

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER Forest Creek Village		STREET ADDRESS, CITY, STATE, ZIP CODE 525 E Thompson Rd Indianapolis, IN 46227	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interview, and record 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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A current physician's order, dated 3/17/25, indicated Resident B's bed was to be in the lowest position.</p> <p>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 have a person-centered care plan developed and implemented.</p> <p>This citation relates to Complaint IN00461240.</p> <p>3.1-35(g)(2)</p>

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
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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 couldn't cut the sausage because it was like rubber.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaint IN00461884.</p> <p>1.3-21(a)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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.</p> <p>Findings include:</p> <p>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 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.</p> <p>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.</p> <p>This citation relates to Complaint IN00461884.</p> <p>3.1-21(i)(2)</p> <p>3.1-21(i)(3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>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)</p> <p>Findings include:</p> <p>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, 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.</p> <p>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.</p> <p>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.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated Resident B had an indwelling urinary catheter.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaints IN00461240 and IN00461884.</p> <p>3.1-18(b)(1)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary environment for the residents for 1 of 1 random observations.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 6/24/25 at 12:10 p.m., the facility was unable to provide a policy by survey exit.</p> <p>This citation relates to Complaints IN00461884 and IN00461240.</p> <p>3.1-19(f)</p>		