STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/22/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00403435 and IN Complaint IN00403 related to the allegal F842. Complaint IN00403 the allegations are of Survey dates: Marcillity number: 00 Provider number: 1 AIM number: 1002 Census bed type: SNF: 3 SNF/NF: 82 Total: 85 Census payor type: Medicare: 5 Medicaid: 51 Other: 29 Total: 85 These deficiency reaccordance with 410	1435 - Federal/State deficiencies tions are cited at F755 and 1818 - No deficiencies related to ited. 18 20, 21 and 22, 2023 10 10 6 10 55199 10 66390	F 00	000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. This provider respectfully requitated the 2567 plan of correction considered the letter of credible allegation and requests desk review (paper compliance) on after 4/6/23.	t s forth s, or ests n be	
F 0755 SS=D Bldg. 00	§483.45 Pharmac	/Pharmacist/Records					1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Anthony Link Executive Director 04/05/2023

Any defiency statement 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 disclodays 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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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(2) MULTIPLE CO A. BUILDING B. WING	nstruction 00	(X3) DATE SURVEY COMPLETED 03/22/2023	
	PROVIDER OR SUPPLIER PARK VILLAGE		STREET A 776 N U WESTFI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEL (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	emergency drugs and biologicals to residents, or obtain them under and described in §483.70(g). The facil permit unlicensed personnel to addrugs if State law permits, but only general supervision of a licensed rows of state law permits, but only general supervision of a licensed rows of supervision, a licensed pharmaceutical services (in procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological meet the needs of each resident. §483.45(b) Service Consultation, must employ or obtain the services licensed pharmacist whoselicensed pharmacist whoselicensed pharmacist whoselicensed pharmacist whoselicensed pharmacist whoselicensed for the provision of pharmacing in the facility. §483.45(b)(2) Establishes a systematic records of receipt and disposition of controlled drugs in sufficient detail an accurate reconciliation; and §483.45(b)(3) Determines that drug are in order and that an account of controlled drugs is maintained and periodically reconciled. Based on interview and record review failed to ensure the prescribed medical ordered by a Physician were acquired facility pharmacy in a timely manner residents reviewed for pharmaceutical (Resident B) Finding includes:	a agreement ity may minister vander the nurse. must including ite indicates of a more all acy services in a more and ite indicates of a more and ite indicates in a more and ite indicates ite indicates in a more and ite indicates in a more and ite indicates ite indica	F 0755	The creation and submission of this plan of correction does no constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. This provider respectfully require that the 2567 plan of correction considered the letter of credible	t s forth s, or ests n be	

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Event ID:

FVLB11

Facility ID: 000106

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPLET	ED
		155199	B. WING			03/22/20)23
		<u> </u>	S	TREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			INION ST		
MAPLE F	PARK VILLAGE				IELD, IN 46074		
		CT L MEN ADVIT OF DEFENSIVE VOTE		-	,	1	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	,	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG		dent B was reviewed on	1.	AG			DATE
		. Diagnoses included, but were			allegation and requests desk	or	
	-	gn neoplasm of the brain (extra			review (paper compliance) on after 4/6/23.	OI	
		m), paroxysmal atrial			F 755 Pharmacy Srvcs/		
		us syndrome, orthostatic			Procedure/ Pharmacist/		
		natoid arthritis, pain, and			Records		
		niparesis following other			Records		
		ease affecting right dominant					
	side.				What corrective action(s) wil	,	
	Side.				be accomplished for those	-	
	Resident B's Electronic Medication				residents found to have been	ո	
	Administration Record was reviewed for the dates				affected by the deficient		
	of 1/26/23 through 2/19/23. The following				practice;		
	prescribed medications were not found to be				 Resident B discharged f 	rom	
	acquired from the facility pharmacy in a timely				facility on 2/19/23. Resident ha		
	manner for Residen	t B:			no negative outcomes due to		
					alleged deficient practice. No		
	a. Calcium 600 mg	(milligrams) + D3 5 mcg			other residents noted to have	been	
	(micrograms) (200	units) (Calcium			affected by this alleged deficie	ent	
	Carbonate-Vitamin	D3) tablet. Administer one			practice.		
		ly from 7:00 a.m. to 11: 00 a.m.					
	1/26/23, was ordere				How other residents having	the	
		n., the medication was not			potential to be affected by the		
	administered due to	it was not available.			same deficient practice will be		
					identified and what correctiv	е	
		reduces signs and symptoms			action(s) will be taken:		
		ng, pain, fatigue, and length of			- All future residents that a		
	-	f moderate to severe			or readmit have potential to be		
		is) 50 mg/ml (milliliter) (1 ml).			affected by the alleged deficie	nt	
	_	subcutaneously (under the			practice.		
	· ·	on Fridays from 7:00 a.m. to			- Facility to provide educati	on	
	11:00 a.m. 1/26/23, was ordere	d			to staff via staff in servicing.	on	
	· ·				Education to include policies 1. General dose preparation/	Of I	
	1/27/23 at 10:59 a.m., the medication was not administered due to it was not available from the facility pharmacy. 1/31/23, the medication was discontinued on this				medication administration and	2	
					Emergency medication supplied	5 3.	
	date.	mon was discontinued on this			What measures will be put in	nto	
	auto.				place and what systemic		
	c Embrel syringe 5	0 mg/ml. Administer 50 mg			changes will be made to		
	c. Linorer syringe J	v mg mi. rummister 50 mg			onanges will be made to	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155199	B. W	ING		03/22/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MADIE					JNION ST		
MAPLE	PARK VILLAGE			WESTE	FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	subcutaneously onc	e a week on Tuesdays from			ensure that the deficient		
	7:00 p.m. to 11:00	o.m.			practice does not reoccur;		
	1/31/23, was ordere	ed.			- Facility to provide educati	on	
	1/31/23 at 6:34 p.m	., the medication was not			to all RNs, LPNs, and QMAs v		
	administered due to it was not available from the				staff in servicing. Education to		
	facility pharmacy. The facility expected the				include General dose prepara		
	resident's family to provide the medication from				medication administration and		
	home.				Emergency medication supplie		
	2/1/23, the medication was discontinued on this				- DNS/ nursing administrati		
	date.				will review each admission/		
					re-admission for needs on the	next	
	d. Entresto (a medication used to treat heart				day utilizing IDT Admission/ R	е	
	failure, which was a condition where the heart				Admissions Review tool.		
	muscle cannot pump blood or fill with blood						
	adequately, so bloo	d backed up and fluid built up					
	in the lungs, which	caused shortness of breath)			How the corrective action(s)		
	tablet 24-26 mg. Ac	lminister one tablet twice a day			will be monitored to ensure t	he	
	by mouth from 7:00	a.m. to 11:00 a.m., and 7:00			deficient practice will not		
	p.m. to 11:00 p.m. 1	Hold for BP (systolic blood			recur, i.e., what quality		
	pressure) less than 9	95.			assurance program will be p	ut	
	1/27/23, was ordere	d.			into place; and by what date		
	1/27/23 at 10:59 a.r	n., the medication was not			the systemic changes for ea	ch	
	administered due to	it was not available from the			deficiency will be completed		
	facility pharmacy.				- The DNS/designee will be		
	1/28/23 at 10:01 a.r	n., the medication was not			responsible for the completion	of	
		another reason. The family			the F755 CQI Tool daily for 4		
		vide the medication from			weeks, then weekly for 5 mon	ths,	
	home that day.				with results reported to the		
	1/28/23 at 11:04 p.r	n., the medication was not			Quality Assurance and		
		it was not available from the			Performance Improvement		
	facility pharmacy.	The facility was awaiting the			Committee.		
	arrival of the medic	ation from the facility					
	pharmacy.						
		n., the medication was not			Date of compliance 4/6/23		
	administered due to another reason. The family						
	was expected to pro	ovide the medication from					
	home that day. 1/29/23 at 7:36 p.m., the medication was not						
	administered due to	it was not available from the					
	facility pharmacy. The facility was awaiting the						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/22/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		ation from the facility		TAG	DEFICIENCY)		DATE	
	pharmacy. 1/30/23 at 9:09 a.m administered due to facility pharmacy.	, the medication was not it was not available from the						
	1/31/23 at 6:34 p.m., the medication was not administered due to another reason. The family was expected to provide the medication from home that day.							
	symptoms such as j and length of morni severe Rheumatoid Administer 7.5 mg 7:00 a.m. to 11:00 a							
	administered due to facility pharmacy. 2/10/23 at 9:39 a.m	n., the medication was not it was not available from the , the medication was not it was not available from the						
	medication used to and high blood pres from 7:00 a.m. to 1 than 95. 1/26/23, was ordere 1/29/23, the medicato another reason. T	nate extended release (a treat several heart conditions sure) 25 mg by mouth daily 1:00 a.m. Hold for a SBP less d. tion was not administered due the family was expected to ion from home that day.						
	medication used to mg administered by 11:00 a.m. 1/26/23, was ordere	ayed release tablet (a treat stomach conditions) 40 mouth daily from 7:00 a.m. to d. tion was not administered due						

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MAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BILLIDING QQ QQ QQ QQ QQ QQ QQ	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
MAPLE PARK VILLAGE (X4) ID SUMMARY STATEMENT OF DETICIENCIE (INCHI DETICIENCY MIST IN BETRICTED BY THIL) TAG TO IT WAS not available from the facility pharmacy. The medication was no order from the facility pharmacy. 1/29/23, the medication was not administered due to another reason. The family was expected to provide the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was availing the delivery of the medication from horder to the facility pharmacy. A current document, titled "Omnicell Inventory." dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 133 p.m., indicated the following medications were available from the Omnicell unit for Temegencies or missing medications. During an interview, on 3/22/23 at 10-40 a.m., the DNS indicated tressed on 3/22/23 at 10-40 a.m., the DNS indicated resident PS Embred was a special-order medication, which had to be obtained by a specialty pharmacy, so the family was asked to provide he medication from home, since the facility pharmacy, so the family was asked to provide he medication from home, since the facility pharmacy, so the family was asked to provide he medication from home, since the facility pharmacy, so the family was asked to provide he medication from home, since the facility pharmacy was unable to obtain the medication from home, since the facility pharmacy as unable to obtain the medication from home, since the facility pharmacy was unable to obtain the medication.	AND PLAN	OF CORRECTION			G	00		
MAPLE PARK VILLAGE MAPLE PARK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING RYGRMATION to it was not available from the facility pharmacy. The medication was on order from the facility pharmacy. 1.29/33, the medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. 1.26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was available from the facility pharmacy. The facility was available from the facility pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 133 p.m., indicated the following medications were available from the Comicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility, Metoprolol Succinate Extended Release 25 mg tablet and Pantoprazole delayed release tablet 40 mg. The DNS indicated Expensions Report in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a specially pharmacy was unable to obtain the medication. The facility persons to the medication from home, since the facility pharmacy was unable to obtain the medication in the medication from home, since the facility plarmacy was unable to obtain the medication in the medication in the medication from home, since the facility persons of the committee of the medication from home, since the facility plarmacy was unable to obtain the medication in the medication i			155199	B. WING	_		03/22/	/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG To it was not available from the facility pharmacy. The medication was on order from the facility pharmacy. I/29/23, the medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility except of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 11:39 p.m., indicated the following medications were available from the Omnicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility. Metoprolol Succinate Extended Release 25 mg tablet and Pantorpacole delayed release tablet 40 mg. The DNS indicated Embred, Entresto and Methotrexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embred was a special-order medication, which had to be obtained by a specially pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy was unable to obtain the medication. The facility received a list of the			2	776	N U	JNION ST	•	
TAG REGULATORY OR IS. CIRCHIFYTHON INFORMATION to it was not available from the facility pharmacy. The medication was on order from the facility pharmacy. 1/29/23, the medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was awaiting the delivery of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 11:33 p.m., indicated the following medications were available from the Omnicell unit (the facility's medication emergency storage unit) during Resident H's stay at the facility: Metoprolol Succinate Extended Release 25 mg tablet and Pantoprozole delayed release tablet 40 mg. The DNS indicated Embred, Entresto and Methotrexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a specialty pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy was unable to obtain the medication. The facility received a list of the	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DECLUDED ON AN OF CORRECTION		(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION To it was not available from the facility pharmacy. The medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. to 11:00 a.m. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was awaiting the delivery of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/3 at 1:33 p.m., indicated the following medications were available from the Omnicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility theorytol Succiniant Extended Release 25 mg tablet and Pantoprazole delayed release tablet 40 mg. The DNS indicated Embrel, Entresto and Methorexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a specially pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy was unable to obtain the medication. The facility received a list of the	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
The medication was on order from the facility pharmacy. 1/29/23, the medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was awaiting the delivery of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 1:33 p.m., indicated the following medications were available from the Omnicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility the Oppolo Succinate Extended Release 25 mg tablet and Pantoprazole delayed release tablet 40 mg. The DNS indicated Embrel, Entresto and Methorexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a specialty pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy was unable to obtain the medication. The facility received a list of the	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY)		DATE
pharmacy. 1/29/23, the medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. 1/26/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was awaiting the delivery of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 1:33 p.m., indicated the following medications were available from the Comnicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility. Metoprolol Succinate Extended Release 25 mg tablet and Pantoprazole delayed release tablet 40 mg. The DNS indicated Embrel, Entresto and Methotrexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a speciality pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy was unable to obtain the medication. The facility received a list of the		to it was not availab	ole from the facility pharmacy.					
1/29/23, the medication was not administered due to another reason. The family was expected to provide the medication from home that day. h. Paxil tablet (a medication used to treat depression) 30 mg daily by mouth from 7:00 a.m. to 11:00 a.m. 1226/23, was ordered. 1/27/23, the medication was not administered due to it was not available from the facility pharmacy. 2/11/23, the medication was not administered due to it was not available from the facility pharmacy. The facility was awaiting the delivery of the medication from the pharmacy. A current document, titled "Omnicell Inventory," dated 3/22/23 and provided by the DNS (Director of Nursing Services) on 3/22/23 at 1:33 p.m., indicated the following medications were available from the Omnicell unit (the facility's medication emergency storage unit) during Resident B's stay at the facility. Metoprolol Succinate Extended Release 25 mg tablet and Pantoprazole delayed release tablet 40 mg. The DNS indicated Embrel, Entresto and Methotrexate Sodium were not listed as one of the common medications kept in the Omnicell unit for Emergencies or missing medications. During an interview, on 3/22/23 at 10:40 a.m., the DNS indicated Resident B's Embrel was a special-order medication, which had to be obtained by a specially pharmacy, so the family was asked to provide the medication from home, since the facility pharmacy, was unable to obtain the medication. The facility received a list of the		The medication was	s on order from the facility					
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FVLB11 Facility ID: 000106

If continuation sheet Page 6 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155199	B. WING		03/22/2023
			CTREET	ADDRESS CITY STATE ZID COD	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				JNION ST	
IVIAPLE	PARK VILLAGE		WESTE	FIELD, IN 46074	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	accepted as a new	admission to the facility, so the			
	facility was aware	of any special medications a			
	new admission was prescribed. The facility was				
	responsible for ens	suring the residents'			
	medications were a	available to be administered at			
	the time they were	due to be given. The			
	1	delivered by the facility			
	pharmacy, but if a	medication was unavailable, at			
		dication pass, the staff should			
		from the Omnicell unit. If the			
	person passing the	medication was unable to			
	obtain the medicat	ion from the Omnicell unit, then			
	the physician or N	P should be notified, and staff			
	should ask for an alternative medication to be				
	given.				
	A current documer	nt, titled "Providing Pharmacy			
	Products and Servi	ces," dated with a revised date			
	of 1/1/13 and provi	ided by the DNS on 3/22/23 at			
	12:47 p.m., indicat	ed "Procedure: 1. Pharmacy			
	will provide facilit	y with the Facility-Specific			
	information Sheet	set forth in (the			
	'Facility-Specific Is	nformation Sheet'), which details			
	how facility staff c	an contact pharmacy			
	twenty-four (24) he	ours a day, seven (7) day a			
		for medications are received			
		escriber when pharmacy is			
		f should take the following			
		physician/prescriber that			
		I and that a delay in medication			
		vented by using a medication			
		facility's Emergency Medication			
		d by state regulation. 4.2 If a			
	medication cannot	· ·			
		er if the medication therapy can			
	be initiated the next morning. It it is possible to				
	initiate the medication therapy the next morning,				
	facility staff should document the conversation				
		and include the start time in			
	_	nedication is considered			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FVLB11 Facility ID: 000106

If continuation sheet Page 7 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155199	B. W	ING		03/22/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
F 0842 SS=D Bldg. 00	essential and cannot contact the emergen pharmacy. The eme page the on-call pha answering service. (directly from a facil physician/prescriber or provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided to answ. This Federal tag relation of the provided tag. (ii) A facility may resident-identifiable accordance with a agent agrees not to information except itself is permitted to \$483.70(i)(1) In accordance with a green that (i) Complete; (ii) Accurately doctorial tag. (iii) Readily access (iv) Systematically \$483.70(i)(2) The confidential all information and provided tag. (iii) Readily access (iv) Systematically \$483.70(i)(2) The confidential all information of the provided tag.	to be substituted or delayed, acy number provided by regency number should either armacist or contact an Orders should be received ity nurse or a licensed and cannot be faxed, emailed rering service personnel" To(i)(1)-(5) I dentifiable Information adent-identifiable information that able to the public. The release information that is to an agent only in a contract under which the to use or disclose the to the extent the facility to do so. I records. Coordance with accepted lards and practices, the ain medical records on are- umented; sible; and organized facility must keep ormation contained in the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FVLB11 Facility ID: 000106

If continuation sheet Page 8 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/22/2023	
	PROVIDER OR SUPPLIEF		776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ot when release is- al, or their resident			
	1 ''	ere permitted by applicable			
	law;				
	(ii) Required by La				
	. ,	payment, or health care			
	operations, as per compliance with 4	-			
		Ith activities, reporting of			
	. , .	domestic violence, health			
	oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes,				
	or to coroners, medical examiners, funeral directors, and to avert a serious threat to				
		s permitted by and in			
	compliance with 4	-			
		facility must safeguard			
		formation against loss,			
	destruction, or una	authonzed use.			
	- ',','	ical records must be			
	retained for-				
		me required by State law; or			
		n the date of discharge equirement in State law; or			
		years after a resident			
	reaches legal age	-			
	\$483,70(i)(5) The	medical record must			
	contain-				
		nation to identify the			
	resident;				
	` '	resident's assessments;			
		ensive plan of care and			
	services provided; (iv) The results of any preadmission				
	1 ' '	ident review evaluations and			
	_	nducted by the State;			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155199	B. W	ING _		03/22	/2023
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			JNION ST		
MADIE	PARK VILLAGE				FIELD, IN 46074		
IVIAFLEF	AIN VILLAGE			WEST	ILLD, IN 40074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. ,	ırse's, and other licensed					
	professional's pro						
	. ,	diology and other diagnostic					
	services reports as required under §483.50.						0.4/0.6/0.00
	Based on interview and record review, the facility		F 08	342	The creation and submission		04/06/2023
	failed to ensure medications were accurately and completely documented on the Electronic				this plan of correction does no		
					constitute an admission by this		
		istration Record (EMAR) for 3			provider of any conclusion set		
	of 3 residents reviewed for accurate and complete				in the statement of deficiencie	s, or	
	documentation. (Residents B, C and D)				of any violation of regulation. This provider respectfully requ	ioete	
	Findings include:				that the 2567 plan of correction		
	1 manigs include.				considered the letter of credib		
	1. The record for Resident B was reviewed on				allegation and requests desk	ic .	
	3/21/23 at 1:51 p.m. Diagnoses included, but were				review (paper compliance) on	or	
	_	gn neoplasm of the brain (extra			after 4/6/23.	Oi	
		em), paroxysmal atrial			and 4/0/23.		
		us syndrome, orthostatic			F 842 Resident Records		
		natoid arthritis, pain, and			Identifiable Information		
		niparesis following other					
		ease affecting the right					
	dominant side.	8 8			What corrective action(s) wil	ı	
					be accomplished for those	-	
	a. Resident B's EM	AR was reviewed for			residents found to have been	n	
	incomplete docume	entation for the dates of 1/26/23			affected by the deficient		
	_	nd the following tasks and			practice;		
	-	ound to be incompletely			- Resident B discharged from		
	documented:	•			facility on 2/19/23. Resident 0		
	1/26/23, Diabetic of	rders: Accucheck four times a			has had no further instances of		
	day. Notify MD if a	accucheck was below 70 or			incomplete documentation rela	ated	
	greater than 350.				to medication administration.		
	1/27/23 at 12:00 p.i	m., there was no documentation					
	this task was completed.				How other residents having	the	
	-				potential to be affected by th		
	1/26/23, Daily Weight for CHF (Congestive Heart				same deficient practice will b	ре	
	Failure). Notify the Medical Doctor of a weight				identified and what correctiv	e	
	gain of three pounds in one day or a weight gain				action(s) will be taken;		
	of five pounds in one week.				- All residents receiving		
		m. to 11:00 a.m., there was no			medication have the potential	to	
	documentation this	task was completed.			be affected by alleged deficier	nt	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155199	B. W	ING		03/22/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			JNION ST	
MADLE	PARK VILLAGE				FIELD, IN 46074	
IVIAPLE	PARK VILLAGE			WESTE	-IELD, IN 46074	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					practice.	
	2/2/23, Embrel syr	ringe (reduces signs and			- Facility to provide education	n to
	symptoms such as	joint swelling, pain, fatigue,			staff via staff in servicing.	
	and length of morr	ning stiffness of moderate to			Education to include policies	on
	severe Rheumatoio	d Arthritis) 50 mg/ml (milliliter)			1.General dose preparation/	
	(1 ml). Administer	50 mg subcutaneously (under			medication administration and	2.
	the skin) once a we	eek on Wednesdays from 7:00			Emergency medication supplied	es.
	a.m. to 11:00 a.m.					
	2/2/23, there was n	no documentation this			What measures will be put ir	ito
	medication was giv	ven.			place and what systemic	
					changes will be made to	
	2/9/23, Humalog Kwik pen Insulin (a medication				ensure that the deficient	
	used to lower blood sugar) 100 units/ml				practice does not reoccur;	
	(millimeters). Adn	ninister 2 units subcutaneously			-Inservice to be completed by	
	three times a day.				4/6/23 educating staff on on	
	_	n., there was no documentation			1.General dose preparation/	
	this medication wa	s given.		medication administration and 2.		
					Emergency medication supplied	
		IAR was reviewed for			- DNS/ Nursing administration	to
		entation for the dates of 1/26/23			review emar/ medication	
	_	nd the following medications			administration records daily	
		naccurately documented:			utilizing F842 CQI Tool for all	
		a medication used to treat heart			residents receiving medication	1.
	· · · · · · · · · · · · · · · · · · ·	condition where the heart				
		np blood or fill with blood				
		od backed up and fluid built up			How the corrective action(s)	
		caused shortness of breath)			will be monitored to ensure t	he
		nilligrams). Administer one tablet			deficient practice will not	
	1	uth from 7:00 a.m. to 11:00 a.m.,			recur, i.e., what quality	
	•	1:00 p.m. Hold for BP (systolic			assurance program will be p	ut
	blood pressure) les				into place; and by what date	
		:00 a.m. to 11:00 a.m.,			the systemic changes for ea	
		icated this medication was not			deficiency will be completed	
	given due to it was unavailable at that time.				- The DNS/designee will be	,
		p.m. to 11:00 p.m., it was			responsible for the completion	of
	documented the medication was not given due to				the F842 CQI Tool daily for 4	
		or the resident's blood pressure.			weeks, then weekly for 5 mon	ths,
		rd lacked a blood pressure			with results reported to the	
		for the resident for this date			Quality Assurance and	
1	and time to indicat	e why the medication was held.			Performance Improvement	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199			JILDING	instruction 00	(X3) DATE : COMPL 03/22 /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	1/30/23 7:00 a.m. to	a.m. to 11:00 a.m., through o 11:00 a.m., documentation cation was not given due to it			Committee.		
	was unavailable at to On 1/30/23 at 7:00 documentation indigiven at that time. On 1/31/23 at 7:00 documentation indigiven at that time. On 1/31/23 at 7:00 documentation indigiven due to it was A current document was provided by the and indicated Embr Sodium was not list medications kept in medication emerger Emergency or missi	cated this medication was a.m. to 11:00 a.m., cated this medication was a.m. to 11:00 a.m., cated this medication was p.m. to 11:00 p.m., cated this medication was not unavailable at that time. t, titled "Omnicell Inventory," e DNS on 3/22/23 at 1:33 p.m., el, Entresto and Methotrexate ted as one of the common the Omnicell unit (the facility's ney storage unit) to obtain for			Date of compliance 4/6/23		
	3/21/23 at 1:10 p.m not limited to, Parki generalized anxiety chronic pain, ataxic of uncertain or unki communication defineed for assistance Resident C's EMAR	Diagnoses included, but were inson's disease, hypertension, disorder, delusional disorders, gait, mild cognitive impairment nown etiology, cognitive icit, unsteadiness on feet, and with personal care.					
	3/21/23, and the fol to be incompletely of 1/30/23, Omeprazol medication used to mg. Administer 20: morning between 7:	the dates of 3/1/23 through lowing medications were found documented: le delayed release capsule (a treat stomach disorders) 20 mg by mouth once in the :00 a.m. to 11:00 a.m. there was no					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/22/2023		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION documentation this medication was given.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			
	1/1/22, Sinemet tab Parkinson's disease, mg every six hours On 3/9/23 at 12:00 documentation this On 3/9/23 at 6:00 a documentation this 12/20/18, Tylenol tareliever) 325 mg. A day by mouth for cl On 3/1/23 at 8:00 a documentation this 3. The record for Ro 3/21/23 at 2:11 p.m not limited to, stable lumbar vertebra, ch thrombosis of deep extremity, chronic of Type II diabetes medisorder. a. Resident D's EM incomplete documentation this 2/28/23, and and tasks were found documented: 2/9/23, Diabetic ord day. Notify the Medwas below 70 or gro On 2/19/23 at 7:00 documentation this Tresiba Flex Touch medication used to	let (a medication used to treat 25-100 mg. Administer 50-200 by mouth. a.m., there was no medication was given. m., there was no medication was given. ablet (a non-narcotic pain dminister 650 mg three times a aronic pain. m., there was no medication was given. besident D was reviewed on Diagnoses included, but were burst fracture of second ronic embolism, and veins of unspecified lower obstructive pulmonary disease, llitus, and generalized anxiety AR was reviewed for matation for the dates of 2/1/23 did the following medications did to be incompletely lers: Accucheck tests twice a dical Doctor if the accucheck eater than 350. a.m., there was no task was completed. U-200 insulin pen (a lower blood sugar) 200 (3 ml). Administer 40 units					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155199		A. BUILDING 00 B. WING		COMPLETED 03/22/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST				
MAPLE PARK VILLAGE			V	/ESTFI	ELD, IN 46074		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	On 2/15/23 at 8:00 documentation this	p.m., there was no medication was given.					
	incomplete docume through 3/21/23, an and tasks were four documented: 2/9/23, Diabetic ord day. Notify the Med was below 70 or gro On 3/5/23 at 7:00 a documentation this On 3/19/23 at 7:00 documentation this On 3/21/23 at 8:00 documentation this 2/9/23, Clonazepant treat anxiety disord three times a day by On 3/19/23 at 8:00 documentation this During an interview	task was completed. a.m., there was no task was completed. p.m., there was no task was completed. p.m., there was no task was completed. n tablet (a medication used to ers) 0.5 mg. Administer 0.5 mg mouth.					
	was not able to say or the task was commost likely was ince asked if she could end been documented at then given the next documented as unan	if the medications were given appleted or not. The blank area complete documentation. When explain why a medication had as not available for a few shifts, time it was due, then evailable the next few times the explain when the explain was a superior or the superior of the medicate of the superior of t					
	and Medication Addate of 1/1/13 and p	elled "General Dose Preparation ministration," with a revised provided by the DNS on m., indicated "Procedure6.					

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

PRINTED: 05/01/2023 FORM APPROVED OMB NO. 0938-039

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 03/22/2023		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE	
	After medication administration, facility staff should take all measures required by the facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (when medications are givenif medications are refused) on appropriate forms" This Federal tag relates to Complaint IN00403435. 3.1-50(a)(1) 3.1-50(a)(2)						

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