STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	a. building <u>00</u>				
		155199	B. WING		08/29/2024			
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF I	PROVIDER OR SUPPLIE	CR.						
MADIE	PARK VILLAGE			776 N UNION ST WESTFIELD, IN 46074				
IVIAI LL I	TARK VILLAGE		WEGII	1 1225, 114 4007 4				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI				
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
F 0000								
D								
Bldg. 00	Test to the contract of	1. 1		<u>  _                                   </u>				
		the Investigation of Complaint	F 0000	The creation and submission				
	IN00439443 and I	N00441461.		this plan of correction does no				
	G 1 : 4 D 100 42	10442 F 1 1/G ( 1 6 1 1		constitute an admission by th				
	_	9443 - Federal/State deficiencies		provider of any conclusion se				
	related to the alleg	ations are cited at F755.		in the statement of deficiencie	es, or			
	Commissint INIO044	11461 No deficiencies related to		of any violation of regulation.	ta			
	the allegations are	1461 - No deficiencies related to		This provider respectfully req				
	the anegations are	ched.		that the 2567 plan of correction considered the letter of credit				
	Survey dates: Aug	ust 28 and 29, 2024			nie			
	Survey dates. Aug	ust 28 and 29, 2024		allegation and requests desk review (paper compliance) or	or			
	Facility number: 0	00106		after 9/12/24.	OI			
	Provider number:			aitei 9/12/24.				
	AIM number: 1002							
	7 Hivi hamber. 1002	200370						
	Census Bed Type:							
	SNF/NF: 86							
	SNF: 2							
	Total: 88							
	Census Payor Type	e:						
	Medicare: 2							
	Medicaid: 36							
	Other: 50							
	Total: 88							
	This deficiency ref	flects State Findings cited in						
	accordance with 4	10 IAC 16.2-3.1.						
	, ,	s completed on September 3,						
	2024.							
F 0755	100 45/ \(\text{3.7.5.5.5}\)	0)						
F 0755	483.45(a)(b)(1)-(3	3)						
SS=D	Pharmacy	-/Dl						
Bldg. 00		s/Pharmacist/Records	E 0755		00/10/2001			
		ion, interview and record	F 0755	F755 Pharmacy Services	09/12/2024			
	review, the facility	failed to ensure a narcotic pain		1.What corrective action(s	)			
LADORATO	DV DIDECTORIS OF PRO	NAMED (CLIBBLIED DEBREGERATA TRAVEIR	ICNIATUDE	TITLE	(VO DATE			
LABORATO	KY DIKECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNA I UKE	(X6) DATE				
Tony Link Executive Director					09/11/2024			

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 disclosable

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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09/20/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/29/2024 155199 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 776 N UNION ST MAPLE PARK VILLAGE WESTFIELD, IN 46074 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE patch was administered at the correct time and will be taken for those new sites were used for the transdermal patch residents found to have been administration for 1 of 1 resident reviewed affected by the deficient (Resident B) and failed to ensure staff were **practice?** The resident showed signing the narcotic count sheets for 4 of 6 no signs or symptoms of injury medication cart narcotic logs reviewed. due to the alleged deficient practice. The resident is receiving Findings include: pain patch per physician order. 1. During an interview, on 8/28/24 at 9:55 a.m., Resident B indicated she was experiencing pain 2.How will you identify and had been provided medication for the pain. other residents having the The resident allowed observation of her Fentanyl potential to be affected by the pain patch. It was located on her right upper arm same deficient practice and and dated 8/27/24. She indicated the patch was what corrective action will be changed every three days. She was not aware of taken? All residents with pain any missed doses of medications, including the patches have the potential to be narcotic pain patch. affected by the alleged deficient practice. All residents with pain The clinical record for Resident B was reviewed patches were checked by on 8/28/24 at 11:29 a.m. The diagnoses included, DNS/Designee to ensure pain but were not limited to, fibromyalgia, chronic pain, patches were administered per and polyneuropathy. MD order, with no discrepancies found. All staff were inserviced A physician's order, initiated on 12/30/23 and and educated on ensuring pain discontinued on 7/22/24, indicated to administer patches are administers at the one Fentanyl patch 50 mcg per hour every 72 correct time, new sites are used hours. The special instructions indicated to rotate for the transdermal patch and staff sites. The time of administration was 4:00 p.m., are to sign the narcotic count (the evening shift). sheets. The documentation on the MAR/TAR indicated, 1.What measures will be put on 7/21/24. RN 1 checked off he had removed the into place or what systemic old patch and placed a new patch to the resident's changes will you make to left shoulder at 2:12 p.m. The reason provided for ensure that deficient practice the early administration of the medication does not recur? Staff were

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administered early.

indicated "...Ls...." There was no other

documentation to explain why the medication was

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inserviced and educated on

administered at the correct time, new sites are used for the

ensuring pain patches are

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155199	B. WING				
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					JNION ST		
MAPLE PARK VILLAGE					FIELD, IN 46074		
IVIAFLEF	AIN VILLAGE			WEST	ILLD, IIN 40074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ostance Record indicated RN 1			transdermal patch and staff ar		
	signed out the narce	otic patch on 7/21/24 at 3:00			sign the narcotic count sheets		
	p.m.				DNS or designee will conduct	t	
					rounds daily to ensuring pain	≀ to ensuring pain	
		ale was reviewed on 8/29/24 at			patches are administered at th		
	_	s scheduled and worked the day			correct time, new sites are use		
		worked were documented, on			for the transdermal patch and		
	the schedule, as 6:2	27 a.m. to 3:14 p.m.			are signing the narcotic count		
					sheets each shift. See attach	ed	
		v, on 8/28/24 at 2:27 p.m., the			audit tools.		
		indicated RN 1 was not able to					
	1	stered the Fentanyl patch early					
		sed the destruction of the old			1.How the corrective action	ı(s)	
		lled a patch which was due at			will be monitored to ensure t	:he	
	_	not recall if he placed the patch			deficient practice will not		
	on the resident or if the patch had fallen off. He				recur, i.e. what quality		
	could not say why he pulled the medication early.				assurance program will be p	ut	
					into place? Facility will use F7	755	
	_	v, on 8/29/24 at 9:24 a.m., LPN 5			Patch site rotation, timely		
		e to check medication orders for			administration, and shift to shi	ft	
		and time the medication was			narcotic count CQI audit tools.		
		ered. They also were to count			Observations will be daily for 2	2	
		d post shift. The staff were to			weeks, 2 times per week for 6	3	
		ards, bottles, patches, and			weeks, and then weekly for 4		
		nurses were required to destroy			months. If 90% compliance is	S	
	medications and sig	gn off on the form.			not achieved, an action plan w	/ill	
					be developed. After six mont	hs	
	T -	iew, on 8/29/24 at 9:42 a.m., RN	1		the QAPI committee will		
		ere to destroy medications with			re-evaluate the continued nee	d for	
		n off on the (destruction)			the audit. Deficiency in this		
		book should be signed at the			practice will result in disciplina	ıry	
	1	of every shift after the count.			action up to and including		
	Old medication patches were to be removed and a new one put on with another nurse present, sites should be rotated, and staff should sign off the				termination of the responsible		
					employee.		
	patch and destroy the	he old patch with another			5. Date of Compliance		
	nurse.				9/12/24		
	During the review of	of the MAR/TAR for Resident					
B it was noted a Fentanyl 50 mcg transdermal		1				I	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155199	A. BUILDING 00  B. WING		COMPLETED 08/29/2024	
		100100		ADDRESS SITE OF THE STATE OF TH	00/20/2027	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD UNION ST		
MAPLE PARK VILLAGE				FIELD, IN 46074		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
TAG		R LSC IDENTIFYING INFORMATION ered to the resident's left	TAG	Dia relative 17	DATE	
	shoulder on 7/18/24					
		21/24 to the resident's left				
	shoulder, and a new	v patch was administered on				
	7/25/24 to the resid	ent's left shoulder.				
	A physician's order	, initiated on 12/30/23 and				
		22/24, indicated to administer				
	one Fentanyl patch	50 mcg per hour every 72				
	hours. The special i	instructions indicated to rotate				
	sites.					
	A physician's order	, initiated on 7/25/24, indicated				
		entanyl patch 50 mcg per hour				
	every 72 hours. The	e special instructions indicated				
	to remove the old p	atch first and rotate sites.				
	3. During an intervi	iew, on 8/29/24 at 9:04 a.m., RN				
	4 indicated staff we	ere to count all narcotic cards,				
	_	Staff needed to sign on/off in				
		k. Staff were to check for				
	_	eation patches every shift.				
		tion needed to be completed				
	the destruction.	d both nurses must sign off on				
	the destruction.					
		sheets were reviewed for all				
	units on 8/29/24 in	conjunction with the				
	medication pass administration.					
	An untitled docume	ent used to count controlled				
	substances, dated August 2024, for the Cottage (memory care) unit indicated the "On-coming nurse signature" and "Off-going nurse signature" was found to be missing signatures for the on-coming nurse for 3 of 85 entries and 7 of 85 entries for the off-going nurse.					
	An untitled docume	ent used to count controlled				
substances, dated August 2024, for the Hall 2						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2024			
NAME OF PROVIDER OR SUPPLIER  MAPLE PARK VILLAGE			776 N	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD F					
	`			CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE			
TAG	North unit indicated signature" and "Off found to be missing nurse for 1 of 85 er off-going nurse.  An untitled docume substances, dated A Forward North unit nurse signature" an was found to be mi on-coming nurse for entries for the off-g	ent used to count controlled	TAG		DATE			
	substances, dated August 2024, for the Moving Forward South unit indicated the "On-coming nurse signature" and "Off-going nurse signature" was found to be missing signatures for the on-coming nurse for 2 of 85 entries and 5 of 85 entries for the off-going nurse.							
	and Medication Ad revised 4/30/24 and Director on 8/29/24 each time a medica correct timeFollo	tled "General Dose Preparation ministration," dated as last d received from the Executive dat 1:20 p.m., indicated "Verify tion is administeredat the wmedication administration g transdermal patch sites"						
	Substances," dated Executive Director indicated "Facilit Verification of Con count all controlled cart in the facility							
	This Federal tag relates to Complaint IN00439443.							

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

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICARD SERVICES							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		155199	B. WING		08/29/2024		
NAME OF PROVIDER OR SUPPLIER  MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-25(b)						
	3.1-25(e)(3)						
	3.1-25(s)(8)						

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