STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Park Village	776 N Union St Westfield, IN 46074

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to protect the residents' right to be free from physical abuse by a CNA for 2 of 3 residents reviewed for abuse. (Resident D and F) This deficient practice resulted in Resident D thinking a staff member was going to kill him, trouble sleeping after the incident, and signs he was scared after the abuse. Resident F had a history of abuse as a child and had two loose teeth in her mouth. The deficient practice was corrected on 2/20/26, prior to the start of the survey, and was therefore past noncompliance.Findings include:1. During an interview, on 3/3/26 at 2:21 p.m., the Executive Director, Director of Nursing and Regional Director of Operations were in attendance and indicated Resident D was blind, had became combative while he was being changed, and CNA 5 put his hands on the resident.The clinical record for Resident D was reviewed on 3/5/26 at 2:29 p.m. The diagnoses included, but were not limited to, dementia with mood disturbance, major depressive disorder, legal blindness, and pain.A care plan, dated 1/15/25, indicated Resident D was legally blind, would not experience negative consequences of vision loss, and would remain physically safe.A care plan, dated 1/15/25, indicated Resident D had hearing loss, would hear and understand communication, and to obtain the resident's attention prior to speaking to him.A nursing progress note, dated 2/10/26 at 10:00 p.m., indicated a head-to-toe assessment was completed. Resident D had a bruise and skin tear measuring 0.5 centimeters (cm) to his left outer arm. His left eyebrow area appeared to be swollen. He had redness observed near the right side of his mouth. He complained of a headache and neck pain.A social service progress note, dated 2/11/26 at 8:17 a.m., indicated Resident D did not sleep well the night before.A facility progress note, dated 2/11/26 at 8:35 a.m., indicated the Executive Director (ED) had spoken to Resident D's daughter regarding the resident's interaction with the CNA last night.During an interview, on 3/3/26 at 11:36 a.m., CNA 3 indicated, on 2/10/26, she heard Resident D yelling in a muffled sound. She arrived at the resident's door at the same time as LPN 4. CNA 3 did not see what CNA 5 was doing to Resident D. CNA 5 was standing next to the bed. LPN 4 told CNA 5 to go home immediately. CNA 3 and LPN 4 finished Resident D's care after they allowed him to rest for a while. Resident D was shaking and frightened after the incident. He had a frightened look on his face. Resident D told CNA 3 that man held his hand over my mouth and tried to kill me Resident D complained of pain in his neck later and had asked for ibuprofen that night and the next day. CNA 5 was suspended, then he was terminated.During an interview, on 3/3/26 at 2:39 p.m., Resident D when asked about the incident, indicated some man attacked him and he thought he was going to die.During an interview, on 3/3/26 at 3:01 p.m., LPN 4 indicated she was on her way to another resident's room when she heard Resident D yelling out in a muffled way, so she went to his room. Without knocking on his door, she walked into his room and found CNA 5 with his left knee bent onto the bed by the resident's side and both his hands over the resident's mouth and nose. CNA 5 was telling the resident to Shut the hell up as he was raising his hands up and down off the resident's nose and mouth. LPN 4 immediately told CNA 5 to leave and go home. She indicated when she walked into Resident D's room and seen CNA 5 standing over the resident with his hands over his nose and mouth he looked like a crazy person. Resident D had a skin tear on his left arm. Resident D told LPN 4 and CNA 3 That bastard tried to kill (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

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The facility was not aware of this incident until the other abuse was investigated.The clinical record for Resident F was reviewed on 3/5/26 at 3:06 p.m. The diagnoses included, but were not limited to, dementia, psychotic disorder with delusions, psychotic disorder with hallucinations, generalized anxiety disorder, osteoarthritis, and major depressive disorder.A care plan, dated 1/16/24, indicated Resident F had experienced trauma and was a survivor of abuse. She was at risk for experiencing re-traumatization, feeling unsafe, untrusting, and/or distressed. An associated trauma trigger was the sight of a male resident. The interventions included, but were not limited to, ensure the resident had a sense of emotional and physical safety (provide female caregivers during personal care when possible and explain the care before and during the care related to a history of trauma). The trauma symptoms identified were intrusive thoughts, feeling upset, and anger and irritability. At the time of the incident with CNA 5, Resident F was being provided personal care by a male caregiver. Her care plan indicated to provide female caregivers when possible. There was no actual date determined for the abuse of Resident F. CNA 5's timecard indicated he had worked on 12/24/25, 12/26/25, 12/30/25 and 12/31/25 on the evening shift. The bruise on Resident F's chin and bilateral cheeks was discovered on 1/1/26. A social service progress note, dated 12/30/25 at 2:06 p.m., indicated the nurse notified social services about the resident's loose teeth. A nursing progress note, dated 12/30/25 at 2:06 p.m., indicated Resident F was observed to have three loose/wiggling front teeth on the left side.A nursing progress note, dated 1/1/26 at 1:22 p.m., indicated the nurse was notified a bruise was observed on Resident F when removing the resident's clothing protector after lunch. The nurse assessed and noted a bruise under Resident F's chin and her bilateral cheeks with various stages of healing. A facility document, titled Event Report, dated 1/1/26 at 1:16 p.m., indicated Resident F had bruising in various stages under her chin and bilateral cheeks observed on 1/1/26. The wound was not from a fall. The area measured 10 cm (centimeters) by 2 cm for the chin and 1 cm by 1 cm to each of her cheeks. All the bruises were in various stages of healing. A nursing progress note, dated 1/1/26 at 9:39 p.m., indicated the bruised areas to the resident's bilateral cheeks and under her chin remained. There were also bruises noted to her bilateral anterior hands with various stages of healing.A nursing progress note, dated 1/2/26 at 7:34 p.m., indicated the bruising remained under Resident F's chin which was yellow and dark purple in color.A nursing progress note, dated 1/3/26 at 5:21 a.m., indicated the bruising remained under Resident F's chin and bilateral cheeks. The bruising was mostly yellow in color with localized dark purple areas. A nursing progress note, dated 1/4/26 at 12:20 a.m., indicated the bruising to the resident's chin continued to resolve.A nursing progress note, dated 1/4/26 at 10:55 a.m., indicated the bruising remained under the chin and was yellow and deep purple in color. A nursing progress note, dated 1/6/26 at 10:31 a.m., indicated the bruising to the resident's chin continued to resolve in various stages of colors. A progress note, dated 1/7/26 at 12:10 p.m., indicated Resident F was observed crying inconsolably in the main dining room prior to lunch service. Therapeutic communication was attempted but was not effective. She seemed to be reliving past traumas of her family's deaths. She had severe cognitive impairment. The root cause of the crying was thought to be overstimulation in the dining room. A nursing progress note, dated 1/9/26 at 12:59 p.m., indicated the resident had bruising under her neck and to her left hand which was resolving.Resident F had a consult with the dentist, on 1/9/26, for a limited oral evaluation for loose teeth. The exam indicated she had lost a bridge between teeth 9 through 11. The teeth have mobility in them. A referral was made to the oral surgeon to have those teeth extracted. A typed facility statement indicated, on 1/1/26, LPN 18 was informed when a CNA (continued on next page)

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