors when closed to their fullest due to the door coordinator not functioning properly. b. the set of smoke barrier doors at the Activities Room did not cfully close when tested. There was a six inch gap between the doors when closer to their fullest due to the door coordinator not functioning properly. Based on interview during the time of each observation, the Maintenance Director and Field Maintenance Supervisor both agreed this set of smoke barrier doors did not close and seal completely when tested. 2. Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors did not have paint on the fire rating tags to ensure	K 0374	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The smoke barrier doors at the activity room and near rooms 11 and 13 have been repaired to function properly. The paint covering the fire rating tags on the smoke barrier doors by room 122 has been removed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A monthly preventative maintenance document will be used to ensure smoke barrier doors function appropriately and that there is no paint on the fire rating tags. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? A monthly preventative maintenance document will be	04/25/2023

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	the doors would resist fire for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. This deficient practice could affect 30 residents, as well as staff and visitors. Findings include: Based on observations on 03/27/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor, both doors in the set of smoke barrier doors by resident room 122 had paint covering the fire rating tags. Based on interview at the time of observation, the Maintenance Director and Field Maintenance Supervisor agreed paint was covering the fire rating tags on the sets of smoke barrier doors. This finding was reviewed with the Executive Director, Maintenance Director and Field Maintenance Supervisor during the exit conference. 3.1-19(b)		used to ensure smoke barrier doors function appropriately and that there is no paint on the fire rating tags. 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? This monthly preventative maintenance document will be reviewed by the QAPI committee overseen by the Executive Director.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.			

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide complete fire drill documentation for 2 of 12 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/27/23 between 10:40 a.m. and 1:40 p.m. with the Maintenance Director and Field Maintenance Supervisor present, 2 of 12 documented fire drills performed during the past 12 month period (07/30/22 at 3:00 p.m. and 09/30/22 at 2:25 a.m.) did not include the names and signatures of staff that participated in the fire drills. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on 2 of 12 fire drill reports during the past 12 month period. This finding was reviewed with the Executive Director, Maintenance Director and Field Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance staff have been educated on the fire drill procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The maintenance director/designee will provide the monthly fire drills to the Executive Director for review to ensure paperwork is completed in its entirety. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The maintenance director/designee will provide the monthly fire drills to the Executive Director for review to ensure paperwork is completed in its entirety. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur i.e. what	04/25/2023

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			quality assurance program will be put into place? The fire drill paperwork will be reviewed by the QAPI committee overseen by the Executive Director.	