STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00439443 and IN00441461. Complaint IN00439443 - Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00441461 - No deficiencies related to the allegations are cited. Survey dates: August 28 and 29, 2024 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 86 SNF: 2 Total: 88 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 50 Total: 88 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 3, 2024.	F 0000	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 9/12/24.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview and record review, the facility failed to ensure a narcotic pain	F 0755	F755 Pharmacy Services **1.What corrective action(s)**	09/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tony Link	Executive Director	09/11/2024

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	patch was administered at the correct time and new sites were used for the transdermal patch administration for 1 of 1 resident reviewed (Resident B) and failed to ensure staff were signing the narcotic count sheets for 4 of 6 medication cart narcotic logs reviewed. Findings include: 1. During an interview, on 8/28/24 at 9:55 a.m., Resident B indicated she was experiencing pain and had been provided medication for the pain. The resident allowed observation of her Fentanyl pain patch. It was located on her right upper arm and dated 8/27/24. She indicated the patch was changed every three days. She was not aware of any missed doses of medications, including the narcotic pain patch. The clinical record for Resident B was reviewed on 8/28/24 at 11:29 a.m. The diagnoses included, but were not limited to, fibromyalgia, chronic pain, and polyneuropathy. A physician's order, initiated on 12/30/23 and discontinued on 7/22/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to rotate sites. The time of administration was 4:00 p.m., (the evening shift). The documentation on the MAR/TAR indicated, on 7/21/24, RN 1 checked off he had removed the old patch and placed a new patch to the resident's left shoulder at 2:12 p.m. The reason provided for the early administration of the medication indicated "...Ls...." There was no other documentation to explain why the medication was administered early.		**will be taken for those residents found to have been affected by the deficient practice?** The resident showed no signs or symptoms of injury due to the alleged deficient practice. The resident is receiving pain patch per physician order. 2. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with pain patches have the potential to be affected by the alleged deficient practice. All residents with pain patches were checked by DNS/Designee to ensure pain patches were administered per MD order, with no discrepancies found. All staff were inserviced and educated on ensuring pain patches are administers at the correct time, new sites are used for the transdermal patch and staff are to sign the narcotic count sheets. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Staff were inserviced and educated on ensuring pain patches are administered at the correct time, new sites are used for the	

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	The Controlled Substance Record indicated RN 1 signed out the narcotic patch on 7/21/24 at 3:00 p.m. The nursing schedule was reviewed on 8/29/24 at 2:27 p.m. RN 1 was scheduled and worked the day shift. His hours he worked were documented, on the schedule, as 6:27 a.m. to 3:14 p.m. During an interview, on 8/28/24 at 2:27 p.m., the Executive Director indicated RN 1 was not able to say why he administered the Fentanyl patch early or if anyone witnessed the destruction of the old patch. RN 1 had pulled a patch which was due at 4:00 p.m., he could not recall if he placed the patch on the resident or if the patch had fallen off. He could not say why he pulled the medication early. During an interview, on 8/29/24 at 9:24 a.m., LPN 5 indicated staff were to check medication orders for the dose, resident, and time the medication was due to be administered. They also were to count the narcotics pre and post shift. The staff were to count all narcotic cards, bottles, patches, and medications. Two nurses were required to destroy medications and sign off on the form. 2. During an interview, on 8/29/24 at 9:42 a.m., RN 6 indicated staff were to destroy medications with two nurses and sign off on the (destruction) sheet. The narcotic book should be signed at the beginning and end of every shift after the count. 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 patch and destroy the old patch with another nurse. During the review of the MAR/TAR for Resident B it was noted a Fentanyl 50 mcg transdermal		transdermal patch and staff are to sign the narcotic count sheets. DNS or designee will conduct rounds daily to ensuring pain patches are administered at the correct time, new sites are used for the transdermal patch and staff are signing the narcotic count sheets each shift. See attached audit tools. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Facility will use F755 Patch site rotation, timely administration, and shift to shift narcotic count CQI audit tools. Observations will be daily for 2 weeks, 2 times per week for 6 weeks, and then weekly for 4 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. 5. **Date of Compliance 9/12/24**	

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	patch was administered to the resident's left shoulder on 7/18/24, a new patch was administered on 7/21/24 to the resident's left shoulder, and a new patch was administered on 7/25/24 to the resident's left shoulder. A physician's order, initiated on 12/30/23 and discontinued on 7/22/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to rotate sites. A physician's order, initiated on 7/25/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to remove the old patch first and rotate sites. 3. During an interview, on 8/29/24 at 9:04 a.m., RN 4 indicated staff were to count all narcotic cards, bottles and patches. Staff needed to sign on/off in the narcotic logbook. Staff were to check for placement of medication patches every shift. Medication destruction needed to be completed with two nurses and both nurses must sign off on the destruction. The narcotic count sheets were reviewed for all units on 8/29/24 in conjunction with the medication pass administration. An untitled document 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 document used to count controlled substances, dated August 2024, for the Hall 2			

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	North unit indicated the "On-coming nurse signature" and "Off-going nurse signature" was found to be missing signatures for the on-coming nurse for 1 of 85 entries and 2 of 85 entries for the off-going nurse. An untitled document used to count controlled substances, dated August 2024, for the Moving Forward North unit indicated the "On-coming nurse signature" and "Off-going nurse signature" was found to be missing signatures for the on-coming nurse for 4 of 85 entries and 4 of 85 entries for the off-going nurse. An untitled document used to count controlled 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. A facility policy, titled "General Dose Preparation and Medication Administration," dated as last revised 4/30/24 and received from the Executive Director on 8/29/24 at 1:20 p.m., indicated "...Verify each time a medication is administered...at the correct time...Follow...medication administration guidelines...rotating transdermal patch sites...." A facility policy, titled "Inventory of Controlled Substances," dated 2/1/18 and received from the Executive Director on 8/29/24 at 12:35 p.m., indicated "...Facility will utilize the "Shift change Verification of Controlled Substances" form to count all controlled substance for each medication cart in the facility...." This Federal tag relates to Complaint IN00439443.			

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	3.1-25(b) 3.1-25(e)(3) 3.1-25(s)(8)			