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	01/30/2025

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00451295 and IN00451872. Complaint IN00451295 - No deficiencies related to the allegations are cited. Complaint IN00451872 - No deficiencies related to the allegations are cited. Survey dates: January 27, 28, 29, & 30, 2025 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 93 SNF: 1 Total: 94 Census Payor Type: Medicare: 1 Medicaid: 77 Other: 16 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 5, 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 the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after February 14, 2025.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record	F 0689	F689 Free of Accident	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Craig	Executive Director	02/11/2025

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 potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the materials for 2 of 2 observations. Finding included: On 1/27/25 at 9:05 a.m., observed the door to the Soiled Utility Room on the west hall across from the laundry room to be unlocked with no staff in the immediate area. In the room, four full sharps containers were observed. One sharps container was not secured and was lying on its side with used needles exposed. During an interview on 1/27/25 at 9:10 a.m., the Maintenance Director indicated that the door to the Soiled Utility Room was supposed to be locked. During an observation on 1/27/25 at 10:00 a.m., the door to Soiled Utility Room was observed to be unlocked with no staff in the area. During an interview on 1/27/25 at 10:11 a.m., Director of Nursing (DON), indicated that the door was supposed to be locked. On 1/27/25 at 10:52 a.m., the DON provided, a copy of American Senior Communities Policy title: Bloodborne Pathogens Exposure Control Plan (ECP), revised date of, 12/2023, and indicated it was the current document in use by the facility. A review of the Policy documented, " ... The facility will provide a safe and healthy work environment for all personnel. The Exposure Control Plan is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standards ..." and " ... Procedure 1, section 6, Infectious Waste indicated, "...a.		Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Upon notification, the soiled utility room door was immediately locked. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? • All residents have the potential to be affected by the alleged deficient practice. • All staff in-service to be completed by the Maintenance Director /designee regarding storage of hazardous materials behind locked doors by February 14, 2025. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • All staff in-service to be completed by the Maintenance Director /designee regarding storage of hazardous materials behind locked doors by February 14, 2025. • Observational rounds will be completed by the Maintenance Director/designee daily to ensure all hazardous materials are behind locked doors. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what	

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	Properly seal sharps container..." 3.1-45(a)(1)		quality assurance program will be put into place? • The DNS/designee will be responsible for the completion of the Environmental QA Tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to document the drug dispositions for 2 of 3 residents reviewed for drug disposition. (Resident 295, Resident 91) Findings included: 1. On 1/29/25 at 10:35 a.m., the clinical record of Resident 295 was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and transient cerebral ischemic attack. A physician's order summary report of medications, dated for active orders as of 6/16/24, included, but were not limited to:	F 0755	F755 Pharmacy Services/Procedures/Pharmacist/ Records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Resident 295 no longer resides at the facility • Resident 91 no longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/14/2025

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	- Eliquis 6 mg (milligrams) for transient cerebral ischemic attack - Norvasc 10 mg for hypertension - Vitamin D3 for vitamin D deficiency A progress note, dated 12/27/24 at 3:04 p.m., indicated Resident 295 was transferred to another facility along with her medications. Resident 295's clinical record lacked documentation listing any name, type, or amount of medications that were sent home with the resident or resident's representative. During an interview on 1/29/25 at 10:50 a.m., the Regional Director of Nursing indicated that the facility lacked documentation for drug dispositions for Resident 295. 2. On 1/29/25 at 10:35 a.m., the clinical record of Resident 91 was reviewed. The diagnoses included, but were not limited to, schizophrenia and anxiety disorder. A physician's order summary report of medications, dated for active orders as of 9/3/24, included, but were not limited to: - Clozapine 200 mg for schizophrenia - Miralax 17 gram for constipation - Terbinafine HCl 250 mg for fungal infection - Sertraline 50 mg for depression A progress note, dated 12/2/24 at 8:00 a.m., indicated Resident 91 was discharged home with family. The clinical record lacked documentation listing any name, type, or amount of medications that		action(s) will be taken; • All residents that are discharged from the facility or are transferred to another facility have the potential to be affected by the alleged deficient practice. • All licensed nursing staff will be in-serviced by DNS/designee on the appropriate process for medication disposition by February 14, 2025 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • All licensed nursing staff will be in-serviced by DNS/designee on the appropriate process for medication disposition by February 14, 2025 • DNS/designee will utilize the IDT Discharge to Home / Transfer to another facility tool with each resident transfer and ensure a copy of the medication disposition record is present How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • The DNS/designee will be responsible for the completion of the Drug Disposition QA Tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is	

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	were sent home with the resident or resident's representative. During an interview on 1/29/25 at 10:50 a.m., the Regional Director of Nursing indicated the facility lacked documentation for drug dispositions for Resident 91. On 1/28/25 at 2:30 p.m., the Director of Nursing provided a policy titled Drug Disposition Policy, dated November, 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated "Procedure: 6. The record of Product Destruction form will be printed and signed by the licensed nurse and witness. 7. The record of Product Destruction form will be placed in the resident's clinical record." 3.1-25(s)(2) 3.1-25(s)(5)		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	