

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  10/11/2024
NAME OF PROVIDER OR SUPPLIER  Maple Park Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>38872</p> <p>Based on interview and record review, the facility failed to conduct care plan meetings at least quarterly for 2 of 2 residents reviewed for care plan conferences/meetings. (Resident 5 and 59)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 5 was reviewed on 10/8/24 at 1:49 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, chronic systolic heart failure, and hypertension.</p> <p>The last documented care plan meeting for Resident 5 was in March 2024.</p> <p>During an interview, on 10/10/24 at 2:34 p.m., the Social Service Director indicated the resident had a care plan in March of this year (2024). The resident should have had one in May and another one in early August. The resident was missing 2 care plan meetings.</p> <p>2. The clinical record for Resident 59 was reviewed on 10/10/24 at 2:29 p.m. The diagnoses included, but were not limited to, hydronephrosis (a condition where one or both kidneys swell due to a buildup of urine), chronic atrial fibrillation, and acute chronic diastolic heart failure.</p> <p>The last documented care plan meeting for Resident 59 was on 6/5/24.</p> <p>During an interview, on 10/10/24 at 2:30 p.m., the Social Service Director indicated care plan meetings were completed quarterly. Resident 59 was due for a care plan meeting in September 2024 and currently there was not a care plan meeting scheduled.</p> <p>A facility document, titled MDS COORDINATOR, updated 5/2018 and received from the Executive Director on 10/11/24 at 8:30 a.m., indicated .The MDS Coordinator is responsible for the .Interdisciplinary Care planning process .establishes and maintains a cyclical schedule related to the .care planning process ensuring adherence to strict federal timelines .Coordinates interdisciplinary care plan meetings and conferences with Social Services, family members and residents to encourage/facilitate family and/or resident participation</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, titled IDT Comprehensive Care Plan Policy, dated as last reviewed 8/2023 and received from the Corporate Support Nurse on 10/10/24 at 3:16 p.m., indicated .It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented .The care plan review may be conducted face to face, via phone conference, video conference, or through written communication per resident and/or representative preference</p> <p>3.1-35(d)(2)(B)</p> <p>3.1-35(e)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48525</p> <p>Based on interview and record review, the facility failed to ensure medications were held according to the physician's ordered hold parameters for 2 of 2 residents reviewed for quality of care. (Resident 36 and 55)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 36 was reviewed on 10/10/24 at 11:02 p.m. The diagnoses included, but were not limited to, essential hypertension, type 2 diabetes, and hyperlipidemia.</p> <p>A physician's order, with a start date of 1/23/24, indicated to give metoprolol succinate (a blood pressure medication) 100 milligrams (mg) extended-release tablet once a day. Hold for a systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60.</p> <p>A current care plan, with a start date of 1/30/24, indicated the resident was at risk for ineffective tissue perfusion related to hypertension and to administer medications as ordered.</p> <p>A review of the Medication Administration Record (MAR) indicated metoprolol succinate was administered on the following dates outside of the physician's ordered hold parameters:</p> <p>On 7/1/24, with a systolic blood pressure of 101 and a heart rate of 55.</p> <p>On 7/6/24, with a heart rate of 52.</p> <p>On 7/9/24, with a heart rate of 55.</p> <p>On 7/17/24, with a heart rate of 59.</p> <p>On 7/18/24, with a heart rate of 56.</p> <p>On 7/27/24, with a systolic blood pressure of 103.</p> <p>On 8/2/24, with a heart rate of 56.</p> <p>On 9/1/24, with a heart rate of 57.</p> <p>On 9/12/24, with a heart rate of 57.</p> <p>On 10/4/24, with a heart rate of 57.</p> <p>During an interview, on 10/10/24 at 4:00 p.m., the Director of Nursing (DON) indicated the documentation indicated the medications were administered during those dates and times.</p> <p>2. The clinical record for Resident 55 was reviewed on 10/9/24 at 11:02 a.m. The diagnoses included, but were not limited to, essential hypertension, type 2 diabetes, and edema.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order, with a start date of 2/15/24, indicated to give metoprolol succinate 50 mg and to hold the medication for a systolic blood pressure of less than 120 or a heart rate of less than 55.</p> <p>A current care plan, with a start date of 2/11/23, indicated the resident was at risk for ineffective tissue perfusion related to hypertension and to administer medications as ordered.</p> <p>A review of the Medication Administration Record (MAR) indicated metoprolol succinate was administered on the following dates outside of the physician's ordered hold parameters:</p> <p>On 7/15/24, with a systolic blood pressure of 116.</p> <p>On 7/16/24, with a systolic blood pressure of 119.</p> <p>On 7/17/24, with a systolic blood pressure of 112.</p> <p>On 7/21/24, with a systolic blood pressure of 117.</p> <p>On 7/22/24, with a systolic blood pressure of 110.</p> <p>On 7/29/24, with a systolic blood pressure of 110.</p> <p>On 7/30/24, with a systolic blood pressure of 110.</p> <p>On 8/6/24, with a systolic blood pressure of 113.</p> <p>On 8/12/24, with a systolic blood pressure of 113.</p> <p>On 8/23/24, with a systolic blood pressure of 114.</p> <p>On 9/1/24, with a systolic blood pressure of 119.</p> <p>On 9/2/24, with a systolic blood pressure of 118.</p> <p>On 9/17/24, with a systolic blood pressure of 115.</p> <p>On 9/27/24, with a systolic blood pressure of 104.</p> <p>During an interview, on 10/10/24 at 4:00 p.m., the DON indicated the documentation indicated the medications were administered during those dates and times.</p> <p>The facility did not provide a policy on following physician's orders.</p> <p>3.1-37(a)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48525</p> <p>Based on observation, interview and record review, the facility failed to ensure unlabeled food was not stored in a medication room refrigerator and medications were stored in the original containers in 1 of 2 medication rooms and 1 of 3 medication carts reviewed for medication storage. (200 hall refrigerator and 300 hall medication cart)</p> <p>Findings include:</p> <p>1. During an observation and interview, on 10/11/24 at 11:49 a.m., the 200-hall medication room supplement refrigerator had 2 unlabeled cans of Canada Dry and a grocery sack with a to-go container of food in it which was unlabeled. Registered Nurse (RN) 3 indicated she was unsure who the 2 cans of Canada Dry and the food belonged to. They did not have labels on them, and they should have had labels.</p> <p>During an interview, on 10/11/24 at 12:05 p.m., the Director of Nursing (DON) indicated food put in the refrigerator should be labeled.</p> <p>38872</p> <p>2. During an observation of the Moving Forward South medication cart there were 20 white oval tablets with marking 4H2 (cetirizine) and one round white table found in the bottom drawer. There was no bottle found to match up with the 20 white oval tablets.</p> <p>During an interview, on 10/11/24 at 12:08 p.m., RN 5 indicated it was possible something spilt.</p> <p>During an interview, on 10/11/24 at 12:29 p.m., the Director of Nursing indicated the cart had been cleaned that morning.</p> <p>A current facility policy, titled Safe Food Handling for Your Loved One, undated and received from the Executive Director upon entrance, indicated .When brought into the facility the food must be labeled as Resident Personal Food. This label will need to include resident name, the name of the item being stored (if not already clearly identified), the date the item is brought into the facility and the date the item must be discarded</p> <p>A current facility policy, titled Storage and Expiration Dating of Medications and Biologicals, dated as last revised on 8/1/24 and received from the Executive Director on 10/11/24 at 1:38 p.m., indicated, .Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received</p> <p>3.1-25(j)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50901</p> <p>Based on observation, interview and record review, the facility failed to ensure staff prepared pureed food in a sanitary manner for 1 of 1 staff member observed to puree food. (Cook 6)</p> <p>Finding includes:</p> <p>During an observation, on 10/8/24 at 10:36 a.m., [NAME] 6 was preparing pureed tuna casserole for lunch.</p> <p>During an observation, on 10/8/24 at 10:44 a.m., while preparing the pureed tuna casserole, [NAME] 6 licked the pureed tuna casserole off the first finger of her right hand. [NAME] 6 then attempted to take the food processor bowl off the base of the appliance to transfer the pureed food into a different container.</p> <p>During an interview, on 10/8/24 at 10:44 a.m., [NAME] 6 indicated she should not have licked the food off her finger and instead, she should have washed her hands.</p> <p>A current facility policy, titled Food Handling, dated 11/15 and received from the Director of Nursing on 10/10/24 at 8:49 a.m., indicated .To provide quality food that is handled in a safe and sanitary manner .All food preparation and serving areas shall be maintained in accordance with state and local sanitation standards, food handling, food preparation, and meal service</p> <p>3.1-21(i)(3)</p>