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	05/21/2025

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 Complaints IN00457850, IN00458538, IN00458615, and IN00458632. Complaint IN00457850 - No deficiencies related to the allegations are cited. Complaint IN00458538 - Federal/State deficiencies related to the allegations are cited at F695, F880 Complaint IN00458615 - Federal/State deficiencies related to the allegations are cited at F925. Complaint IN00458632 - Federal/State deficiencies related to the allegations are cited at F554, F641, F761, and F842. Survey dates: May 20 and 21, 2025 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 90 SNF: 2 Total: 92 Census Payor Type: Medicare: 4 Medicaid: 77 Other: 11 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Neha Patel	HFA	06/12/2025

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 0554 SS=D Bldg. 00	Quality review completed June 2, 2025. 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for 1 of 1 residents observed with medications at the bedside. (Resident C) Findings include: On 5/20/25 at 8:36 a.m., observed a small pill cup with a round brown tablet sitting on Resident C's bedside table. Resident C was resting in bed. During an interview on 5/20/25 at 8:37 a.m., LPN 2 indicated the brown tablet was senna (medication used to treat constipation) 8.6 milligrams (mg) and should not have been left in Resident C's room. The clinical record for Resident C was reviewed on 5/20/25 at 9:43 a.m. The diagnoses included, but were not limited to, diabetes and metabolic encephalopathy. A quarterly Minimum Data Set (MDS) assessment, dated 3/28/25, indicated Resident C had minimum cognitive impairment. The clinical record lacked a self medication administration assessment. During an interview on 5/21/25 at 12:45 p.m., the Director of Nursing (DON) indicated there was no self medication administration assessment completed for Resident C. On 5/21/25 at 8:17 a.m., the Director of Nursing	F 0554	1. Small pill cup and brown tablet were removed and disposed of appropriately. 2. All residents have the potential to be affected by the same deficient practice. Residents who were identified to self administer medications were assessed to determine if able to self medicate. 3. Nurses will be educated on the Self-Administration of Medications policy and not leave medications at bedside if not appropriate by 6/20/25. DNS/Designee will round daily on ten residents to ensure medications are not left at bedside for residents who cannot self medicate. 4. To ensure compliance, the DNS/Designate is responsible for the completion of the Medication Storage/Medication Administration Prep Review QAPI tool weekly times four, monthly times six, and then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	06/27/2025

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	(DON) provided a copy of a facility policy, titled Self Administration of Medications, dated 1/2015, and indicated this was the current policy used by the facility. A review of the policy indicated if a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation. This citation relates to Complaint IN00458632 3.1-11(a)			
F 0641 SS=D Bldg. 00	483.20(g)(h)(i)(j) Accuracy of Assessments Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for a resident that was admitted with an indwelling urinary catheter for 1 of 3 residents reviewed for accuracy of the MDS assessment. (Resident F) Findings include: The clinical record was reviewed for Resident F on 5/20/25 at 11:50 a.m. The diagnoses included, but were not limited to, neurogenic bladder, severe morbid obesity, and diabetes. An Admission Observation, dated 3/28/25, indicated Resident F was admitted with an indwelling urinary catheter An Admission MDS assessment, dated 4/4/25, indicated Resident F did not have an indwelling urinary catheter when he was admitted. A physician's order, initiated on 3/28/25 and	F 0641	1. MDS is modified to accurately reflect the resident with an indwelling urinary catheter. 2. All residents have the potential to be affected by the same deficient practice. MDS/Designee completed an MDS audit for residents with indwelling catheters to ensure accuracy. 3. MDS Coordinator will be educated on the appropriately coding the MDS according to the residents' condition by 6/20/25. 4. To ensure compliance, the MDS/Designee is responsible for the completion of the Coding Error Audit tool weekly times four weeks, monthly times six months, and then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved, an action plan will be	06/27/2025

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	discontinued on 4/10/25, indicated Resident F had an indwelling urinary catheter. During an interview on 5/21/25 at 9:25 a.m., RN 1 indicated Resident F's MDS assessment should have indicated he had an indwelling urinary catheter. On 5/21/25 at 12:58 p.m., reviewed the Resident Assessment Instrument (RAI) Manual, dated 10/2023. A review of the RAI Manual indicated if a resident used an indwelling urinary catheter at any time in the seven days prior to the assessment date it should be documented on the MDS assessment. This citation relates to Complaint IN00458632. 3.1-31(d)		developed to ensure compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure oxygen tubing had been changed, a nebulizer machine was cleaned, and the nebulizer tubing was changed for 3 of 3 residents reviewed. (Resident B, Resident D, Resident E) Findings include: 1. On 5/20/25 at 8:43 a.m., Resident B's nebulizer machine (small machine used to administer liquid inhalation medications) was observed to be stained a purplish color and dusty. The nebulizer machine was sitting on the floor next to the heating unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over	F 0695	1. Oxygen tubing was changed for Residents B and D, nasal canula was changed for Resident D, nebulizer machine was cleaned for Resident B, nebulizer face mask was changed for Residents B and D, water bottle was changed for Residents D and E. 2. All residents with respiratory orders have the potential to be affected by the same deficient practice. All residents receiving oxygen and nebulizer treatments were checked to ensure oxygen tubing was changed per protocol, nebulizer machines were clean, and nebulizer tubing was changed	06/27/2025

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	the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heating unit. The nebulizer face mask was dated 4/13/25. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated a nebulizer machine should not have been placed on the floor and oxygen tubing, the nebulizer tubing, and mask should have been changed weekly. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's order, intiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5mg (milligrams)/3 ml (milliliter) inhalation solution administer one vial by nebulizer every four hours. 2. On 5/20/25 at 8:54 a.m., observed a blue oxygen concentrator sitting next to Resident D's bed. A clear tube connected to the oxygen concentrator extended to a clear plastic water bottle (humidity) with a green lid. The water bottle was dated 3/25/25. Another clear tube connected to the water bottle extended approximately 6 feet and then around Resident D's ears and into the nose (nasal canula). The nasal canula tubing was dated 3/20/25. The clinical record for Resident D was reviewed on 5/21/25 at 10:17 a.m. The diagnosis included, but was not limited to, chronic obstructive pulmonary disorder.		per protocol. 3. Nurses will be educated on Oxygen Therapy procedures. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the Oxygen Therapy QAPI tool weekly times four weeks, monthly times six months, and then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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A current physician's, initiated 12/6/24, indicated Oxygen 1 liter per minute every shift.

3. On 5/20/25 at 9:06 a.m., observed Resident E lying in bed with a nebulizer mask (a mask shaped to fit over the nose and mouth) placed over Resident E's mouth with mist of nebulizer solution spraying out into the open air. There was no staff present in Resident E's room for approximately one minute. The oxygen concentrator was sitting on the floor next to Resident E's bed. A clear tube connected to the oxygen concentrator extended to a clear plastic bottle (humidity) with a green lid. The water bottle was dated 4/21/25.

The clinical record for Resident E was reviewed on 5/21/25 at 8:39 a.m. The diagnoses included, but were not limited to, encephalopathy, neurogenic bladder, and chronic obstructive pulmonary disease.

The current physician's orders included, but were not limited to:

- Change nebulizer tubing one time weekly, initiated 3/6/25.

- Change oxygen tubing and humidity one time weekly, initiated 3/6/25.

During an interview on 5/21/25 at 11:40 a.m., the Director of Nursing (DON) indicated she was unaware of a policy for changing the oxygen and nebulizer tubing and humidity, but the oxygen tubing, nebulizer tubing, and mask should have been changed weekly.

On 5/21/25 at 1:00 p.m., the facility was unable to provide a policy regarding changing oxygen

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	tubing, nebulizer tubing and nebulizer face mask. This citation relates to Complaint IN00458538. 3.1-47(a)(6)			
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 prescription medications were secured for 2 of 2 random observations. Two prescription medications were sitting on top of an unlocked medication cart in a high traffic resident area unsupervised by staff; and two vials of a prescription aerosol medication were sitting in a resident's room who was not prescribed the aerosol medication. (Resident B) Findings include: 1. During an observation on 5/20/25 at 8:05 a.m., observed the west 200 hall medication cart to be unlocked and sitting against the wall near the nurses station. There was no staff supervising the medication cart. On top of the medication cart, observed a white plastic bottle labeled H-Chlor12 0.125% (prescription wound cleanser used to prevent infection) with approximately two ounces of solution remaining in the bottle and a full plastic bottle labeled lactulose (prescription medication used to treat hepatic encephalopathy and constipation) 10 grams (gm)/15 milliliters (ml) solution. During an interview on 5/20/25 at 8:07 a.m., LPN 1 indicated lactulose and H-chlor12 should have been secured and the medication cart should have been locked or supervised by staff.	F 0761	1. Identified medications of wound cleanser and lactulose, albuterol inhalation solution, was removed from the top of the medication cart and securely stored. 2. All residents have the potential to be affected by the same deficient practice. All medication carts were checked to ensure no medications were left unattended or carts left unlocked when not in use. 3. Nurses will be educated on the Medication Storage and Expiration Policy by 6/20/25. DNS/Designee will round daily to ensure medications are not left unattended or carts left unlocked. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the Medication Storage QAPI tool weekly times four, monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	06/27/2025

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	2. On 5/20/25 at 8:43 a.m., observed two unopened clear plastic vials of albuterol inhalation solution (prescription aerosol medication to help breathe more easily) 0.63 milligrams (mg)/3 ml sitting next to Resident B's nebulizer mask on top of the heater unit under the window. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated the albuterol inhalation solution should have been secured in the medication cart. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's order, initiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5 mg/3 ml inhalation solution administer one vial by nebulizer every four hours. The clinical record for Resident B lacked a physician's order for albuterol inhalation solution 0.63 mg/3 ml. On 5/21/25 at 8:17 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 medications including treatment items should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. This citation relates to Complaint IN00458632. 3.1-25(m)			

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 4 residents reviewed for documentation. (Resident B, Resident F) Findings include: 1. On 5/20/25 at 8:43 a.m., observed Resident B's dirty nebulizer machine (small machine used to administer liquid inhalation medications) sitting on the floor next to the heat unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heat unit. The nebulizer face mask was dated 4/13/25. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. The current physician's orders indicated: - Ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5 milligrams (mg)/3 milliliters (ml) inhalation solution administer one vial by nebulizer every four hours, initiated 4/30/25. The Medication Administration Record (MAR), dated 5/1/25 at 12:00 a.m. through 5/20/25 at 8:00 a.m., indicated ipratropium-albuterol 0.5mg/3ml nebulizer solution, document pulse, respirations,	F 0842	1. Resident B's MAR is documented to indicate the MD orders are followed and pulse and respirations are documented. Urine output for Resident F is being documented in the resident's clinical record. 2. All residents with nebulizer orders and indwelling catheters have the potential to be affected by the same deficient practice. All residents with nebulizer orders and indwelling catheters were reviewed to ensure MD orders are followed and documented. 3. Nurses will be educated on the expectations of completing the MAR documentation for nebulizer treatments by 6/20/25. DNS/Designee will review MAR during IDT meeting to ensure physician orders are followed related to documenting in the medical record pulse and respirations and urine output from the indwelling catheter. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the Medication Storage/Medication Administration and Prep Review QAPI tool weekly times four weeks, monthly times six months, and quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved, an action	06/27/2025

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	and breath sounds before administration and breath sounds and minutes of therapy after administration. The MAR lacked completed documentation for the administrations of ipratropium-albuterol 0.5mg/3ml nebulizer solution as follows: - On 5/2/25 at 12:00 a.m., left blank. - On 5/2/25 at 4:00 p.m., pulse and respirations before administration were left blank. - On 5/9/25 at 12:00 a.m., breath sounds before administration, breath sounds after administration, and minutes of treatment were left blank. - On 5/11/25 at 8:00 a.m., left blank. - On 5/11/25 at 12:00 p.m., left blank. - On 5/12/25 at 12:00 a.m., left blank. - On 5/12/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/12/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/13/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/13/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 8:00 a.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/14/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/16/25 at 8:00 a.m., minutes of treatment was		plan will be developed to ensure compliance.	

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	left blank. - On 5/16/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/16/25 at 4:00 p.m., minutes of treatment was left blank. - On 5/16/25 at 8:00 p.m., minutes of treatment was left blank. - On 5/17/25 at 8:00 a.m., minutes of treatment was left blank. - On 5/17/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/17/25 at 8:00 p.m., minutes of treatment was left blank. - On 5/18/25 at 8:00 a.m., minutes of treatment was left blank. - On 5/19/25 at 8:00 a.m., left blank. 2. The clinical record for Resident F was reviewed on 5/20/25 at 11:50 a.m. The diagnoses included, but were not limited to, neurogenic bladder, severe morbid obesity, and diabetes. The physician's orders indicated: - Record urine output from urinary catheter every shift, initiated on 3/28/25 and discontinued on 4/10/25. The Treatment Administration Record (TAR), dated 4/1/25 at 7:00 a.m. through 4/10/25 at 3:00 p.m., lacked documentation that the urinary output was measured as follows: - On 4/3/25 there was no documentation for day shift. - On 4/4/25 there was no documentation for day shift. - On 4/9/25 there was no documentation for night shift.			

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	During an interview on 5/21/25 at 11:40 a.m., the Director of Nursing (DON) indicated the facility did not have a policy on documentation, but all documentation should have been completed. This citation relates to Complaint IN00458632 3.1-50(a)(1) 3.1-50(a)(2)			
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 3 of 3 residents reviewed for infection control. A nebulizer machine and tubing were not maintained in a sanitary manner, a catheter bag was on the floor, and soiled linens, and a brief were not disposed of in a sanitary manner. (Resident B, Resident E, Resident F) Findings include: 1. On 5/20/25 at 8:43 a.m., observed Resident B's dirty nebulizer machine (small machine used to administer liquid inhalation medications) sitting on the floor next to the heat unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heat unit. The nebulizer face mask was dated 4/13/25. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated Resident B's nebulizer machine should not have been placed on the floor and should have been cleaned. The nebulizer mask should	F 0880	1. Oxygen tubing was changed, nebulizer machine was cleaned, nebulizer tubing was changed. Nebulizer mask was replaced for Resident B. Urinary catheter bag for Resident E was removed from the floor and placed in a bag. Resident G's soiled brief, gown, and linen were placed in appropriate receptacles. 2. All residents with respiratory and catheter orders have the potential to be affected by the same deficient practice. All residents utilizing a nebulizer machine and catheter were observed to ensure the nebulizer machine was clean, tubing was appropriately bagged, and catheter bags were appropriately positioned by the DNS/Designee. All rooms were observed for soiled linens and briefs on the floor by CARE Companions/Designee to ensure appropriate infection control practices. 3. Nurses will be educated on the	06/27/2025

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	05/21/2025

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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	have been placed in a bag not left lying out on the heat unit. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's, initiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5mg/3ml inhalation solution administer one vial by nebulizer every four hours. 2. On 5/20/25 at 9:06 a.m., observed Resident E's urinary catheter bag sitting directly on the floor with approximately 400 milliliters (ml) of yellow liquid inside. On 5/20/25 at 9:07 a.m., Qualified Medication Aide (QMA) 1 indicated Resident E's catheter bag should not have been left on the floor. The clinical record for Resident E was reviewed on 5/21/25 at 8:39 a.m. The diagnoses included, but were not limited to, encephalopathy and neurogenic bladder. An admission Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident E was admitted with an indwelling urinary catheter. A current physician's order, initiated 3/6/25, indicated Foley catheter size 14 French scale (Fr) with 10 milliliter (ml) balloon. During an interview on 5/20/25 at 9:03 a.m., RN 1 indicated catheter bags should not be touching the floor.		deficient practices by 6/20/25. DNS/Designee will conduct rounds each day to ensure appropriate infection control practices are followed related to nebulizer machines, catheter bags, and soiled linens and briefs. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the Oxygen Therapy and Catheter Care QAPI tool weekly times four weeks, monthly times six months, and then quarterly thereafter. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	155241	A. BUILDING 00 B. WING	05/21/2025

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FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

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	3. On 5/20/25 at 8:11 a.m., observed a soiled brief, gown, and linen lying on the floor in Resident G's room. Resident G was not in his room. During an interview on 5/20/25 at 8:13 a.m., CNA 1 indicated Resident G's brief, gown, and linen were soiled with urine and should not have been left on the floor. The clinical record for Resident G was reviewed on 5/20/25 at 9:32 a.m. The diagnoses included, but were not limited to, lung cancer, dementia, and dysphagia. A quarterly MDS assessment, dated 4/4/25, indicated Resident G was always incontinent of bladder. On 5/21/25 at 12:35 p.m., the Director of Nursing (DON) provided a copy of a facility policy, titled Nursing Department Infection Control, dated 12/2024, and indicated this was the current policy used by the facility. A review of the policy indicated urinary drainage tubes and bags should not touch the floor. Bag/contain contaminated linen. Store equipment in a way that prevents contamination. Administer treatment according to professional standards. This citation relates to Complaint IN00458538. 3.1-18(b)(1)			
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program Based on observation, interview, and record review, the facility failed to ensure the facility was free from roaches for 1 of 1 random observations.	F 0925	1. Room and hallway was cleaned immediately outside of Resident H's room.	06/27/2025

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	155241	A. BUILDING 00 B. WING	05/21/2025

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	Finding includes: On 5/20/25 at 9:09 a.m., observed a brown cockroach crawling on the floor outside a resident's room. At that time, Resident H indicated he had seen a roach near his door. On 5/21/25 at 8:15 a.m., the Administrator provided a copy of a facility policy, titled Pest Control, dated 9/2023, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will maintain an effective pest control program so that the facility is free from pests. This citation relates to Complaint IN00458615 3.1-19(f)(4)		2. All residents have the potential to be affected by the same deficient practice. All rooms and hallways were checked for roaches and deep cleaning occurred as needed. 3. All staff will be educated on the Pest Control policy and Pest Logbook by 6/20/25. CARE Companions/Designee will check rooms for cleanliness and pest issues. Any identified area will be deep cleaned. 4. To ensure compliance, the Housekeeping Supervisor/Designee is responsible for the completion of the Housekeeping/Environmental Cleanliness QAPI tool weekly times four weeks, monthly times six months, and quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	