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	06/24/2025

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 the Investigation of Complaints IN00461240 and IN00461884. Complaint IN00461240 - Federal/State deficiencies related to the allegations are cited at F656, F880, and F921. Complaint IN00461884 - Federal/State deficiencies related to the allegations are cited at F804, F812, F921, and F880. Survey dates: June 23 and 24, 2025 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 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.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record	F 0656	1. Resident B's care plan was	07/07/2025

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

Neha Patel | HFA | 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.

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	review, the facility failed to ensure person-centered care plan interventions were implemented for a resident with a high risk for a falls for 1 of 3 residents reviewed for falls. (Resident B) Findings include: On 6/23/25 at 11:08 a.m., observed Resident B's lying in bed. The bed was approximately two feet from the floor, not in the lowest position. At that time, Qualified Medication Aide (QMA) 1 entered Resident B's room and indicated the bed should not have been left that high. The clinical record for Resident B was reviewed on 6/23/25 at 9:29 a.m. The diagnoses included, but were not limited to, congestive heart failure, diabetes, and respiratory failure. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated Resident B was moderately cognitively impaired and had a history of two or more falls with one injury while a resident at the facility. A care plan, dated 3/6/25, indicated Resident B was at risk for falls. The interventions included, but were not limited to, bed in lowest position. A current physician's order, dated 3/17/25, indicated Resident B's bed was to be in the lowest position. On 6/24/25 at 8:32 a.m., the Director of Nursing provided a copy of a facility policy, titled Comprehensive Care Plan Policy, dated 8/2023, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility that every resident would		checked and resident's bed was placed in the lowest position. 2. All residents who have fall interventions in place have the potential to be affected by the alleged deficient practice. All residents who had a care plan for at risk for falls were reviewed by DNS/Designee to ensure interventions listed on the care plan were in place. 3. Nursing staff were educated on the comprehensive care policy. CARE Companions will check fall interventions are in place five times a week. 4. CARE Companions checked all residents' profiles to ensure fall interventions were put into place. DNS/Designee will check fall interventions for 10 residents weekly times four weeks, monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	have a person-centered care plan developed and implemented. This citation relates to Complaint IN00461240. 3.1-35(g)(2)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) 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 time, Resident C indicated she rarely received hot food because the food sat in the hallway. Resident C indicated her food was cold and she	F 0804	1. Resident C's meal was heated at preferred temperature and assisted with feeding. Resident D's meal was heated at preferred temperature. 2. All residents who prefer hallway trays have the potential to be affected by the alleged deficient practice. 3. CNAs were educated on passing trays immediately upon arrival of the hallway carts and assistance with resident's meal temperatures and feeding. 4. Culinary Manager/Designee will observe hall tray pass related to temp of food five times a week for four weeks, monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	07/07/2025

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	couldn't cut the sausage because it was like rubber. On 6/23/25 at 8:54 a.m., observed Resident D sitting on her bed with her meal tray on her table sitting in front of her. Resident D ate approximately fifty percent of the meal and had a balled up napkin sitting on the food. At that time, Resident D indicated her food wasn't hot again and she didn't want to eat it. Resident D had not asked for her meal to be reheated because it took too long. On 6/24/25 at 8:32 a.m., the Director of Nursing provided a copy of a facility policy, titled Food Temperatures, dated 5/2025, and indicated this was the current policy used by the facility. A review of the policy indicated all hot and cold food would be served to the resident at a temperature that was considered palatable at the time the resident received the food. This citation relates to Complaint IN00461884. 1.3-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review the facility failed to ensure food was served in a sanitary environment for 1 of 2 kitchen observations. The kitchen floors were dirty. Findings include: During the initial tour of the kitchen on 6/23/25 from 8:26 a.m. until 8:32 a.m., observed buildup of an unknown dark substance, dust, debris, a screwdriver, and several plastic lids under a	F 0812	1. The observed buildup of an unknown dark substance, dust, and debris were immediately cleaned under the freezer. The buildup of dust and debris under the shelves in the dry storage room was immediately cleaned. 2. No residents have the potential to be affected by the alleged deficient practice. Kitchen floors were cleaned throughout by	07/07/2025

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	freezer of the main kitchen area. A buildup of dust and debris under the shelves in the dry storage room was observed. At that time, the dietary supervisor indicated the floors under the freezer and in the dry storage room should have been cleaned. On 6/24/25 at 11:45 a.m., the Director of Nursing provided a copy of a facility policy, titled Cleaning Floors, Tables, and Chairs, dated 7/2015, and indicated this was the current policy used by the facility. A review of the policy indicated kitchen floors will be kept clean and sanitary. This citation relates to Complaint IN00461884. 3.1-21(i)(2) 3.1-21(i)(3)		culinary manager/designee. 3. Culinary staff were educated on the cleaning schedule touching on these areas. Culinary manager/designee will check areas five times a week. Culinary Manager/Designee will observe kitchen floors daily to ensure floors are clean and no extra debris is present. 4. Culinary Manager/Designee will complete a Short Sanitation audit weekly for four weeks, monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
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 enhanced barrier precautions (the use of gown and gloves during high contact resident care activities for residents that are at increased risk to transfer or become infected with multi-drug resistant organisms) were implemented for a resident with an indwelling urinary catheter for 1 of 3 residents reviewed for infection control. (Resident B) Findings include: On 6/23/25 at 8:58 a.m., observed Licensed Practical Nurse (LPN) 1 and CNA 1 transferring Resident B to the bed with a mechanical lift. Hanging on the door inside Resident B's room,	F 0880	1. LPN 1 and CNA 1 were immediately educated on Enhanced Barrier Precautions/donning and doffing and gown and gloves were placed according to policy. 2. All residents with Enhanced Barrier Precautions have the potential to be affected by the alleged deficient practice. 3. Nursing staff were educated on Enhanced Barrier Precautions policy. 4. DNS/Designee will complete the Enhanced Barrier Precautions QAPI tool weekly for four weeks,	07/07/2025

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	personal protective equipment was observed with individually wrapped plastic gowns, gloves, and masks. Once Resident B was transferred to bed, observed LPN 1 hang Resident B's urinary catheter bag on the bed frame below the mattress. LPN 1 was wearing gloves but no gown and CNA 1 was not wearing gloves nor gown. During an interview on 6/23/25 at 9:14 a.m., CNA 1 indicated staff should have been wearing a gown and gloves when transferring Resident B. The clinical record for Resident B was reviewed on 6/23/25 at 9:29 a.m. The diagnosis included, but was not limited to, obstructive uropathy. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated Resident B had an indwelling urinary catheter. A Care Plan, dated 6/13/25, indicated Resident B was at risk of transferring or becoming colonized with a multi-drug resistant organism and required enhanced barrier precautions because Resident B had an indwelling urinary catheter. The interventions included, but were not limited to, enhanced barrier precautions. On 6/24/25 at 8:32 a.m., the Director of Nursing 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 wear gown and gloves for a resident with an indwelling urinary catheter during transfers. This citation relates to Complaints IN00461240 and IN00461884. 3.1-18(b)(1)		monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure a sanitary environment for the residents for 1 of 1 random observations. Findings include: During the initial tour of the 100 Hall on 6/23/25 from 8:30 a.m. until 8:35 a.m., observed buildup of an unknown black substance along the floorboards and the floorboard trim throughout the 100 hall. On 6/23/25 at 11:30 a.m., observed approximately six inches of the black substance along the floorboards and the floor trim be scraped up. The substance was thick, black, and tar like with hair and other debris mixed with it. At that time the Director of Nursing indicated that should have been scraped up when the housekeeper cleaned the floor. During an interview on 6/23/25 at 11:41 a.m., the Housekeeping Supervisor indicated the floors are cleaned daily and the staff should be scraping the buildup off the floor at that time. On 6/24/25 at 12:10 p.m., the facility was unable to provide a policy by survey exit. This citation relates to Complaints IN00461884 and IN00461240. 3.1-19(f)	F 0921	1. The black substance located along the floorboards and the floor trim were immediately scraped up. 2. All residents have the potential to be affected by the alleged deficient practice. the floor boards and floor trim was checked throughout the facility by housekeeping supervisor/designee to ensure these were clean and sanitary. 3. Floor Tech was educated on the cleaning schedule of the floorboards and floor trim. Housekeeping Supervisor/Designee will audit the floorboards and floor trim weekly. 4. Housekeeping Supervisor/Designee will complete the Environmental QAPI tool weekly times four weeks, monthly times six months, then quarterly thereafter. The results of these audits will be reviewed by the QAPI Committee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	07/07/2025