Jennifer Voss

PRINTED: 01/09/2023 FORM APPROVED OMB NO. 0938-039

01/01/2023

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155199	B. WI	NG		12/15/	2022
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			INION ST		
MAPLE	PARK VILLAGE				IELD, IN 46074		
101/ (1 LL 1	THAT VILLAGE			WEGII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0580	483.10(g)(14)(i)-(i	. , .					
SS=D		(Injury/Decline/Room, etc.)					
Bldg. 00	§483.10(g)(14) No	otification of Changes.					
	(i) A facility must in	mmediately inform the					
	resident; consult v						
	physician; and not	tify, consistent with his or					
		resident representative(s)					
	when there is-						
	• •	volving the resident which					
		nd has the potential for					
	requiring physician						
		hange in the resident's					
	•	or psychosocial status					
	•	ation in health, mental, or					
		us in either life-threatening					
		cal complications);					
	, ,	r treatment significantly					
	(that is, a need to	discontinue an existing					
	form of treatment	due to adverse					
		to commence a new form					
	of treatment); or						
	• •	ransfer or discharge the					
	resident from the f	facility as specified in					
	§483.15(c)(1)(ii).						
		notification under paragraph					
	(0)(ection, the facility must					
	ensure that all per	tinent information specified					
		s available and provided					
	upon request to th						
	` '	ıst also promptly notify the					
		esident representative, if					
	any, when there is						
	(A) A change in ro						
		ecified in §483.10(e)(6); or					
	` '	esident rights under Federal					
	-	gulations as specified in					
	paragraph (e)(10)						
	` '	ust record and periodically					
		ss (mailing and email) and					
	phone number of	the resident					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	L	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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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Executive Director

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155199	B. WI	NG		12/15	/2022
	PROVIDER OR SUPPLIER PARK VILLAGE	8		776 N U	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	representative(s).						
	facility that is a co defined in §483.5) admission agreem configuration, included that comprise the and must specify to room changes bet under §483.15(c)(Based on observation review, the facility management program to iffication to the prepresentative in a tresidents reviewed and resident representative in a tresident representative i	uding the various locations composite distinct part, the policies that apply to tween its different locations 9). on, interview and record failed to ensure their skin um was followed for hysician and the resident imely manner for 2 of 3 for notification of physician entative. (Resident C and D) ew, on 12/14/22 at 1:27 p.m., tive Director) and DNS g Services) in attendance. The ident C was burnt by her coffee a.m. She had a 12 by 13 cm ed area to her left buttocks. ary physician was not notified urn. LPN 5 indicated in her ext shift would notify the and Nurse assessed her left lay (11/23/22) at 4:22 p.m., 4.5 cm partial thickness burn d and starting to blister. The neted the physician at that	F 05	580	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. This provider respectfully requitate the 2567 plan of correction considered the letter of credibial allegation and requests desk review (paper compliance) on after 1/2/23. F 580 Notify of changes (injury/decline/etc.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C & D's, MD and representative have been notion of the Burn incident How other residents having a potential to be affected by the	ot s s forth s, or lests in be le or	01/02/2023
		m. Diagnoses included, but were			same deficient practice will be		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED)
		155199	B. W	ING		12/15/2022	2
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	2			JNION ST		
MADLE	PARK VILLAGE				FIELD, IN 46074		
MAPLE	ARK VILLAGE			WEST	-IELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COM	MPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	not limited to, chronic obstructive pulmonary				identified and what correctiv	e	
disease, iron deficiency anemia, osteo arthritis,				action(s) will be taken:			
	chronic pain, heredi	itary and idiopathic			No other residents were ident	ified	
	neuropathies, and co	erebral infarction.			to have been affected by this		
					alleged deficient practice		
	_	dated 11/23/22 at 2:13 a.m.,			All residents have the potentia	al to	
	indicated the reside	nt had a bright red 12 by 13 cm			be affected by the alleged defi	cient	
		buttock, which was red, warm,			practice		
	and hot around the	wound area.					
					Inservice to be completed by		
		ted 11/23/22 at 6:35 a.m.,			1/2/2023 educating Nursing st	aff	
		hift nurse would follow up			on skin management program	for	
with the NP (Nurse Practitioner).				notification to the physician an	d		
					the resident representative in	a	
		ted 11/24/22 at 4:22 p.m.,			timely manner		
	indicated the NP wa	as notified of the burn with					
	wound orders.				What measures will be put in	to	
					place and what systemic		
	1	y, on 12/14/22 at 3:56 p.m.,			changes will be made to		
		d she was behind the nurse's			ensure that the deficient		
	_	e was burnt by the coffee. She			practice does not reoccur;		
	_	ere to show RN 4 how to use			Inservice to be completed by		
	_	naker to make her a cup of			1/2/2023 educating Nursing st		
		eximately 2:15 a.m. The nurse			on skin management program		
		coffee in her locking coffee			notification to the physician an		
		ying to exit through the gate at			the resident representative in	a	
		the handle of her mug got			timely manner		
	_	part of the gate door and pulled			DNS/designee will review the		
		cup off. The hot coffee spilt			facility activity report daily to		
		er leg and down under her			ensure MD and Resident		
		ent's left buttock wound was			Representative have been not	ified	
		dressing on it as a partial			of all skin events have been		
		nd degree burn). There was a					
		rosanguineous drainage			How the corrective action(s)	_	
		wsheet under the resident.			will be monitored to ensure t	he	
		as approximately a 75%			deficient practice will not		
		wound had a wrinkled			recur, i.e., what quality		
		all open areas throughout the			assurance program will be p	ut	
		vas no slough or necrotic			into place; and by what date		
	tissue present in the	wound bed.			the systemic changes for each	ch	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155199	B. W	NG		12/15/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			JNION ST		
MADIE	PARK VILLAGE				FIELD, IN 46074		
	AINI VILLAGE			WESTI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					deficiency will be completed		
	2. During an interview, on 12/14/22 at 1:27 p.m.,				The DNS/designee will be		
	with the ED (Executive Director) and DNS				responsible for the completion		
	(Director of Nursing Services) in attendance.				the Nursing Audit CQI Tool 5		
	When asked about Resident D's burn to her left				week for 4 weeks, then weekly		
	thigh, the DNS indicated after reading Resident				5 months, with results reporte	d to	
	D's progress notes from her medical record, on				the Quality Assurance and		
	· ·	ent asked for Chicken Noodle			Performance Improvement		
	•	d the soup. As RN 4 was			Committee.		
		the resident, Resident D			If a threshold of 95% is not		
	-	ut of RN 4's hands and the			achieved, an action plan will b		
		sident's left thigh. RN 4			developed to ensure complian	ce.	
		the resident's skirt and			After six months the QAPI		
		m (centimeter) area of skin			committee will re-evaluate the		
		DNS indicated at that time; she			continued need for the audit.		
		the resident being burnt nor if					
	she had a burn wou	nd presently.					
	On 12/14/22 at 1.50	p.m., with the DNS present,					
		id-thigh area was observed to					
		cm scarred area (measured by					
	-	ime, the DNS indicated the area					
	· ·	n a blistered 2nd degree burn					
		ed from the Chicken Noodle					
	· ·	ner left thigh. The area was					
	now healed.	ier iert tingin The area was					
	new neuron						
	The record for Resi	dent D was reviewed on					
		m. Diagnoses included, but were					
	_	itive communication deficit,					
	_	alorie malnutrition, dementia					
	_	turbances, delirium due to					
		e disorder with delusions, and					
	paranoid personalit						
		-					
	A progress note, da	ted 11/24/22 at 11:18 p.m.,					
		nt had requested Chicken					
		anack. RN 4 reheated her a					
	_	esident the bowl was hot. The					
	resident insisted on	sitting the bowl on her lap					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/15/2022	
	PROVIDER OR SUPPLIER		776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		LISC IDENTIFYING INFORMATION the nurse's hands spilling	TAG	DEFICIENCY)	DATE
	~	p on the resident's left thigh.			
		e resident's skirt observing a 4			
		r) pink skin discoloration on her			
		ald continue to monitor.			
	Resident D's record	lacked any further			
	documentation the	physician and the resident's			
	guardian being noti	fied of the burn incident.			
	During an interview	y, on 12/15/22 at 3:20 p.m., the			
	DNS and ED were	in attendance. The DNS			
	· ·	Turse Practitioner) from the			
	•	ated the facility wounds, did			
		D's left thigh that day			
		as healed. There was no			
		on of the burn incident to the			
	_	prior to the DNS notifying the NP on 12/14/22 at 7:30 p.m. She			
		ne resident's guardian to			
		urn incident as of the date and			
	time of this intervie				
	A current policy, tit	led "Skin Management			
	•	22 and provided by the ED on			
	12/14/22 at 2:30 p.r				
		und Nurse: The facility will			
		arse responsible for oversight the skin management			
	program. The woun	•			
		eam] will review, assess and			
		ew skin alterations in skin			
		ing business day to determine			
		ement wound/skin integrity			
	_	ns and then on a weekly			
	basisPROCEDUF	RE FOR ALTERATIONS IN			
	SKIN INTEGRITY				
		1. Alterations in skin integrity			
	-	the MD/NP, the resident and/or			
	resident representat	ive as well as to the direct care			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPL	
		155199	B. Wl	NG		12/15/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	staff. 2. Treatment of MD/NP"	order will be obtained from					
	This Federal tag rela	ates to Complaint IN00396664.					
	3.1-5(a)(1)						
F 0609 SS=D Bldg. 00		, , , , , , ,					
	violations involving exploitation or mis injuries of unknow misappropriation or reported immediathours after the alle events that cause or result in serious than 24 hours if thallegation do not in result in serious be administrator of thofficials (including Agency and adult state law provides care facilities) in a through established \$483.12(c)(4) Repinvestigations to the designated repofficials in accordatincluding to the St 5 working days of	treatment, including n source and of resident property, are ely, but not later than 2 egation is made, if the the allegation involve abuse s bodily injury, or not later e events that cause the nvolve abuse and do not odily injury, to the e facility and to other to the State Survey protective services where for jurisdiction in long-term ccordance with State law and procedures. For the results of all the administrator or his or oresentative and to other ance with State law, ate Survey Agency, within the incident, and if the s verified appropriate					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155199	B. W	ING		12/15/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	t .			JNION ST	
MAPLE F	PARK VILLAGE				FIELD, IN 46074	
	Г				, 	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	F.0	TAG	DETERMET)	DATE
		on, interview and record failed to ensure the "Long	F 0	609	NAME A COMPOSITION OF THE PROPERTY OF THE PROP	01/02/2023
		9			What corrective action(s) will	II
		Reporting Policy" was reporting incidents for 2 of 3			be accomplished for those	_
					residents found to have been	n
		for mandatory incident			affected by the deficient	
	reporting (Resident	s C and Dj.			practice;	on l
	Findings include:				Resident D's care plan has be	;C II
	rmanigs include:				updated with appropriate interventions	
	The Medline Plus N	Medical Encyclopedia, at			interventions	
	https://medlineplus.				How other residents having	tho
		affected both the outer and			potential to be affected by th	
		It caused pain, redness,			same deficient practice will I	
	1	ing. The burn was called a			identified and what corrective	
	_	in disorder (or burn).			action(s) will be taken;	
	partiai-tinekness sk	in disorder (or burn).			No other residents were ider	ntified
	The National Healtl	h Service of the United			to have been affected by this	itilica
		nhs.uk, indicated a burn was			alleged deficient practice	
	_	such as an iron or a fire. A			Any resident that is requesting	n hot
	1	y something wet (liquid) such			liquids has the potential to be	
	· ·	m. Burns were assessed by			effected on the alleged deficie	
		kin was damaged and which			practice	
	1	ffected. A second-degree burn			Inservice to be completed by	
	1 -	ermal burn involving the			1/2/2023 educating staff on th	e
		r layer of skin) and part of the			skin management program ar	
		f skin just below the Epidermis,			having a care plan initiated to	
		e blood capillaries, nerve			include resident specific	
	endings, sweat glan	ds and hair follicles.) The			interventions	
	Dermis was damage	ed. The skin was pale pink and				
	painful and may be	come blistered. A third-degree			What measures will be put ir	nto
	_	ermal or Partial Thickness burn.			place and what systemic	
		Dermis were damaged. The			changes will be made to	
		blotchy, may be dry or moist			ensure that the deficient	
		n and blistered and may or may			practice does not reoccur;	
	not be painful.				Inservice to be completed by	
					1/2/2023 educating staff on th	е
	_	ew, on 12/14/22 at 1:27 p.m.,			skin management program ar	
	,	tive Director) and DNS			having a care plan initiated to)
		g Services) in attendance. The			include resident specific	
	DNS indicated Resi	ident C was burnt by her coffee			intervention	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/15/2022		
NAME OF PROVIDE			77	6 N U	DDRESS, CITY, STATE, ZIP COD NION ST ELD, IN 46074	•	
MAPLE PARK V (X4) ID PREFIX TAG on 11/ (centing The W same of 14.5 or redder Nurse treatment the resist to the she in did not she did no	SUMMARY SACH DEFICIEN GULATORY OR 1/23/22 at 3:42 meter) redden found Nurse a day (11/23/22) metal thickned and started contacted the sent orders. We sident's burn to Federal mand dicated she did to the theoretical form of the federal mand dicated she did to the theoretical form of the federal mand dicated she did to the theoretical form of the federal mand dicated she did to the federal mand dicated she did to the federal mand dicated she did to the federal form of the federal form of the federal form of the federal fed	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION a.m. She had a 12 by 13 cm ed area to her left buttocks. Assessed her left buttocks the buttocks the contact at 4:22 p.m., observing a 13 by consist burn which was detent to blister. The Wound physician for wound hen asked if the ED reported to the state agency, according atory reportable guidelines, denote, as the resident's burn cortable criteria at that time, so to report it. Ident C was reviewed on the Diagnoses included, but were the obstructive pulmonary the obstructive p	77	6 N U ESTFI	NION ST	date is y ch the veek to	(X5) COMPLETION DATE
buttoe area w blister mild b applie On 12 wound (2nd c was a	k, which mea vas red, warm ring noted. Th burning sensat d to the burn a /14/22 at 3:56 d was observe legree burn) c small amount	ckness burn to the left sured 13 by 14.5 cm. The burn to touch and there was e resident was experiencing a ion to the area. Treatment area as ordered. p.m., the resident's left buttock d as a partial thickness wound aused from hot coffee. There of serosanguineous drainage wsheet under where the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 12/15/	ETED
	PROVIDER OR SUPPLIEF PARK VILLAGE			776 N U	DDRESS, CITY, STATE, ZIP COD NION ST ELD, IN 46074		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	resident's left buttor was approximately wound had a wrink areas throughout th slough or necrotic t bed. 2. During an intervi with the ED (Execu (Director of Nursin When asked about thigh, the DNS indi D's progress notes t 11/24/22, the reside soup. RN 4 reheate handing the soup to grabbed the soup or soup spilt on the re- immediately lifted to observed a 4 by 4 c	ck area laid. The wound color a 75% reddish color. The led appearance with small open e wound bed. There was no issue present in the wound dew, on 12/14/22 at 1:27 p.m., ative Director) and DNS g Services) in attendance. Resident D's burn to her left cated after reading Resident from her medical record, on ent asked for Chicken Noodle d the soup. As RN 4 was the resident, Resident D at of RN 4's hands and the sident's left thigh. RN 4 the resident's skirt and m (centimeter) area of skin DNS indicated, at that time, she		IAG	DARGEN		DATE
	did not know about she had a burn wou report Resident D's according to the Fe guidelines, because	the resident being burnt nor if nd presently. She did not burn to the state agency deral mandatory reportable she did not know the resident nicken Noodle soup until this					
	Resident D's left m have an 0.8 by 0.6 of the DNS). The DNS previously been a b which occurred from	D p.m., with the DNS present, id-thigh area was observed to come scarred area (measured by S indicated the area had listered 2nd degree burn area, on the Chicken Noodle soup of thigh. The area was now					
		dent D was reviewed on n. Diagnoses included, but were					

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER		776 N	T ADDRESS, CITY, STATE, ZIP COD N UNION ST TFIELD, IN 46074	•
PREFIX (EACH DEFICIENCE	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE
moderate protein-ca with behavioral dist	tive communication deficit, lorie malnutrition, dementia urbances, delirium due to disorder with delusions, and v disorder.			
indicated the resider Noodle soup for a so bowl and told the re resident insisted on and grabbed it from some of the hot soup The nurse raised the by 4 cm (centimeter	ed 11/24/22 at 11:18 p.m., at had requested Chicken nack. RN 4 reheated her a sident the bowl was hot. The sitting the bowl on her lap the nurse's hands spilling to on the resident's left thigh. The resident's skirt observing a 4 pink skin discoloration on her ld continue to monitor.			
Reporting Policy," vand provided by the indicated "I. Compr Federal and State Ri reportingNote: 'Al regulation is defined (incident) that is obsyet been investigate states: The results of reported to the admir representative and to with State law (includent and if the anappropriate corrective State Rulesb) 410 immediately inform followed by written hours of unusual occupants.	led "Long Term Care Incident with a revision date of 6/7/22 ED on 12/15/22 at 3:28 p.m., ehensive Care Facilities: A. ules related to incident leged violation' in the above das a situation or occurrence served or reported but has not d. a) 42 CFR 483.13 (C)(4) f all investigations must be nistrator or his designated to other officials in accordance adding to the State survey and the own officials in working days of the leged violation is verified we action must be taken. (2) IAC 16.2-3.1-13(g) (1) states: ing the division by telephone, notice within twenty-four (24) currences that irreverently safety, or health of the including, but not limited to, dentsStaff failing to identify,			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPL A. BUILDING B. WING	COM) DATE SURVEY COMPLETED 12/15/2022		
	PROVIDER OR SUPPLIER PARK VILLAGE		776	EET ADDRESS, CITY, STATE N UNION ST STFIELD, IN 46074	∃, ZIP COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED 1	TO THE APPROPRIATE	(X5) COMPLETION
TAG	assess, monitor, and suffering an acute of incidents reportable OCCURRENCE TI THE WELFARE, S RESIDENT Examp degree"	d respond to a resident onditionC. Types of under State rules only 1. HAT DIRECTLY THREATENS AFETY, OR HEALTH OF A lesburns greater than first ates to Complaint IN00396664.	TAG	DEFICIE	ency)	DATE
SS=D Bldg. 00	Care Plan Timing §483.21(b) Compos §483.21(b)(2) A compos file of the comprehension of the comprehension of the attending (B) A registered not the resident. (C) A nurse aide we resident. (D) A member of file staff. (E) To the extent participation of the representative(s). included in a resident participation of the representative is composed for the development of the representative is composed for the repres	and Revision rehensive Care Plans comprehensive care plan in 7 days after completion sive assessment. In interdisciplinary team, that Ilimited to physician. The physician is a series with responsibility for the food and nutrition services for acticable, the for a resident and the resident's An explanation must be the resident and their resident determined not practicable and of the resident's care attention of the resident's care				

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPL	
		155199	B. Wl	NG		12/15/	2022
	PROVIDER OR SUPPLIER			776 N U	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interdisciplinary te including both the quarterly review as Based on observation review, the facility with interventions to potentially being but receiving hot snacks developed for 1 of 3 plans. (Resident D) Finding includes: During an interview the ED (Executive I Nursing Services) in about Resident D's lindicated, after read notes from her mediresident asked for C reheated the soup. At to the resident, Resident's left thigh, resident's left thigh, resident's skirt and c (centimeter) area of indicated, at that time resident being burnt presently. At that time to know about the had a burn wound pure the record for Resident's cognimoderate protein-capital states.	am after each assessment, comprehensive and ssessments. on, interview and record failed to ensure a plan of care o prevent a resident from unt in the future while is from staff members was a residents reviewed for care of the comprehensive and record failed to ensure a plan of care or prevent a resident from unt in the future while is from staff members was a residents reviewed for care of the comprehensive and plan of care or prevent a resident from an attendance. When asked burn to her left thigh the DNS ling Resident D's progress ical record, on 11/24/22, the Chicken Noodle soup. RN 4 as RN 4 was handing the soup out of the soup spilt on the RN 4 immediately lifted the observed a 4 x 4 cm are skin discoloration. The DNS one, she did not know about the thor if she had a burn wound one, the ED indicated she did resident being burnt or if she	F 06	TAG	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D's care plan has be updated with appropriate interventions How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action(s) will be taken; No other residents were ident to have been affected by this alleged deficient practice. Any resident that is requesting liquids has the potential to be effected on the alleged deficient practice. Inservice to be completed by 1/2/2023 educating staff on the skin management program and having a care plan initiated to include resident specific interventions What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur; Inservice to be completed by	the see natified and sent	
	paranoid personality	e disorder with delusions, and y disorder.			1/2/2023 educating staff on the skin management program an having a care plan initiated to	ıd	
l .	Ī		1		i naving a care plan initiated to)	i

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X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155199 12/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 776 N UNION ST MAPLE PARK VILLAGE WESTFIELD, IN 46074 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A progress note, dated 11/24/22 at 11:18 p.m., include resident specific indicated the resident had requested Chicken intervention Noodle soup for a snack. RN 4 reheated her a MDS/designee will Review/update bowl and told the resident the bowl was hot. The care plans when a resident has resident insisted on sitting the bowl on her lap alterations in their skin integrity and grabbed it from the nurse's hands spilling How the corrective some of the hot soup on the resident's left thigh. action(s) will be monitored to The nurse raised the resident's skirt observing a 4 ensure the deficient practice by 4 cm (centimeter) pink skin discoloration on her will not recur, i.e., what quality left thigh. Staff would continue to monitor. assurance program will be put into place; and by what date The resident's record lacked a care plan with the systemic changes for each interventions on how the facility would prevent deficiency will be completed any potential future burn incidents if the resident The DNS/designee will be would decide to grab another hot bowl/cup of responsible for the completion the soup and/or liquid from a staff member. Nursing Audit CQI Tool 5 x/ week for 4 weeks, then weekly for 5 During an interview, on 12/15/22 at 3:20 p.m., the months, with results reported to DNS and ED indicated the resident did not have a the Quality Assurance and plan of care following the burn incident due to RN Performance Improvement 4 did not follow the Skin Management Program Committee. and notify the LPN 4 (Wound Nurse) of the left -If a threshold of 95% is not thigh burn area. achieved, an action plan will be developed to ensure compliance. A current policy, titled "Skin Management After six months the QAPI Program," dated 5/22 and provided by the ED on committee will re-evaluate the 12/14/22 at 2:30 p.m., indicated continued need for the audit. "...Definitions...Wound Nurse: The facility will designate license nurse responsible for oversight and coordination of the skin management program. The wound nurse and/or IDT [Interdisciplinary Team] will review, assess and document on any new skin alterations in skin integrity the following business day to determine root cause and implement wound/skin integrity healing interventions and then on a weekly basis...PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY-PRESSURE AND NON-PRESSURE...6. A plan of care will be initiated to include resident specific risk factors

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/15/2022		
	ROVIDER OR SUPPLIER PARK VILLAGE		7	776 N UI	DDRESS, CITY, STATE, ZIP COD NION ST ELD, IN 46074		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
F 0689 SS=D Bldg. 00	and contributing fact interventions impleted interventions impleted. This Federal tag relication of the variable indicated after reading the ED (Executive Indicated after reading testing in the soup of the resident asked for C reheated the soup of the resident, she is a factor of the resident asked for C reheated the soup of the resident, she is a factor of the resident and the soup of the resident and the residen	stors with appropriate mented" ates to Complaint IN00396664. sion/Devices ents. ensure that - resident environment faccident hazards as is n resident receives sion and assistance devices ats. on, interview and record failed to ensure their skin m was followed regarding yound nurse once a scald burn at and monitoring throughout of a new scald burn for 1 of 3 for accidents. (Resident D) 7, on 12/14/22 at 1:27 p.m., with Director) and DNS (Director of a attendance. When asked burn to her left thigh, the DNS ing Resident D's progress ical record, on 11/24/22, the chicken Noodle soup. RN 4 as RN 4 was handing the soup grabbed the soup out of RN up spilt on the resident's left	F 0689)	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Wound Nurse, MD/NP and PO have been notified of Resident skin alteration. The area is healed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Inservice to be completed by 1/2/23 educating staff on the sign management program, related notification of the wound Nurse MD/NP and POA, assessment	he e be kin to	01/02/2023
	thigh. RN 4 immedi	ately lifted the resident's skirt			and monitoring throughout the		

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CTATEMENT OF DEFICIENCIES VI) DROWINED/CUIDDI IED/CUIA V2) M					NCTRICTION	(V2) D + 777	CLIDATEN
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	_		00	COMPLETED	
155199		B. W	B. WING			12/15/2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					JNION ST		
MAPLE F	PARK VILLAGE			WESTF	FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		4 cm (centimeter) area of skin			healing process of a new burn	1	
		DNS was unable to find any			No other residents were ident	tified	
		ion in the resident's record			to have been affected by this		
		ment or monitoring through			alleged deficient practice		
		of the resident's burn to her			Any resident that is requesting	g hot	
	-	24/22 to the present date of			liquids has the potential to be		
		indicated she did not know			effected on the alleged deficie	nt	
		being burnt nor if she had a			practice		
	_	tly. The ED indicated she did					
		resident being burnt or if she			What measures will be put ir	nto	
	had a burn wound p	oresently.			place and what systemic		
					changes will be made to		
	On 12/14/22 at 1:50 p.m., with the DNS present,				ensure that the deficient		
		id-thigh area was observed to			practice does not reoccur;		
	-	em scarred area (measured by		Inservice to be completed by			
	the DNS). At that ti	ime, the DNS indicated the area			1/2/23 educating staff on the s	skin	
		n a blistered 2nd degree burn			management program, related	d to	
	area, which occurre	ed from the Chicken Noodle			notification of the wound Nurs	e,	
	soup spilling onto h	ner left thigh. The area was			MD/NP and POA, assessmen	t	
	now healed.				and monitoring throughout the	;	
					healing process of a new burn	1	
		Medical Encyclopedia, at					
	https://medlineplus				DNS/designee will review the		
	_	affected both the outer and			facility activity report daily to		
	-	It caused pain, redness,			ensure burns great than first		
	•	ring. The burn was called a			degree are reported per the sl	kin	
	partial-thickness sk	in disorder (or burn).			management program		
	The National Healt	h Service of the United			Facility to provide on going		
					education on the skin		
	Kingdom, at www.nhs.uk, indicated a burn was caused by dry heat such as an iron or a fire. A				management program, as nee	hed	
	scald was caused by something wet (liquid) such			1			
	as hot water or steam. Burns were assessed by			How the corrective actio			
	how seriously the skin was damaged and which			will be monitored to ensure the deficient practice will not			
	layers of skin was affected. A second-degree burn			recur, i.e., what quality			
	was a superficial dermal burn involving the			1		ut	
	Epidermis (the outer layer of skin) and part of				assurance program will be put into place; and by what date		
	Dermis (the layer of skin just below the Epider				the systemic changes for each		
	` •	e blood capillaries, nerve			deficiency will be completed		
		ids and hair follicles.) The			The DNS/designee will be		
l l	manigo, swear glan	and man romeros.) The	- 1		I THE DINO/GESIGNEE WILLDE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/15/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
MAPLE F (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR Dermis was damage painful and may bee burn was a Deep De The Epidermis and skin turned red and and became swoller not be painful. The record for Resir 12/14/22 at 3:15 p.r not limited to, cogn moderate protein-ca with behavioral dist dementia, psychotic paranoid personality The resident had a c problem of she had goal was she would communication date included, but were r resident to lip read, speaking to her, 4/6 written communicat and adjust tone as n The resident had a c exhibited cognitive BIMS (Brief Intervi was less than 13, w) severely cognitively diagnosis of dement dated 4/6/22. Long continue to participe dated 3/8/22. Interv limited to, 4/6/22, p prompts and cues as	tare plan, dated 4/6/22, with a hearing loss. The long-term hear and understand and 3/8/23. The interventions not limited to, 4/6/22, allow the 4/6/22, face the resident when 1/22, provide with materials for tion, and 4/6/22, speak clearly	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) responsible for the completion the Nursing Audit CQI Tool 5 week for 4 weeks, then weekl 5 months, with results reporte the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliar After six months the QAPI committee will re-evaluate the continued need for the audit.	DATE DATE DATE DATE			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
		155199	B. WINC	<u> </u>		12/15/	2022
	PROVIDER OR SUPPLIER	2		776 N U	IDDRESS, CITY, STATE, ZIP COD INION ST IELD, IN 46074		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		<u> </u>	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	The resident had a	care plan with a problem of she					
	required assistance	with ADL's including, but not					
	limited to, eating du	ue to decreased mobility,					
	dementia with beha	viors, delirium, hypertension,					
	kyphosis, and back	and leg pain. Long term goal					
	was for the resident	to desire to maintain ADL					
		n independence dated 3/8/22.					
		ded, but were no limited to,					
	3/31/22, assist with	eating and drinking as needed.					
	A quarterly MDS (Minimum Data Set)					
		0/5/22, indicated Resident D's					
		which indicated she was					
	cognitively impaired. The functional status for						
	ADL'S (Activities for Daily Living) indicated she						
	required set-up assi	stance (help only) and limited					
	assistance (staff pro	ovide guided maneuvering of					
	limbs or other non-weight bearing assistance, but						
	the resident was hig	ghly involved in the activity)					
	with her meals.						
	A progress note, da	ted 11/24/22 at 11:18 p.m.,					
		nt had requested Chicken					
		snack. RN 4 reheated her a					
		esident the bowl was hot. The					
		sitting the bowl on her lap					
		the nurse's hands spilling					
	_	p on the resident's left thigh.					
		e resident's skirt observing a 4					
	by 4 cm (centimeter) pink skin discoloration on her left thigh. Staff would continue to monitor. Resident D's record lacked any further documentation of assessments other than the 11/24/22 progress note or monitoring of the burnt						
	area to her left thigh	C					
	_	v, on 12/15/22 at 3:20 p.m., with					
		attendance, the DNS indicated					
the NP (Nurse Practitioner) from the Healogics,							

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
	155199		B. W	B. WING			12/15/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				1				
MADLE DADK VILLACE			776 N UNION ST WESTFIELD, IN 46074					
MAPLE PARK VILLAGE				WESTE	TELD, IN 40074			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	who treated the faci	ility wounds, did not assess						
	Resident D's left thi	igh because her burn was						
	healed. RN 4 did no	ot follow the Skin Management						
	Program and notify	the LPN 4 (Wound Nurse) of						
	the left thigh burn a	rea. Therefore, there was no						
	assessment or moni	toring of the burn area						
	through the healing	process completed by the						
	Wound Nurse.							
	A current policy, tit	tled "Skin Management						
	Program," dated 5/2	22 and provided by the ED on						
	12/14/22 at 2:30 p.r	m., indicated						
	"DefinitionsWo	ound Nurse: The facility will						
	designate license nurse responsible for oversight							
	and coordination of the skin management							
	program. The woun	nd nurse and/or IDT						
	[Interdisciplinary T	eam] will review, assess and						
	document on any no	ew skin alterations in skin						
	integrity the follow	ing business day to determine						
	root cause and impl	lement wound/skin integrity						
	healing intervention	ns and then on a weekly						
		RE FOR ALTERATIONS IN						
	SKIN INTEGRITY	-PRESSURE AND						
	NON-PRESSURE:	1. Alterations in skin integrity						
	will be reported to t	the MD/NP, the resident and/or						
	resident representat	rive as well as to the direct care						
	staff. 2. Treatment	order will be obtained from						
	MD/NP4. All nev	vly identified areas after						
	admission will be d	ocumented on the New Skin						
	Event. 5. The woun	d nurse/designee will be						
	notified of alteration	ns in skin integrity. a) The						
		nee is responsible for						
	communicating to IDT on a weekly basis for							
	pressure and non-pressure wounds. b) The							
	wound nurse/design	nee will complete further						
	evaluation of the w	ounds identified and complete						
	the appropriate skin	evaluation on the next						
	business day. The 'o	observed' date indicated on						
	the Wound Manage	ement document is the date the						
	wound was assessed	d, including but not limited to						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	` ′	ILDING	nstruction 00	(X3) DATE COMPI 12/15	LETED	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	measurements, staging, condition of tissue, and drainageii) Wound management entries will be completed for non-ulcers (bruises, skin tear, abrasion, rashes). If no signs of complications or worsening win condition of skin alteration and doesn't meet the guideline for IDT weekly Wound Review the wound management entry can be closed after 72 hours7. IDT will review residents with alterations in skin integrity weekly, if applicable, based on the IDT initial and Weekly Wound Documentation Policy" This Federal tag relates to Complaint IN00396664. 3.1-45(a)(1) 3.1-45(a)(2)							

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