STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 8, 9,10, 13 and 14, 2024 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 1 Medicaid: 31 Other: 15 Total: 47 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 19, 2025.	F 0000		
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review, and interview, the facility failed to follow documentation procedures of dispensed medications on the Controlled Drug Record of administered narcotics for 5 of 24 residents observed for pharmacy services. (Residents 16, 15, 13, 49, and 50) Findings include:	F 0755	1 Controlled Drug records for all affected residents have been reviewed with count on record and amount on drug card matching. (see attached QA sheet) 2 Controlled Drug records for all other residents have been reviewed with count on record and amount of drug on card matching. (see attached QA sheet)	01/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cullen Istre	ADM	01/27/2025

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 disclo 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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	During an observation on 1/8/25 at 1:42 p.m., of the 300 Hall medication cart, the following concerns were identified: 1. Resident 16's Viberzi had a count of 14 tablets left on the Controlled Drug Record. The resident's medication card contained 13 tablets of Viberzi. The Controlled Drug Record indicated no tablets of Viberzi had been signed out. The physician's order, dated 7/2/24, indicated the nurse was to administer 100 mg (milligrams) of Viberzi one time a day for Irritated Bowel Syndrome (IBS). The January 2025 Medication Administration Record (MAR) indicated the Viberzi was last administered on 1/8/25 between 8:00 a.m. and 11:00 a.m., by Licensed Practical Nurse (LPN) 5. 2. Resident 15's Gabapentin had a count of 14 capsules left on the Controlled Drug Record. The resident's medication card contained 12 capsules of the Gabapentin. The LPN indicated that she had administered two capsules to the resident. The Controlled Drug Record indicated the last dose was administered on 1/7/25 at 9:32 p.m., by LPN 4. The physician's order, dated 11/17/24, indicated the nurse was to administer two capsules of 600 mg Gabapentin three times daily for type 2 diabetes mellitus with diabetic neuropathy. The January 2025 MAR indicated the Gabapentin capsules were last administered on 1/8/25 between 8:00 a.m. and 11:00 a.m., by LPN 5. 3. Resident 13's Gabapentin had a count of 17 capsules left on the Controlled Drug Record. The		3 In-servicing will be completed on policy and procedure for controlled substance administration/documentation with nurses and QMA's (see attached policy with signature page) 4 Controlled Drug records for all residents will be reviewed at a random time once daily, by the DON or designee, per the following schedule to ensure medication is being administered and documented at the same time. 1.) Daily Monday thru Friday x 1 month then 2.) Three days a week Monday thru Friday x 1 month then 3.) One day a week x 2 months then 4.) One day every other week x 2 months then 5.) Will be determined by QAPI committee at next quarterly meeting if monitoring should be continued or can be discontinued r/t no discrepancies noted for 2 months. If discrepancies noted then QA will continue until there are 2 consecutive months discrepancy free.	

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	resident's medication card contained 16 capsules of the Gabapentin. The Controlled Drug Record indicated the last dose was administered on 1/7/25 at 8:18 p.m., by LPN 4. The physician's order, dated 1/13/24, indicated the nurse was to administer one capsule three times daily for pain. The January 2025 MAR indicated the Gabapentin capsule was last administered on 1/8/25 between 8:00 a.m. and 11:00 a.m., by LPN 5. 4. Resident 49's Tramadol had a count of 16 tablets left on the Controlled Drug Record. The resident's medication card contained 15 tablets of the Tramadol. The Controlled Drug Record indicated the last dose was administered on 1/7/25 at 8:17 p.m., by LPN 4. The physician's order, dated 4/3/24, indicated the nurse was to administer one tablet two times daily for chronic pain. The January 2025 MAR indicated the Tramadol tablet was last administered on 1/8/25 between 8:00 a.m. and 11:00 a.m., by LPN 5. 5. Resident 50's Gabapentin had a count of 29 capsules left on the Controlled Drug Record. The resident's medication card contained 27 capsules of the Gabapentin. The Controlled Drug Record indicated the last dose was administered 1/7/25 at 8:20 p.m., by LPN 4. LPN 5 indicated there were two different times that the medication was given during the day. The physician's order, dated 8/28/24, indicated the nurse was to administer one capsule three times daily for pain.			

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	The January 2025 MAR indicated the Gabapentin capsule was last administered on 1/8/25 between 8:00 a.m. and 11:00 a.m., and on 1/8/25 between 2:00 p.m. and 4:00 p.m., by LPN 5. During an interview on 1/8/25 at 1:51 p.m., LPN 5 indicated she had not signed out the narcotics because she didn't have a pen. She should have signed them out at the time of administration. The Controlled Substance Monitoring and Administration policy and procedure, last reviewed on 9/3/24, included, but was not limited to, " ...18. Controlled substances in solid form are to be withdrawn from the area/container they are stored, counted, and recorded on the Narcotic Sign-out Sheet with each administration ... Documentation All documentation the Narcotic Sign-out Sheet and MAR/eMAR [electronic Medication Administration Record] are to be legible and clear ... 2. When documenting withdrawal of medications from the locked narcotic drawer or medication locker in the refrigerator, the actual date and actual time of the withdrawal is to be documented on the Narcotic Sign-out Sheet ..." 3.1-25(b)(1)(c)			