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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Creek Village	525 E Thompson Rd Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 45292 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)