STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 the Investigation of Complaints IN00446258 and IN00447945. Complaint IN00446258 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00447945 - Federal/state deficiencies related to the allegations are cited at F744. Unrelated deficiencies are cited. Survey dates: December 12 and 16, 2024 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 15 Medicaid: 76 Other: 37 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 29, 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 regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective 1/31/2025. We respectfully request paper compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments	F 0641	**F 641**	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessment accuracy for behaviors for 1 of 3 residents reviewed for behavior management. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/16/24 at 11:00 a.m. The diagnoses included, but were not limited to, senile degeneration of the brain, dementia with agitation, dementia with psychotic disturbance, and anxiety disorder. A Significant Change MDS assessment, dated 9/30/24, indicated Resident B exhibited no behaviors. Upon review of the progress notes, the following date(s) were indicative of Resident B exhibiting behaviors: 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/27/24, 9/28/24, & 9/29/24. An interview conducted with the MDS Coordinator, on 12/16/24 at 1:28 p.m., indicated Social Services was responsible for completing the MDS section regarding behaviors.		It is the practice of Westminster Village North to ensure Minimum Data Set (MDS) assessment accuracy for behaviors. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident B continues to reside at Westminster Village North. The MDS assessment dated 9/30/24 was modified to accurately reflect that the resident exhibited behaviors during the assessment period. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit was completed of all residents' behavior section of MDS to ensure accuracy. SSD educated on MDS accuracy and the criteria for exhibiting behaviors/not exhibiting behaviors. All staff who complete sections of MDS assessments are educated on accuracy of assessments. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** SSD educated on MDS accuracy and the criteria for coding behaviors on the MDS. All staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
			who complete sections of MDS assessments are educated on accuracy of assessments. MDS Coordinator and MDS assistant to verify behavior status accuracy prior to submission of the MDS assessment. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** MDS Coordinator and/or designee will audit 5 current MDS in reference window weekly x 4 weeks, and monthly for 90 days. Results on all quality improvement audits will be reported to the QAPI committee for review. There must be at least three consecutive months with no findings to discontinue the audit.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview and record review, the facility failed to ensure a resident with dementia and behaviors was care planned for behaviors along with resident specific interventions on approach to care, ensure visits were conducted of a mental health provider, and document approaches to care when Resident B exhibited behaviors for 1 of 3 residents reviewed for behavior management. Findings include: The clinical record for Resident B was reviewed	F 0744	**F 744** It is the practice of Westminster Village North to ensure that if a resident who displays or is diagnosed with dementia receives the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. **What corrective action will be accomplished for those residents found to have been**	01/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	on 12/16/24 at 11:00 a.m. The diagnoses included, but were not limited to, senile degeneration of the brain, dementia with agitation, dementia with psychotic disturbance, and anxiety disorder. An Admission MDS assessment, dated 5/24/24, indicated severe cognitive impairment, physical behaviors directed towards others occurred one to three days, significant risk for injury and interference with care regarding behaviors, and rejection of care every four to six days. A psychiatric visit form, dated 6/27/24, indicated Resident B had multiple behaviors including refusing medications and being combative with care. Treatment goals were for Resident B to have stabilization to mood and psychosis. A care conference document, dated 7/25/24, indicated discussion was held with Resident B's family regarding care preferences and being combative with care. The evaluation/goals had a suggestion to reach out to the Certified Nurse Aide (CNA) instructor for new techniques on how to approach resident during perineal care. A discussion to educate staff about Resident B's preferences and have a posting of strategies of approach in Resident B's room. A care conference document, dated 8/8/24, indicated Resident B's family wanted monitoring of staff interacting with Resident B to determine behaviors. Resident B becomes combative during perineal care and that had been consistent with every facility Resident B resided in. A Social Services Quarterly Note, dated 8/23/24, indicated Resident B exhibited behaviors that consisted of yelling out, refusal of medications, refusal of care, combative with facility staff, and		**affected by the deficient practice?** Resident B continues to reside at Westminster Village North. Resident B's care plans have been reviewed and updated to identify resident's targeted behaviors and individualized interventions, including non-pharmacological interventions. Resident B's care plan has been updated to reflect that resident no longer benefits from mental health services related to cognition decline and additional gains were becoming less likely. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with a diagnosis of dementia or a like diagnosis have the potential to be affected by this finding. SSD and/or designee will complete an audit of all residents with the potential to be affected related to dementia and/or psych diagnosis. Any resident identified by the audit as lacking and/or needing personalized care plans with behavioral interventions will be added, updated and corrected at that time. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An inservice for healthcare staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	physically aggressive with facility staff. A counseling progress note, dated 8/29/24, indicated Resident B was gradually modifying her behavior. The treatment objectives consisted of the current care plan with interventions to generally focus on reducing the problems of anxiety and depression. The plan was to continue to monitor, encourage, and educate. A counseling note, dated 9/12/24, indicated Resident B was not seen due to services terminated related to cognition decline and additional gains were becoming less likely. A Significant Change MDS assessment, dated 9/30/24, indicated Resident B exhibited no behaviors. A care plan for pain, revised 12/2/24, indicated Resident B had nonsensible responses and needs were anticipated by staff. The interventions included, but were not limited to, observe and report changes in usual routine, withdrawal, or resistance to care. A care plan for psychosocial well-being, initiated on 11/7/24 and revised on 12/12/24, indicated Resident B had a history of trauma and ineffective coping related to dementia to where she may become agitated and/or combative with care. The interventions included, but were not limited to, consult with Social Services, psych services as needed, explain the steps of care that you are providing prior to initiating services (initiated on 12/12/24), and give Resident B space and time to herself before attempting again (initiated on 12/12/24). There were no care plans specific to behaviors		will be conducted on or before 1/31/2025 by the SSD and/or Designee. This inservice will include review of the facility policy related to behavior tracking, documentation and individualized behavior care plans. All clinical staff will be educated on the process and best practices for behavior documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The SSD and/or Designee will be responsible for completing the QAPI audit tool related to behavior management weekly for 4 weeks, and monthly for 90 days. Results on all quality improvement audits will be reported to the QAPI committee for review. There must be at least three consecutive months with no findings to discontinue the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	exhibited by Resident B and non-pharmacological and/or resident specific interventions listed for such behaviors until 12/12/24. The progress notes reviewed, from September 2024 to December 2024, indicated behaviors were exhibited for the following number of day(s): September 2024 consisted of 24 out of 30 days with behaviors exhibited, October 2024 consisted of 23 out of 31 days with behaviors exhibited, November 2024 consisted of 25 out of 30 days with behaviors exhibited, and December 2024 consisted of 11 out of 12 days with behaviors exhibited. A care plan for anxiety, initiated on 12/12/24, indicated Resident B may become agitated and yell out. The interventions included, but were not limited to, encourage resident to discuss her feelings, Resident B enjoyed sitting out in the common area, offer routine care plan meetings, and provide one-on-one visits as needed. The progress notes reviewed for Resident B indicated all behaviors exhibited by Resident B did not include the approach to the behavior by facility staff, documentation of resident specific approaches/interventions, and what interventions/approaches were successful or unsuccessful. An interview conducted with Nurse 4, on 12/16/24 at 11:30 a.m., indicated Resident B had verbal and physical aggression towards staff on a regular basis. The facility staff would attempt to redirect Resident B multiple times in an attempt to see what interventions would be effective, but nothing seemed to work. The staff would ask the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	resident what she wanted and when they returned with the items requested, Resident B would then deny those items. An interview conducted with the former Social Services Director, on 12/12/24 at 2:04 p.m., indicated the behavior management program was not appropriate at managing the residents with behaviors. There were no interviews conducted with resident, staff, and/or families to see what interventions could be implemented that were resident specific. The residents were given pharmacological interventions, and nothing was geared towards non-pharmacological interventions in an attempt to help with behaviors. How the staff approach the residents was important and it wasn't being discussed for implementation for the care plans regarding residents with behaviors. An interview conducted with the Director of Nursing (DON), on 12/16/24 at 3:00 p.m., indicated the charting wasn't reflective of interventions and approaches for Resident B's behaviors. Resident B was being seen by mental health providers, but her cognition became so poor, and she couldn't progress any further with the mental health services being provided. The facility staff have tried numerous attempts in response to Resident B's behaviors, but they were hardly effective. A policy entitled "Behavior Health Services", undated, was provided by the Administrator on 12/16/24 at 11:06 a.m. The policy indicated the following, "...Policy explanation and Compliance Guidelines...3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	choice, and safety... 7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will... d. Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable...f. Assess and develop a person-centered care plan for concerns identified in the resident's assessment...g. Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis... i. Ensure appropriate follow-up assessment, if needed... j. Discuss potential modifications to the care plan... k. Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident... 8. The resident, and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall... a. Have interventions that are person-centered... d. Account for the resident's experiences and preferences... f. Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated... 12. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists...." This citation relates to Complaint IN00447945.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 0755 SS=D Bldg. 00	3.1-37(a) 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure a narcotic pain medication was administered per the physician orders for 1 of 3 residents reviewed for pain management. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/16/24 at 11:00 a.m. The diagnoses included, but were not limited to, senile degeneration of the brain, dementia with agitation, dementia with psychotic disturbance, and anxiety disorder. A physician order, dated 10/20/24, indicated a fentanyl patch (narcotic pain-relieving patch) 12 mcg (micrograms) was to be applied every three days. This order ended on 11/19/24. A hospice note, dated 11/6/24, indicated an order to increase Resident B's fentanyl patch from 12 mcg to 25 mcg and change the patch every three days. A physician order, dated 11/7/24, indicated to apply a 25 mcg fentanyl patch to Resident B every three days. A controlled drug use record form for Resident B's 25 mcg fentanyl patch indicated one was administered on 11/10/24. A controlled drug use record form for Resident B's 12 mcg fentanyl patch indicated one was	F 0755	**F 755** It is the practice of Westminster Village North to ensure pharmaceutical services are provided in a manner to assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident B continues to reside at Westminster Village North. Resident B continues to receive fentanyl patch as ordered by the physician. A medication error report has been completed for the fentanyl patches that were given between 11/10/24 and 11/26/24 in error and nurses involved have been counseled. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Any residents with an order for a fentanyl patch have the potential to be affected. An audit has been completed by the DON and/or designee to confirm that the orders and MARS are accurate	01/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	administered on 11/10/24. An incorrect dose was administered of a total of 37 mcg, on 11/10/24, when the physician order was for only 25 mcg at that time. A hospice note, dated 11/26/24, indicated to increase the fentanyl patch from 25 mcg to 37 mcg by applying a 25 mcg patch and a 12 mcg patch every three days. An interview conducted with the Director of Nursing (DON), on 12/16/24 at 3:00 p.m., indicated the nursing staff were to follow physician orders for medication administration. A policy titled "Nursing - Medication Administration", undated, was provided by the DON on 12/16/24 at 3:00 p.m. The policy indicated medications were to be administered in accordance with the prescriber orders, including any required time frame. This citation relates to Complaint IN00446258. 3.1-25(b)		with the correct dosage for the fentanyl patches. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses and QMAs will be educated on the process and best practices for Nursing Medication Administration. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DON and/or Designee will be responsible for completing the QAPI audit tool related to narcotic patch administration weekly for 4 weeks, and monthly for 90 days. Results on all quality improvement audits will be reported to the QAPI committee for review. There must be at least three consecutive months with no findings to discontinue the audit.	