PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

			MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155241				COMPL 02/10/	
		100241	D. W.			02/10/	2023
NAME OF F	PROVIDER OR SUPPLIER	L.		525 E T	ADDRESS, CITY, STATE, ZIP COD THOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Didg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/10/25  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 89.  Quality Review completed on 02/12/25		E 00	E 0000  K000  The creation and submission this plan of correction does constitute an admission by the provider of any conclusion in the statement of deficient of any violation of regulation provider respectfully requeses the 2567 plan of correction is considered the letter of credictallegation and requests desireview (paper compliance) of after February 24, 2025.		ot s forth es, or This that	
K 0000							'
Bldg. 01							
3149. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 02/10/ Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety 0	00145 55241	this plan of constitute provider of in the state of any viol provider returned the 2567 proconsidered allegation review (page 1500 provider returned to the 2567 proconsidered allegation review (page 2500 provider returned to the 2567 provider returned to the 2567 provider review (page 2500 provider returned to the 2567 provider return		K000 The creation and submission of this plan of correction does not constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation of regulation. provider respectfully requests the 2567 plan of correction be considered the letter of credib allegation and requests desk review (paper compliance) on after February 24, 2025.	ot s forth ss, or This that	
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	TITLE		(X6) DATE

John Craig **Executive Director** 02/24/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TH8421 Facility ID: 000145 If continuation sheet

						PRIN'	TED:	02/27/2025
DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES							ROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0	938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155241	B. WING				02/10/2025	
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 525 E THOMPSON RD INDIANAPOLIS, IN 46227					
(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	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D	ATE
	Requirements for Pa	articipation in						
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),						
	Life Safety from Fi	re and the 2000 Edition of the						
	National Fire Protect	ction Association (NFPA) 101,						
	Life Safety Code (L	SC), Chapter 19, Existing						
	Health Care Occupa	ancies and 410 IAC 16.2.						

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 89 at the time of this visit.

This one-story facility was determined to be of Type V (000) construction and is fully sprinklered.

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 02/12/25

K 0321 SS=E Bldg. 01

## Hazardous Areas - Enclosure

**NFPA 101** 

Based on observation and interview, the facility failed to ensure 1 of 8 hazardous areas such as a soiled linen rooms, was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect as many as 16 residents, 4 staff, and 2 visitors.

Findings include:

Based on observations made with the Maintenance Supervisor during a tour of the facility at 11:27 a.m. on 02/10/25, the corridor door K 0321

#### K321 Hazardous Areas-**Enclosure**

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

- Upon notification, the soiled utility (linen) room door was immediately forcibly closed and latched into the door frame.
- To correct the deficiency, a shim was placed between the hinge at the bottom of the door and the door jamb. This allowed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TH8421

Facility ID: 000145

If continuation sheet

Page 2 of 8

02/24/2025

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155241	B. W	ING		02/10/2025	
				OTT DET	ADDRESS SITU STATE TO SOF		
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
FOREST ORFEW VILLAGE					HOMPSON RD		
FOREST	CREEK VILLAGE			INDIAN	APOLIS, IN 46227		
(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	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to the Soiled utility	room between the Activities			the door to fully close and latc	h	
	room and the south	nurse's station was equipped			into the door frame, appropria	tely	
	with a self-closing	device but the door failed to			self-closing, separating other		
	fully close and latch	n into the door frame when			spaces by a smoke resistant		
	tested three separate	e times. When swinging to			door.		
	close, the door bour	nced off the door jamb on the			How other residents having th	e	
	latching side and le	ft a one-inch gap between the			potential to be affected by the		
		amb on the latching side of the			same deficient practice will be		
		rview at the time of			identified and what corrective		
	observation, the Ma	intenance Supervisor			action will be taken?		
	acknowledged the o				<ul> <li>All residents and visite</li> </ul>	ors	
		ardous area failed to self-close			have the potential to be affect		
		oor frame stating that he			by the alleged deficient praction		
		stant address the door issue			<ul> <li>To correct the deficient</li> </ul>	псу,	
	as soon as possible.				a shim was placed between th		
					hinge at the bottom of the doo	r	
	_	viewed with the Maintenanct			and the door jamb. This allow		
		facility Administrator at the			the door to fully close and latc		
	exit conference on (	02/10/25.			into the door frame, appropria	tely	
					self-closing, separating other		
	3.1-19(b)				spaces by a smoke resistant		
					door.		
					What measures will be put into		
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec		
					All staff in-service to be		
					completed by the Maintenance	e	
					Director /designee regarding		
					separation of hazardous space		
					such as the soiled linen room	and	
					other spaces, by a smoke		
					resistant door, by February 24	·,	
					2025.  Observational rounds	ا	
					_		
					be completed by the Maintena		
					Director/designee daily to ens the soiled linen room door is n		
						IUW	
					appropriately self-closing and		
			1		latches into the door frame.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TH8421

Facility ID: 000145

If continuation sheet Page 3 of 8

PRINTED: 02/27/2025

	R MEDICARE & MEDIC						IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155241	· /	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 02/10/	SURVEY .ETED
	PROVIDER OR SUPPLIER			525 E 1	ADDRESS, CITY, STATE, ZIP COD FHOMPSON RD IAPOLIS, 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)	ATE	(X5) COMPLETION DATE
K 0324	NFPA 101				How the corrective actions will monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place?  The Maintenance Director/designee will be responsible for the completion the Hazardous Area Enclosur Tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shi until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure compliar Deficiency in this practice will result in disciplinary action up and including termination of the employee responsible.	ient iat II be of e QA iffts the not e nce.	
SS=E Bldg. 01	Cooking Facilities						
	failed to provide an returning cooking a when the kitchen he was designed and in extinguishing syste Ventilation Control Commercial Cookin Edition Section 12.	approved method for ppliances to where they were pod extinguishing equipment astalled for 1 of 1 kitchen hood m. NFPA 96, Standard for and Fire Protection of the Operations Section 2011 1.2.2, states cooking appliances a shall not be moved, modified,	K 0	324	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice?  The floor where the flat guand the stove reside has been painted with yellow paint outling where the appliances need to returned, following maintenant.	ents by the rill n ning be	02/24/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

or rearranged without prior re-evaluation of the

fire-extinguishing system by the system installer

Event ID:

TH8421

Facility ID: 000145

the fire hood.

If continuation sheet

cleaning, ensuring they are under

Page 4 of 8

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 02/10/2025 155241 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 525 E THOMPSON RD INDIANAPOLIS, IN 46227 FOREST CREEK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE or servicing agent, unless otherwise allowed by How other residents having the the design of the fire extinguishing system. potential to be affected by the Section 12.1.2.3 states the fire-extinguishing same deficient practice will be system shall not require reevaluation where the identified and what corrective cooking appliances are moved for the purposes of action(s) will be taken? maintenance and cleaning, provided the All residents, visitors, and appliances are returned to approved design staff have the potential to be location prior to cooking operations, and any affected by the alleged deficient disconnected fire-extinguishing system nozzles practice. attached to the appliances are reconnected in The floor where the flat grill accordance with the manufacturer's listed design and the stove reside has been manual. Section 12.1.2.3.1 states an approved painted with yellow paint outlining method shall be provided that will ensure that the where the appliances need to be appliance is returned to an approved design returned, following maintenance or location. The deficient practice could affect as cleaning, ensuring they are under many as 24 residents, 6 staff, and 2 visitors within the fire hood. the facility. What measures will be put into place or what systemic changes Findings include: will be made to ensure that the deficient practice does not recur? Based on observations made with the All staff in-service to be Maintenance Supervisor during a tour of the completed by the Maintenance facility at 11:50 a.m. on 02/10/25, the six (6) burner Director /designee regarding electric stove and the flat grill which was located returning the appliances between on the cooking line under the hood in the kitchen the yellow outline on the floor, was not provided with an approved method that following maintenance or cleaning, would ensure that the appliances were returned to ensuring they are under the fire an approved design location after they had been hood, by February 24, 2025. moved for maintenance and/or cleaning. Based on Observational rounds will be interview at the time of the observation, the completed by the Maintenance Maintenance Supervisor stated that he was not Director/designee daily to ensure aware an approved method should be provided to the flat grill and stove are within

FORM CMS-2567(02-99) Previous Versions Obsolete

ensure that the appliances were returned to an

approved design location after maintenance or

done to the kitchen stove or floor to meet code

compliance as soon as possible.

cleaning and added that he would have something

This finding was reviewed with the Maintenance

Supervisor and the facility Administrator at the

Event ID:

TH8421

Facility ID: 000145

place:

If continuation sheet

the yellow lines on the floor, and

How the corrective action(s) will be

monitored to ensure the deficient

practice will not recur, what quality assurance program will be put into

The Maintenance

under the fire hood.

Page 5 of 8

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155241		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/10/2025	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD THOMPSON RD	
FOREST	CREEK VILLAGE			NAPOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	exit conference on (	LSC IDENTIFYING INFORMATION	TAG		DATE
	3.1-19(b)	2/10/25.		Director/designee will be responsible for the completion the Cooking Appliance QA To weekly times 4 weeks, month 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 ED. If the threshold of 95% is achieved an action plan will be developed to ensure compliar Deficiency in this practice will result in disciplinary action up and including termination of the employee responsible.	the not e noce.
K 0345 SS=C Bldg. 01	failed to maintain the that it had accurate accordance with the 2012 edition, Section 2010 edition 2010	on and interview, the facility the fire alarm system to assure time and date information in requirements of NFPA 101- ns 19.3.4 and 9.6 and NFPA 72 tions 14.1, 14.1.1. This deficient t all residents, staff, and	K 0345	K345 Fire Alarm System What corrective action(s) will accomplished for those reside found to have been affected be deficient practice?  The fire alarm system display screen was reset to return the accurate date and time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.  All residents, visitors, and staff have the potential to affected by the alleged deficient practice.  The fire alarm system	ents by the  enting ent

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TH8421

Facility ID: 000145

If continuation sheet

Page 6 of 8

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155241	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/10/2025
	ROVIDER OR SUPPLIER		525 E	ADDRESS, CITY, STATE, ZIP COD THOMPSON RD NAPOLIS, IN 46227	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	an interview at the the Maintenance Super unaware of the disc the alarm company updated on the fire he could.	time of the observation, the visor indicated he was repancy and would contact to have the displayed date alarm control panel as soon as viewed with the Maintenanct facility Administrator at the		display screen was reset to re the accurate date and time. What measures will be put int place or what systemic chang will be made to ensure that th deficient practice does not re • All staff in-service to completed by the Maintenand Director /designee regarding assuring the fire alarm panel displays the accurate date and time by February 24, 2025. • Observational rounds be completed by the Maintena Director/designee daily to ass the fire alarm panel displays the accurate date and time. How the corrective action(s) to monitored to ensure the defic practice will not recur, what q assurance program will be purplace: • The Maintenance Director/designee will be responsible for the completion the Fire Alarm Display Panel Tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all sh until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will b developed to ensure compliant	eflect  to ges ne cur? be ce  ad s will ance sure the will be cient uality ut into  n of QA  ifts  the not ee nce.
				Deficiency in this practice will result in disciplinary action up and including termination of the	o to

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155241	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE COMPL <b>02/10</b> /	ETED
NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE				525 E T	ADDRESS, CITY, STATE, ZIP COD HOMPSON RD APOLIS, IN 46227		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	employee responsible.		DATE

Event ID: TH8421 Facility ID: 000145 If continuation sheet Page 8 of 8