STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING -- B. WING	02/10/2025

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
E 0000 Bldg. --	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 0000	K000 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 24, 2025.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/10/25 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 At this Life Safety Code survey, Forest Creek Village was found not in compliance with	K 0000	K000 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 24, 2025.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and is fully sprinklered. 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. 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	NFPA 101 Hazardous Areas - Enclosure 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	02/24/2025

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	155241	A. BUILDING 01 B. WING	02/10/2025

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	to the Soiled utility room between the Activities room and the south nurse's station was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to close, the door bounced off the door jamb on the latching side and left a one-inch gap between the door and the door jamb on the latching side of the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame stating that he would have his assistant address the door issue as soon as possible. This finding was reviewed with the Maintenanct Supervisor and the facility Administrator at the exit conference on 02/10/25. 3.1-19(b)		the door to fully close and latch into the door frame, appropriately self-closing, separating other spaces by a smoke resistant door. 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 and visitors have the potential to be affected by the alleged deficient practice. • To correct the deficiency, a shim was placed between the hinge at the bottom of the door and the door jamb. This allowed the door to fully close and latch into the door frame, appropriately self-closing, separating other spaces by a smoke resistant door. 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 separation of hazardous spaces, such as the soiled linen room and other spaces, by a smoke resistant door, by February 24, 2025. • Observational rounds will be completed by the Maintenance Director/designee daily to ensure the soiled linen room door is now appropriately self-closing and latches into the door frame.	

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			How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • The Maintenance Director/designee will be responsible for the completion of the Hazardous Area Enclosure 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 employee responsible.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer	K 0324	**K324 Cooking Facilities** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The floor where the flat grill and the stove reside has been painted with yellow paint outlining where the appliances need to be returned, following maintenance or cleaning, ensuring they are under the fire hood.	02/24/2025

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	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 24 residents, 6 staff, and 2 visitors within the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility at 11:50 a.m. on 02/10/25, the six (6) burner electric stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and/or cleaning. Based on interview at the time of the observation, the Maintenance Supervisor stated that he was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning and added that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This finding was reviewed with the Maintenance Supervisor and the facility Administrator at the		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 be affected by the alleged deficient practice. The floor where the flat grill and the stove reside has been painted with yellow paint outlining where the appliances need to be returned, following maintenance or cleaning, ensuring they are under the fire hood. 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 returning the appliances between the yellow outline on the floor, following maintenance or cleaning, ensuring they are under the fire hood, by February 24, 2025. Observational rounds will be completed by the Maintenance Director/designee daily to ensure the flat grill and stove are within the yellow lines on the floor, and under the fire hood. 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 Maintenance	

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	exit conference on 02/10/25. 3.1-19(b)		Director/designee will be responsible for the completion of the Cooking Appliance 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 employee responsible.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility at 11:32 a.m. on 02/10/25, the date displayed on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date to be 01/23/25 whereas the correct date was 02/10/25. Based on	K 0345	**K345 Fire Alarm System** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • The fire alarm system display screen was reset to reflect 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 be affected by the alleged deficient practice. • The fire alarm system	02/24/2025

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	an interview at the time of the observation, the Maintenance Supervisor indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date updated on the fire alarm control panel as soon as he could. This finding was reviewed with the Maintenanct Supervisor and the facility Administrator at the exit conference on 02/10/25. 3.1-19(b)		display screen was reset to reflect the accurate date and time. 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 assuring the fire alarm panel displays the accurate date and time by February 24, 2025. • Observational rounds will be completed by the Maintenance Director/designee daily to assure the fire alarm panel displays the accurate date and time. 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 Maintenance Director/designee will be responsible for the completion of the Fire Alarm Display Panel 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	

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			employee responsible.	