SS=D

Bldg. 00

Neha Patel

PRINTED: 07/09/2025

EPARTMENT OF HEALTH AND HU	FORM APPROVED		
ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	155241	B. WING	06/24/2025

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD FOREST CREEK VILLAGE INDIANAPOLIS. IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0000 Bldg. 00 This visit was for the Investigation of Complaints F 0000 The creation and submission of IN00461240 and IN00461884. this Plan of Correction does not constitute an admission by this Complaint IN00461240 - Federal/State deficiencies provider of any conclusion set related to the allegations are cited at F656, F880, forth in the statement of and F921. deficiencies, or of any violation of regulation. Complaint IN00461884 - Federal/State deficiencies This provider respectfully related to the allegations are cited at F804, F812, requests that this 2567 Plan of F921, and F880. Correction be considered the Letter of Credible Allegation of Survey dates: June 23 and 24, 2025 Compliance and requests a desk review. Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 85 SNF: 4 Total: 89 Census Payor Type: Medicare: 3 Medicaid: 71 Other: 15 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 1, 2025. F 0656 483.21(b)(1)(3)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

F 0656

**HFA** 

1. Resident B's care plan was

07/07/2025

07/07/2025

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.

Develop/Implement Comprehensive Care Plan

Based on observation, interview, and record

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155241	B. WING			06/24/2025	
		l		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			THOMPSON RD		
EODEST	CREEK VILLAGE				APOLIS, IN 46227		
FUREST	OREEN VILLAGE			INDIAN	AFULIS, IN 40221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review, the facility				checked and resident's bed w	as	
	_	e plan interventions were			placed in the lowest position.		
		resident with a high risk for a			2. All residents who have fall		
	falls for 1 of 3 resid	ents reviewed for falls.			interventions in place have the	•	
	(Resident B)				potential to be affected by the		
					alleged deficient practice. All		
	Findings include:				residents who had a care plan		
					at risk for falls were reviewed	by	
		3 a.m., observed Resident B's			DNS/Designee to ensure		
		ed was approximately two feet			interventions listed on the care	e	
		in the lowest position. At that			plan were in place.		
		dication Aide (QMA) 1 entered			Nursing staff were educated	d on	
	Resident B's room and indicated the bed should				the comprehensive care policy	<b>/</b> .	
	not have been left the	hat high.			CARE Companions will check	fall	
					interventions are in place five		
		for Resident B was reviewed			times a week.		
		a.m. The diagnoses included,			4. CARE Companions checke	d all	
		d to, congestive heart failure,			residents' profiles to ensure fa	II	
	diabetes, and respir	atory failure.			interventions were put into pla	ce.	
					DNS/Designee will check fall		
	A quarterly Minimu				interventions for 10 residents		
		/4/25, indicated Resident B			weekly times four weeks, mon	-	
		gnitively impaired and had a			times six months, then quarter	-	
		ore falls with one injury while a			thereafter. The results of these	Э	
	resident at the facili	ty.			audits will be reviewed by the		
					QAPI Committee. If a threshol		
	_	8/6/25, indicated Resident B			95% is not achieved, an action		
		The interventions included,			plan will be developed to ensu	ire	
	but were not limited	l to, bed in lowest position.			compliance.		
	A assument1	la andon, data d 2/17/25					
	A current physician's order, dated 3/17/25, indicated Resident B's bed was to be in the lowest						
		bs ded was to be in the lowest					
	position.						
	On 6/24/25 at 9:22 a m the Director of Nameina						
	On 6/24/25 at 8:32 a.m., the Director of Nursing provided a copy of a facility policy, titled						
		re Plan Policy, dated 8/2023,					
	_	ras the current policy used by					
		w of the policy indicated it was					
	ine policy of the fac	cility that every resident would	1				

X1) PROVIDER/SUPPLIER/CLIA	ľ	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		A. BUILDING 00			COMPLETED	
155241	B. WI	NG		06/24/	/2025	
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE		525 E 1	THOMPSON RD			
STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION	
LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
red care plan developed and						
to Complaint IN00461240.						
pear, Palatable/Prefer						
Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure residents received meals that were palatable and at a proper temperature for 2 of 4 residents reviewed for palatability and proper temperature of food. (Resident C, Resident D)  Findings include:  On 6/23/25 at 8:35 a.m. until 8:45 a.m., observed a metal cart sitting in the hallway with a meal tray for Resident C. At that time, CNA 2 indicated the meal trays had been delivered to the hall at approximately 8:30 a.m. and then CNA 2 walked away from the cart.  On 6/23/25 at 8:50 a.m., observed CNA 1 remove a meal tray for Resident C and deliver it to Resident C's room. CNA 1 removed the lid from the plate and asked Resident C to let him know if she needed anything else. CNA 1 left Resident C's room.  On 6/23/25 at 8:51 a.m. observed Resident C try to cut a sausage link on her plate with a fork but was not able to do so. Resident C had a frustrated look on her face and tasted the scrambled eggs. At that		804	at preferred temperature and assisted with feeding. Resider D's meal was heated at prefer temperature.  2. All residents who prefer hal trays have the potential to be affected by the alleged deficie practice.  3. CNAs were educated on passing trays immediately upour arrival of the hallway carts and assistance with resident's meat temperatures and feeding.  4. Culinary Manager/Designed observe hall tray pass related temp of food five times a weel four weeks, monthly times six months, then quarterly therea. The results of these audits will reviewed by the QAPI Commil of threshold of 95% is not achieved, an action plan will be	nt rred llway ent on d al e will to k for fter. I be ttee.	07/07/2025	
	ESTATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION  red care plan developed and  to Complaint IN00461240.  pear, Palatable/Prefer on, interview, and record failed to ensure residents were palatable and at a proper f 4 residents reviewed for per temperature of food.  ent D)  a.m. until 8:45 a.m., observed a the hallway with a meal tray hat time, CNA 2 indicated the delivered to the hall at a.m. and then CNA 2 walked  a.m., observed CNA 1 remove a ent C and deliver it to Resident emoved the lid from the plate C to let him know if she te. CNA 1 left Resident C's  a.m. observed Resident C try to n her plate with a fork but was esident C had a frustrated look	IDENTIFICATION NUMBER 155241  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION red care plan developed and  to Complaint IN00461240.  Pear, Palatable/Prefer on, interview, and record failed to ensure residents were palatable and at a proper f4 residents reviewed for per temperature of food. ent D)  a.m. until 8:45 a.m., observed a the hallway with a meal tray hat time, CNA 2 indicated the delivered to the hall at a.m. and then CNA 2 walked  a.m., observed CNA 1 remove a ent C and deliver it to Resident emoved the lid from the plate C to let him know if she i.e. CNA 1 left Resident C's  a.m. observed Resident C try to in her plate with a fork but was esident C had a frustrated look ed the scrambled eggs. At that dicated she rarely received hot od sat in the hallway.	IDENTIFICATION NUMBER 155241  STREET: 525 E T INDIAN  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION red care plan developed and  to Complaint IN00461240.  TAG  TO STREET: 525 E T INDIAN  TAG  PREFIX TAG  TAG  TAG  TAG  F 0804  F 0804	IDENTIFICATION NUMBER  155241  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227  ID PREFIX CROSS-REFERENCED TO THE APPROPRIA TAG  1. Resident C's meal was heated at prefer the prefer the properture and assisted with feeding. CA USING THE APPROPRIA TAG  1. RESIDENCY  1. RESIDENCY  1. RESIDENCY  1	IDENTIFICATION NUMBER  155241  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION red care plan developed and  to Complaint IN00461240.  FOR a pear, Palatable/Prefer on, interview, and record failed to ensure residents were palatable and at a proper f4 residents reviewed for per temperature of food. Int D)  A. B. BUILDING 525 E THOMPSON RD INDIANAPOLIS, IN 46227  ID PREFIX TAG  FORME CORRECTION EXCEPTION ACTION SHOULD BE EXCESS-REPERBURY ACTION SHOULD BE EXCESS-REPERBURY.  TO SHOULD THE ACTION SHOULD BE EXCESSED.  A SCHAMEN SHOULD BE EXCESSED.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155241		A. BUILDING 00 CC		(X3) DATE SURVEY  COMPLETED  06/24/2025			
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE		525 E	STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION			
TAG		a LSC IDENTIFYING INFORMATION sage because it was like	TAG	Di Reiseri	DATE		
	sitting on her bed we sitting in front of he approximately fifty balled up napkin sit Resident D indicate and she didn't want asked for her meal too long.  On 6/24/25 at 8:32 aprovided a copy of Temperatures, dated was the current policy food would be served temperature that was time the resident recommendation.	percent of the meal and had a ting on the food. At that time, d her food wasn't hot again to eat it. Resident D had not to be reheated because it took  a.m., the Director of Nursing a facility policy, titled Food d 5/2025, and indicated this cy used by the facility. A v indicated all hot and cold ed to the resident at a is considered palatable at the					
	1.3-21(a)(2)						
F 0812 SS=E Bldg. 00	Based on observation review the facility of served in a sanitary observations. The last Findings include:  During the initial to from 8:26 a.m. until an unknown dark su	e/Prepare/Serve-Sanitary on, interview, and record failed to ensure food was environment for 1 of 2 kitchen citchen floors were dirty.  our of the kitchen on 6/23/25 18:32 a.m., observed buildup of abstance, dust, debris, a veral plastic lids under a	F 0812	1. The observed buildup of an unknown dark substance, dus and debris were immediately cleaned under the freezer. The buildup of dust and debris und the shelves in the dry storage room was immediately cleane 2. No residents have the potent to be affected by the alleged deficient practice. Kitchen floorwere cleaned throughout by	t, e ler d. ntial		

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f		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155241	B. WI	NG	_	06/24/	/2025
	PROVIDER OR SUPPLIER		•	525 E 1	ADDRESS, CITY, STATE, ZIP COD THOMPSON RD NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	D DANGUIDENG TO THE CONTROL OF THE C		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·	DATE
	freezer of the main	kitchen area. A buildup of dust			culinary manager/designee.		
	and debris under the	e shelves in the dry storage			3. Culinary staff were educate	d on	
	room was observed.	At that time, the dietary			the cleaning schedule touching	g on	
	supervisor indicated	I the floors under the freezer			these areas. Culinary		
	and in the dry storag	ge room should have been			manager/designee will check		
	cleaned.				areas five times a week. Culin	ary	
					Manager/Designee will observ	re	
	On 6/24/25 at 11:45	a.m., the Director of Nursing			kitchen floors daily to ensure		
	provided a copy of	a facility policy, titled Cleaning			floors are clean and no extra		
	Floors, Tables, and	Chairs, dated 7/2015, and			debris is present.		
	indicated this was th	ne current policy used by the			4. Culinary Manager/Designed	e will	
	facility. A review of	f the policy indicated kitchen			complete a Short Sanitation a		
	floors will be kept o	lean and sanitary.			weekly for four weeks, monthly	y	
		times six months, then quarterly					
	This citation relates	to Complaint IN00461884.			thereafter. The results of these	Э	
					audits will be reviewed by the		
	3.1-21(i)(2)				QAPI Committee. If a threshol	d of	
	3.1-21(i)(3)				95% is not achieved, an action	1	
					plan will be developed to ensu	ire	
					compliance.		
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention						
	Based on observation	on, interview, and record	F 08	380	1. LPN 1 and CNA 1 were		07/07/2025
	review, the facility	failed to ensure enhanced			immediately educated on		
	barrier precautions	(the use of gown and gloves			Enhanced Barrier		
	during high contact	resident care activities for			Precautions/donning and doffi	ng	
	residents that are at	increased risk to transfer or			and gown and gloves were pla	aced	
	become infected wi	th multi-drug resistant			according to policy.		
	organisms) were im	plemented for a resident with			2. All residents with Enhanced	l	
	an indwelling urina	ry catheter for 1 of 3 residents			Barrier Precautions have the		
	reviewed for infecti	on control. (Resident B)			potential to be affected by the		
	<u> </u>				alleged deficient practice.		
	Findings include:				Nursing staff were educated		
					Enhanced Barrier Precautions	i	
		a.m., observed Licensed			policy.		
	· ·	N) 1 and CNA 1 transferring			4. DNS/Designee will complete		
		ed with a mechanical lift.			the Enhanced Barrier Precaut		
	Hanging on the doo	r inside Resident B's room,			QAPI tool weekly for four wee	ks.	l

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155241	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>		ESURVEY LETED 1/2025		
	PROVIDER OR SUPPLIER		525 E	STREET ADDRESS, CITY, STATE, ZIP COD  525 E THOMPSON RD  INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	personal protective individually wrapped masks. Once Residuals observed LPN 1 had catheter bag on the LPN 1 was wearing 1 was not wearing good During an interview indicated staff shou and gloves when transport on 6/23/25 at 9:29 a was not limited to, of A quarterly Minimulassessment, dated 6 had an indwelling with a multi-drug reenhanced barrier properties on 6/24/25 at 8:32	equipment was observed with ed plastic gowns, gloves, and ent B was transferred to bed, ing Resident B's urinary bed frame below the mattress. It gloves but no gown and CNA gloves nor gown.  If on 6/23/25 at 9:14 a.m., CNA 1 lld have been wearing a gown ansferring Resident B.  If or Resident B was reviewed a.m. The diagnosis included, but obstructive uropathy.  In Data Set (MDS)  In Data Set (MDS)		monthly times six mon quarterly thereafter. The these audits will be retithe QAPI Committee. Threshold of 95% is not an action plan will be consure compliance.	nths, then he results of viewed by If a ot achieved,			
	indicated this was the facility. A review o	recautions, dated 3/2025, and he current policy used by the f the policy indicated wear r a resident with an indwelling ting transfers.						
	-	to Complaints IN00461240						
	3.1-18(b)(1)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155241		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL <b>06/24</b> /	LETED		
	PROVIDER OR SUPPLIER		525 E	STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE		
F 0921 SS=D Bldg. 00	Based on observation failed to ensure a sare residents for 1 of 1  Findings include:  During the initial to from 8:30 a.m. untion an unknown black of floorboards and the the 100 hall.  On 6/23/25 at 11:30 six inches of the blat floorboards and the substance was thick and other debris mind Director of Nursing been scraped up with the floor.  During an interview Housekeeping Supercleaned daily and the buildup off the floor On 6/24/25 at 12:10 provide a policy by	a.m., observed approximately ack substance along the floor trim be scraped up. The approximately ack substance along the floor trim be scraped up. The approximately ack substance along the floor trim be scraped up. The approximately approxi	F 0921	1. The black substance locate along the floorboards and the trim were immediately scraped 2. All residents have the poter to be affected by the alleged deficient practice. the floor boand floor trim was checked throughout the facility by housekeeping supervisor/desito ensure these were clean ar sanitary.  3. Floor Tech was educated the cleaning schedule of the floorboards and floor trim. Housekeeping Supervisor/Designee will audifloorboards and floor trim wee 4. Housekeeping Supervisor/Designee will com the Environmental QAPI tool weekly times four weeks, mor times six months, then quarter thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshol 95% is not achieved, an action plan will be developed to ensurcompliance.	floor d up. htial ards ggnee hd on t the kly. plete hthly rly e	07/07/2025		

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