STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00443865 Complaint IN00443865- No Federal/State deficiencies related to the allegations are cited. Survey dates: October 7, 8, 9, 10 and 11, 2024. Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 78 SNF: 6 Total: 84 Census Payor Type: Medicare: 6 Medicaid: 36 Other: 42 Total: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 18, 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 regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 10/28/24.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision 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)	F 0657	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth	10/28/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tony Link	Executive Director	10/24/2024

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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	Findings include: 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. The last documented care plan meeting for Resident 5 was in March 2024. 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. 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. The last documented care plan meeting for Resident 59 was on 6/5/24. 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. 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		in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 10/28/24. F 657 Care Plan Timing and Revision **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Care plan meeting for resident 5 was held on 10/16/24. Care plan for resident 59 was held on 10/25/24. **1.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 have the potential to be affected by the alleged deficient practice. No other residents were known to not have at a minimum a quarterly care plan meeting. MDS coordinator, nurse manager, and social services staff were inserviced on care plan expectation and time frames for them to be held, at least quarterly. **1.What measures will be put into place or what systemic changes will you make to**	

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	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...." 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...." 3.1-35(d)(2)(B) 3.1-35(e)		**ensure that deficient practice does not recur?** MDS nurse, nurse manager, and social services staff were inserviced on care plan expectation and time frames for them to be held, at least quarterly. Social Services Director and MDS coordinator will utilize singular calendar for coordinating care plans and ensuring they occur at a minimum quarterly. **1.How the corrective action(s) 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 Social Services Director will use will use F657 CQI audit tool. Observations will be weekly for 3 months, and then monthly for 3 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. 5. **Date of Compliance 10/28/24**	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care 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) Findings include: 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. 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. 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. 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: On 7/1/24, with a systolic blood pressure of 101 and a heart rate of 55. On 7/6/24, with a heart rate of 52. On 7/9/24, with a heart rate of 55. On 7/17/24, with a heart rate of 59. On 7/18/24, with a heart rate of 56. On 7/27/24, with a systolic blood pressure of 103. On 8/2/24, with a heart rate of 56.	F 0684	F 684 Quality of Care **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice**? Resident 36 and 55 were not affected due to the alleged deficient practice. **1.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 resident who have an order for medications with hold parameters have the potential to be affected by this alleged deficient practice. All residents with an order for medications with a hold parameter were reviewed with appropriate changes made/ updated. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All Nurses and QMAs were inserviced on ensuring medications are administered timely and per physician orders. Hold parameters were reviewed and any needed changes were made with physicians authorization. Audits have been initiated to ensure daily	10/28/2024

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	On 9/1/24, with a heart rate of 57. On 9/12/24, with a heart rate of 57. On 10/4/24, with a heart rate of 57. 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. 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. 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. 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. 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: On 7/15/24, with a systolic blood pressure of 116. On 7/16/24, with a systolic blood pressure of 119. On 7/17/24, with a systolic blood pressure of 112. On 7/21/24, with a systolic blood pressure of 117. On 7/22/24, with a systolic blood pressure of 110. On 7/29/24, with a systolic blood pressure of 110. On 7/30/24, with a systolic blood pressure of 110. On 8/6/24, with a systolic blood pressure of 113. On 8/12/24, with a systolic blood pressure of 113. On 8/23/24, with a systolic blood pressure of 114. On 9/1/24, with a systolic blood pressure of 119.		compliance, see below. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**. Facility will use F684 CQI audit tool. DNS/ designee will use Medication Administration/ Hold Parameters QAPI tool, daily X 4 weeks, weekly X 2 months, and monthly X 3 months. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **Date of Compliance 10/28/24**	

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	On 9/2/24, with a systolic blood pressure of 118. On 9/17/24, with a systolic blood pressure of 115. On 9/27/24, with a systolic blood pressure of 104. 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. The facility did not provide a policy on following physician's orders. 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals 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) Findings include: 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. 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.2. During an	F 0761	F761 Label/ store drugs biologicals 1. **1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Food was removed immediately from the 200 hall medication room supplement refrigerator. All loose medications were collected from the Moving Forward South medication cart and were destroyed and re ordered as needed. No other instances were observed in any other medication carts. 2. **2. 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 have the potential to be affected by this	10/28/2024

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	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. During an interview, on 10/11/24 at 12:08 p.m., RN 5 indicated it was possible something spilt. During an interview, on 10/11/24 at 12:29 p.m., the Director of Nursing indicated the cart had been cleaned that morning. 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...." 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...." 3.1-25(j)		alleged deficient practice. Nurses and QMAs have been inserviced on proper food storage policy, refrigerator use, and medication cart/ medication storage . 3. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Nursing administration will review all nurses stations medication rooms, refrigerators, and medication carts to ensure compliance. Discussions will also continue on daily clinical rounds with all nursing staff. 4. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Med Medication room refrigerators and medication carts will be inspected daily X 4 weeks, then weekly x 2 months, then monthly X 3 months to ensure compliance. After six months the CQI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. 5. **Date of Compliance** 10/28/24	

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F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary 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) Finding includes: During an observation, on 10/8/24 at 10:36 a.m., Cook 6 was preparing pureed tuna casserole for lunch. During an observation, on 10/8/24 at 10:44 a.m., while preparing the pureed tuna casserole, Cook 6 licked the pureed tuna casserole off the first finger of her right hand. Cook 6 then attempted to take the food processor bowl off the base of the appliance to transfer the pureed food into a different container. During an interview, on 10/8/24 at 10:44 a.m., Cook 6 indicated she should not have licked the food off her finger and instead, she should have washed her hands. 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...." 3.1-21(i)(3)	F 0812	F812 Food Procurement, store, prepare, serve sanitary 1. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **2. 2. 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 an order for pureed food have the potential to be affected by this alleged deficient practice. All residents with orders for pureed food have been reviewed for necessity and will continue to receive that physician specified diet. **3. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All dietary staff, including cook #6, have been inserviced on ensuring food is prepared in a sanitary manner. Dietary manager, RD assistant, and Regional RD staff will conduct inspections and observations to ensure food is prepared in a sanitary manner.	10/28/2024

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			4. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? CQI tool for F812 will be completed daily for 4 weeks, then weekly for 5 months to ensure food is prepared in a sanitary manner. After six months the CQI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **5. Date of Compliance** 10/28/24	