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	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Creek Village	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)
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 resident was assessed to self-administer his own medications prior to leaving the resident's medication in his room unsupervised for 1 of 3 random observations. (Resident B) Findings include:On 1/15/26 at 8:08 a.m., observed two pill cups sitting on Resident B's dresser. One pill cup with Resident B's name written on the side contained an unmarked small white pill. The other pill cup was not labeled with a name and contained a large piece of candy, an unmarked small white pill, a yellow capsule, and a large white tablet. During an interview on 1/15/26 at 8:15 a.m., Licensed Practical Nurse (LPN) 1 opened the medication cart and compared the pills in the cups to Resident B's medications and indicated the medications belonged to Resident B. The small white pill was melatonin (prescription medication used to treat insomnia) 5 milligrams (mg), the yellow capsule was gabapentin (prescription medication used to treat nerve pain) 300 mg, and the large white tablet was gabapentin 600 mg. LPN 1 indicated the medication should not have been left in Resident B's room. The clinical record for Resident B was reviewed on 1/15/26 at 11:35 a.m. The diagnoses included, but were not limited to, chronic pain and neuropathy. An annual Minimum Data Set (MDS) assessment, dated 11/1/25, indicated Resident B was cognitively intact. The physician's orders indicated:- Gabapentin 300 mg capsule orally twice daily, initiated 1/22/25.- Gabapentin 600 mg tablet orally at bedtime, initiated 1/22/25.- Melatonin 5 mg tablet orally at bedtime, initiated 1/19/25. The clinical record for Resident B lacked a self-medication administration assessment and lacked a physician's order to self-administer his own medications. On 1/16/26 at 9:00 a.m., the Director of Nursing provided a copy of a facility policy, titled Self Administration of Medications, dated 01/2015, and indicated this was the current policy used by the facility. A review of the policy indicated if a resident desired to self-administer their own medications a self-administration of medication assessment would be completed and a physician's order would be obtained specifying the resident's ability to self-administer medications. 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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a clean sanitary environment was provided for 3 of 3 random resident rooms observed. Urinals were left on the floor, soiled paper products were left in a trash can without a trash bag, toilets were dirty and leaking. (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]) Findings include: 1. On 1/15/26 at 8:08 a.m., room [ROOM NUMBER] was observed. A full closed urinal sitting on the floor with dark yellow urine inside was observed. The window side of the room was cluttered with personal belongings sitting along the wall. At that time, Resident B indicated the full urinal had been sitting on the floor for a couple days.During an interview on 1/15/26 at 8:15 a.m., Licensed Practical Nurse (LPN) 1 indicated Resident B's urinal should have been emptied and not left sitting on the floor. 2. On 1/15/26 at 8:25 a.m., room [ROOM NUMBER] was observed. In the bathroom, there was a strong odor of urine and feces. Dried feces on the rim of the toilet bowl and the toilet seat was observed. A trash can without a bag was almost full of toilet paper with dried feces on it and another trash can without a bag was observed to have a urine soiled brief in it. During an interview on 1/15/26 at 8:28 a.m., CNA 1 indicated the trash cans should have had bags in them and should have been emptied. The staff should have notified housekeeping to clean the toilet.3. On 1/15/26 at 8:30 a.m., room [ROOM NUMBER] was observed. In the bathroom, a white blanket folded over and sitting on the floor in front of Resident D's toilet was observed. The blanket was stained with dark brown on the top. At that time, Resident D indicated the blanket was stained brown from shoe and footprints. She had been folding a hospital blanket into four and placing it on the floor in front of the toilet because the toilet had a leak. The blanket had been changed out every week or two. During an interview on 1/15/26 at 8:32 a.m., CNA 2 indicated the blanket had been changed about every week. The blanket should not have been left on the floor. This citation relates to Intake 2711487. 3.1-19(f)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when pests were observed in a residents rooms for 2 of 3 rooms observed. (room [ROOM NUMBER], room [ROOM NUMBER]) Findings include:1. On 1/15/26 at 8:08 a.m., inside room [ROOM NUMBER], observed a dresser with a meal tray sitting on top that had dried peas, potatoes, and an open chocolate pudding cup. A small roach-like insect was observed to be crawling out of the peas. At that time, Resident B indicated he hadn't seen a roach in his room in approximately a week, and the meal tray was from dinner the previous night. A Pest Control Report, dated 10/27/25 at 2:22 p.m., indicated cockroaches were noted during service in resident rooms and hallways. Access for service was limited due to clutter and stored items. Most resident rooms had too much clutter to actually service. Please remove or store items to allow access for service. 2. On 1/15/26 at 8:17 a.m., room [ROOM NUMBER] was observed. In the bathroom, a roach-like insect was observed crawling up the bathroom wall underneath the sink. On 1/16/26 at 9:00 a.m., the Director of Nursing 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 of pests. This citation relates to Intake 2711487.3.1-19(f)(4)