STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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 Complaint IN00445164. Complaint IN00445164 - Federal/State deficiencies related to the allegations are cited at F659. Survey date: October 24, 2024 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 90 SNF: 2 Total: 92 Census Payor Type: Medicare: 2 Medicaid: 73 Other: 17 Total: 92 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 29, 2024.	F 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after November 10, 2024.	
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons Based on interview and record review, the facility failed to ensure that a staff member (QMA 2) followed pain medication administration protocols by administering a controlled substance on the wrong day at the wrong time for 1 of 3 residents	F 0659	F659 Qualified Persons What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B is receiving pain medications per	11/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danielle Smith	DNS	11/12/2024

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 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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	reviewed for pain medications. (Resident B) Finding includes: On 10/24/24 at 9:00 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, respiratory failure, COPD (a lung disease that makes it difficult to breathe), opioid dependence, and hepatitis C (a viral infection that affects the liver). A physician's order report, dated 9/1/24 to 10/24/24 indicated: Fentanyl (a potent synthetic schedule II controlled opioid drug given for pain relief) was prescribed on 9/26/24 with a stop date of 9/29/24. Staff were to apply the 12 mcg (micrograms) Fentanyl transdermal patch once every three days and to rotate the site of application. A new physician order, dated 9/29/24 with no end date, indicated apply Fentanyl 12 mcg transdermal patch every three days and rotate the site. The old patch was to be removed and disposed of properly. A progress note, dated 9/29/24 at 1:22 p.m., indicated that Resident B requested that staff give her the old Fentanyl patch when patches were changed. Resident B stated that her insurance paid for the patches and Resident B should be able to keep them. Nursing staff explained they had to be removed and disposed of according to rules and guidelines. During an interview on 10/24/24 at 9:20 a.m., Resident B indicated that about 3 weeks ago her Fentanyl pain patch was not put on correctly and said she did not get the medications.		physician . 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 medication have the potential to be affected by the alleged deficient practice. An audit was completed for all residents with pain medications to ensure given per physician orders. An in-service will be completed by DNS/designee for all licensed nursing staff on or before 11/10/24 on pain medication administration, including verifying correct time per policy What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? An in-service will be completed by DNS/designee for all licensed nursing staff on or before 11/10/24 on pain medication administration, including verifying correct time per policy MAR to be audited daily by DNS/designee to ensure pain medications given per orders to include correct time. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete the Medication Administration CQI audit tool for six months with audits being completed once weekly for one month, and then	

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	During an interview on 10/24/24 at 10:35 a.m., the DON (Director of Nursing) indicated that Resident B received a new order for Fentanyl transdermal patches at the end of September. The DON further indicated that Resident B had let staff know that QMA 2 had removed the old patch, the first patch ordered, placed on 9/26/24, with a new Fentanyl patch on the evening of 9/28/24. Resident B informed nursing staff of this the next day on 9/29/24. QMA 2 did sign it out of the paper narcotic tracking book but did not inform licensed nursing staff, a supervisor, or the physician. The Fentanyl patch was not ordered to be changed until the next day. When the resident made staff aware; they informed the physician and were told to keep the patch placed on 9/28/24 on the resident until 10/2/24 and then to keep to the schedule as ordered every three days. On 10/24/24 at 11:30 a.m., the DON provided a copy of a policy dated 12/1/07 and titled "General Dose Preparation and Medication Administration, and indicated it was the policy currently in use by the facility. A review of the policy indicated that prior to administration of medications facility staff should take all measures required by facility policy, including verifying the correct time of medication administration. This citation relates to Complaint IN00445164. 3.1-35(g)(2)		monthly for 5 months by a nurse manager or . The Medication Administration CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. Date of Compliance 11/10/2024	