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	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Creek Village	525 E Thompson Rd Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for 1 of 1 residents observed with medications at the bedside. (Resident C) Findings include: On 5/20/25 at 8:36 a.m., observed a small pill cup with a round brown tablet sitting on Resident C's bedside table. Resident C was resting in bed. During an interview on 5/20/25 at 8:37 a.m., LPN 2 indicated the brown tablet was senna (medication used to treat constipation) 8.6 milligrams (mg) and should not have been left in Resident C's room. The clinical record for Resident C was reviewed on 5/20/25 at 9:43 a.m. The diagnoses included, but were not limited to, diabetes and metabolic encephalopathy. A quarterly Minimum Data Set (MDS) assessment, dated 3/28/25, indicated Resident C had minimum cognitive impairment. The clinical record lacked a self medication administration assessment. During an interview on 5/21/25 at 12:45 p.m., the Director of Nursing (DON) indicated there was no self medication administration assessment completed for Resident C. On 5/21/25 at 8:17 a.m., the Director of Nursing (DON) provided a copy of a facility policy, titled Self Administration of Medications, dated 1/2015, and indicated this was the current policy used by the facility. A review of the policy indicated if a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation. This citation relates to Complaint IN00458632 3.1-11(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for a resident that was admitted with an indwelling urinary catheter for 1 of 3 residents reviewed for accuracy of the MDS assessment. (Resident F) Findings include: The clinical record was reviewed for Resident F on 5/20/25 at 11:50 a.m. The diagnoses included, but were not limited to, neurogenic bladder, severe morbid obesity, and diabetes. An admission Observation, dated 3/28/25, indicated Resident F was admitted with an indwelling urinary catheter An admission MDS assessment, dated 4/4/25, indicated Resident F did not have an indwelling urinary catheter when he was admitted . A physician's order, initiated on 3/28/25 and discontinued on 4/10/25, indicated Resident F had an indwelling urinary catheter. During an interview on 5/21/25 at 9:25 a.m., RN 1 indicated Resident F's MDS assessment should have indicated he had an indwelling urinary catheter. On 5/21/25 at 12:58 p.m., reviewed the Resident Assessment Instrument (RAI) Manual, dated 10/2023. A review of the RAI Manual indicated if a resident used an indwelling urinary catheter at any time in the seven days prior to the assessment date it should be documented on the MDS assessment. This citation relates to Complaint IN00458632. 3.1-31(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen tubing had been changed, a nebulizer machine was cleaned, and the nebulizer tubing was changed for 3 of 3 residents reviewed. (Resident B, Resident D, Resident E) Findings include: 1. On 5/20/25 at 8:43 a.m., Resident B's nebulizer machine (small machine used to administer liquid inhalation medications) was observed to be stained a purplish color and dusty. The nebulizer machine was sitting on the floor next to the heating unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heating unit. The nebulizer face mask was dated 4/13/25. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated a nebulizer machine should not have been placed on the floor and oxygen tubing, the nebulizer tubing, and mask should have been changed weekly. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's order, intiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5mg (milligrams)/3 ml (milliliter) inhalation solution administer one vial by nebulizer every four hours. 2. On 5/20/25 at 8:54 a.m., observed a blue oxygen concentrator sitting next to Resident D's bed. A clear tube connected to the oxygen concentrator extended to a clear plastic water bottle (humidity) with a green lid. The water bottle was dated 3/25/25. Another clear tube connected to the water bottle extended approximately 6 feet and then around Resident D's ears and into the nose (nasal canula). The nasal canula tubing was dated 3/20/25. The clinical record for Resident D was reviewed on 5/21/25 at 10:17 a.m. The diagnosis included, but was not limited to, chronic obstructive pulmonary disorder. A current physician's, initiated 12/6/24, indicated Oxygen 1 liter per minute every shift. 3. On 5/20/25 at 9:06 a.m., observed Resident E lying in bed with a nebulizer mask (a mask shaped to fit over the nose and mouth) placed over Resident E's mouth with mist of nebulizer solution spraying out into the open air. There was no staff present in Resident E's room for approximately one minute. The oxygen concentrator was sitting on the floor next to Resident E's bed. A clear tube connected to the oxygen concentrator extended to a clear plastic bottle (humidity) with a green lid. The water bottle was dated 4/21/25. The clinical record for Resident E was reviewed on 5/21/25 at 8:39 a.m. The diagnoses included, but were not limited to, encephalopathy, neurogenic bladder, and chronic obstructive pulmonary disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current physician's orders included, but were not limited to: - Change nebulizer tubing one time weekly, initiated 3/6/25. - Change oxygen tubing and humidity one time weekly, initiated 3/6/25. During an interview on 5/21/25 at 11:40 a.m., the Director of Nursing (DON) indicated she was unaware of a policy for changing the oxygen and nebulizer tubing and humidity, but the oxygen tubing, nebulizer tubing, and mask should have been changed weekly. On 5/21/25 at 1:00 p.m., the facility was unable to provide a policy regarding changing oxygen tubing, nebulizer tubing and nebulizer face mask. This citation relates to Complaint IN00458538. 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure prescription medications were secured for 2 of 2 random observations. Two prescription medications were sitting on top of an unlocked medication cart in a high traffic resident area unsupervised by staff; and two vials of a prescription aerosol medication were sitting in a resident's room who was not prescribed the aerosol medication. (Resident B) Findings include: 1. During an observation on 5/20/25 at 8:05 a.m., observed the west 200 hall medication cart to be unlocked and sitting against the wall near the nurses station. There was no staff supervising the medication cart. On top of the medication cart, observed a white plastic bottle labeled H-Chlor12 0.125% (prescription wound cleanser used to prevent infection) with approximately two ounces of solution remaining in the bottle and a full plastic bottle labeled lactulose (prescription medication used to treat hepatic encephalopathy and constipation) 10 grams (gm)/15 milliliters (ml) solution. During an interview on 5/20/25 at 8:07 a.m., LPN 1 indicated lactulose and H-chlor12 should have been secured and the medication cart should have been locked or supervised by staff. 2. On 5/20/25 at 8:43 a.m., observed two unopened clear plastic vials of albuterol inhalation solution (prescription aerosol medication to help breathe more easily) 0.63 milligrams (mg)/3 ml sitting next to Resident B's nebulizer mask on top of the heater unit under the window. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated the albuterol inhalation solution should have been secured in the medication cart. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's order, initiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5 mg/3 ml inhalation solution administer one vial by nebulizer every four hours. The clinical record for Resident B lacked a physician's order for albuterol inhalation solution 0.63 mg/3 ml. On 5/21/25 at 8:17 a.m., the Director of Nursing (DON) provided a copy of a facility policy, titled Medication Storage and Expiration Policy, dated 11/2024, and indicated this was the current policy used by the facility. A review of the policy indicated medications including treatment items should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. This citation relates to Complaint IN00458632. 3.1-25(m)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 4 residents reviewed for documentation. (Resident B, Resident F) Findings include: 1. On 5/20/25 at 8:43 a.m., observed Resident B's dirty nebulizer machine (small machine used to administer liquid inhalation medications) sitting on the floor next to the heat unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heat unit. The nebulizer face mask was dated 4/13/25. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. The current physician's orders indicated: - Ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5 milligrams (mg)/3 milliliters (ml) inhalation solution administer one vial by nebulizer every four hours, initiated 4/30/25. The Medication Administration Record (MAR), dated 5/1/25 at 12:00 a.m. through 5/20/25 at 8:00 a.m., indicated ipratropium-albuterol 0.5mg/3ml nebulizer solution, document pulse, respirations, and breath sounds before administration and breath sounds and minutes of therapy after administration. The MAR lacked completed documentation for the administrations of ipratropium-albuterol 0.5mg/3ml nebulizer solution as follows: - On 5/2/25 at 12:00 a.m., left blank. - On 5/2/25 at 4:00 p.m., pulse and respirations before administration were left blank. - On 5/9/25 at 12:00 a.m., breath sounds before administration, breath sounds after administration, and minutes of treatment were left blank. - On 5/11/25 at 8:00 a.m., left blank. - On 5/11/25 at 12:00 p.m., left blank. - On 5/12/25 at 12:00 a.m., left blank. - On 5/12/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/12/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/13/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/13/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 8:00 a.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/14/25 at 4:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/14/25 at 8:00 p.m., breath sounds after administration and minutes of treatment were left blank. - On 5/16/25 at 8:00 a.m., minutes of treatment was left blank. - On 5/16/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/16/25 at 4:00 p.m., minutes of treatment was left blank. - On 5/16/25 at 8:00 p.m., minutes of treatment was left blank. - On 5/17/25 at 8:00 a.m., minutes of treatment was left blank. - On 5/17/25 at 12:00 p.m., minutes of treatment was left blank. - On 5/17/25 at 8:00 p.m., minutes of treatment was left blank. - On 5/18/25 at 8:00 a.m., minutes of treatment was left blank. - On 5/19/25 at 8:00 a.m., left blank. 2. The clinical record for Resident F was reviewed on 5/20/25 at 11:50 a.m. The diagnoses included, but were not limited to, neurogenic bladder, severe morbid obesity, and diabetes. The physician's orders indicated: - Record urine output from urinary catheter every shift, initiated on 3/28/25 and discontinued on 4/10/25. The Treatment Administration Record (TAR), dated 4/1/25 at 7:00 a.m. through 4/10/25 at 3:00 p.m., lacked documentation that the urinary output was measured as follows: - On 4/3/25 there was no documentation for day shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/4/25 there was no documentation for day shift. - On 4/9/25 there was no documentation for night shift. During an interview on 5/21/25 at 11:40 a.m., the Director of Nursing (DON) indicated the facility did not have a policy on documentation, but all documentation should have been completed. This citation relates to Complaint IN00458632 3.1-50(a)(1) 3.1-50(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control practices for 3 of 3 residents reviewed for infection control. A nebulizer machine and tubing were not maintained in a sanitary manner, a catheter bag was on the floor, and soiled linens, and a brief were not disposed of in a sanitary manner. (Resident B, Resident E, Resident F) Findings include: 1. On 5/20/25 at 8:43 a.m., observed Resident B's dirty nebulizer machine (small machine used to administer liquid inhalation medications) sitting on the floor next to the heat unit under the window. A clear tube extended from the nebulizer machine up and connected to a clear face mask shaped to fit over the nose and mouth with a small chamber to hold the liquid inhalation solution. The nebulizer face mask was not in a bag but was lying directly on the heat unit. The nebulizer face mask was dated 4/13/25. During an interview on 5/20/25 at 8:51 a.m., LPN 1 indicated Resident B's nebulizer machine should not have been placed on the floor and should have been cleaned. The nebulizer mask should have been placed in a bag not left lying out on the heat unit. The clinical record for Resident B was reviewed on 5/20/25 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, dementia, and morbid obesity. A current physician's, initiated 4/30/25, indicated ipratropium-albuterol (prescription medication used to help breathe more easily) 0.5mg/3ml inhalation solution administer one vial by nebulizer every four hours. 2. On 5/20/25 at 9:06 a.m., observed Resident E's urinary catheter bag sitting directly on the floor with approximately 400 milliliters (ml) of yellow liquid inside. On 5/20/25 at 9:07 a.m., Qualified Medication Aide (QMA) 1 indicated Resident E's catheter bag should not have been left on the floor. The clinical record for Resident E was reviewed on 5/21/25 at 8:39 a.m. The diagnoses included, but were not limited to, encephalopathy and neurogenic bladder. An admission Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident E was admitted with an indwelling urinary catheter. A current physician's order, initiated 3/6/25, indicated Foley catheter size 14 French scale (Fr) with 10 milliliter (ml) balloon. During an interview on 5/20/25 at 9:03 a.m., RN 1 indicated catheter bags should not be touching the floor. 3. On 5/20/25 at 8:11 a.m., observed a soiled brief, gown, and linen lying on the floor in Resident G's room. Resident G was not in his room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 8:13 a.m., CNA 1 indicated Resident G's brief, gown, and linen were soiled with urine and should not have been left on the floor. The clinical record for Resident G was reviewed on 5/20/25 at 9:32 a.m. The diagnoses included, but were not limited to, lung cancer, dementia, and dysphagia. A quarterly MDS assessment, dated 4/4/25, indicated Resident G was always incontinent of bladder. On 5/21/25 at 12:35 p.m., the Director of Nursing (DON) provided a copy of a facility policy, titled Nursing Department Infection Control, dated 12/2024, and indicated this was the current policy used by the facility. A review of the policy indicated urinary drainage tubes and bags should not touch the floor. Bag/contain contaminated linen. Store equipment in a way that prevents contamination. Administer treatment according to professional standards. This citation relates to Complaint IN00458538. 3.1-18(b)(1)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure the facility was free from roaches for 1 of 1 random observations. Finding includes: On 5/20/25 at 9:09 a.m., observed a brown cockroach crawling on the floor outside a resident's room. At that time, Resident H indicated he had seen a roach near his door. On 5/21/25 at 8:15 a.m., the Administrator provided a copy of a facility policy, titled Pest Control, dated 9/2023, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will maintain an effective pest control program so that the facility is free from pests. This citation relates to Complaint IN00458615 3.1-19(f)(4)