CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0			
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 42 Survey Date: 11/1 Facility Number: Provider Number: AIM Number: 100 At this Emergency Park Village was f Emergency Prepar Medicare and Mediand Suppliers, 42 0	4/22 000106 155199 0266390 Preparedness survey, Maple found to be in compliance with edness Requirements for licaid Participating Providers CFR 483.73. 6 certified beds. At the time of sus was 89.	E 00	000	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation. This provider respectfully required that the 2567 plan of correctic considered the letter of credit allegation and requests desk review (paper compliance) or after 12/14/22.	ot is et forth es, or uests on be ole	
Bldg. 01	Licensure Survey of Department of Heat 483.90(a). Survey Date: 11/1 Facility Number: Provider Number: AIM Number: 100	000106 155199	K 0	000	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation. This provider respectfully required that the 2567 plan of correction considered the letter of credit allegation and requests desk review (paper compliance) or after 12/14/22.	ot is et forth es, or uests on be ole	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Village was found not in compliance with

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIER		776 N U	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	
TAG	Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facility Type V (111) const The facility has a findetection in the corr corridors, and batter all resident sleeping capacity of 106 and of this survey. All areas where resi- were sprinkled and services were sprinkled.	the and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2. The was determined to be of ruction and was fully sprinkled. The alarm system with smoke ridors, spaces open to the ry powered smoke detectors in rooms. The facility has a had a census of 89 at the time dents have customary access all areas providing facility thed.	TAG	DETALEACTI	DATE
K 0232 SS=E Bldg. 01	unobstructed) sent at least 4 feet and convenient remove on stretchers, exception 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on observation failed to meet the clover 5 corridors or 19.2.3.4(5). LSC 19 corridor width is at the required width s	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by	K 0232	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The large table has been removed from the area between the second se	n en

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Event ID:

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Facility ID: 000106

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155199	B. W	NG		11/14/	2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>	
NAME OF I	PROVIDER OR SUPPLIE	R			JNION ST		
MADIE	PARK VILLAGE				FIELD, IN 46074		
IVIAFLE	-ARK VILLAGE			WEST	- IELD, IN 40074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions are met:				312 and 314		
	(a) the fixed furniture is securely attached to the floor or to the wall.				How will you identify other		
					residents having the potential	al	
	(b) the fixed furniture does not reduce the clear				to be affected by the same		
		lor width to less than six feet,			deficient practice and what		
		l by LSC 19.2.3.4(2).			corrective action will be take		
	1 1	are is located only on one side			No residents were affect		
	of the corridor.				by the alleged deficient practi		
	(d) the fixed furniture is grouped such that each				· All residents, visitors, s		
	grouping does not exceed an area of 50 square				have the potential to be affect		
	feet. (e) the fixed furniture groupings addressed in LSC				by the alleged deficient praction	се	
	19.2.3.4(5) (d) are separated from each other by a				What measures will be put in	ıto	
	distance of at least 10 feet.				place or what systemic		
	* *	are is located so as to not			changes you will make to		
		ouilding service and fire			ensure that the deficient		
	protection equipme			practice does not recur?			
		ghout the smoke compartment			Staff have been in-serv	iced	
		electrically supervised			on ensuring corridors are		
		etection system in accordance			continuously maintained free	of all	
		r the fixed furniture spaces are			obstructions		
	-	ed to allow direct supervision	A Maintenance audit tool				
		from a nurse's station or similar	will be completed monthly for one				
	space.				year to ensure all means of eq	gress	
		partment is protected			are being maintained	L	
		pproved, supervised automatic			A visual inspection by the formula in the form		
		accordance with LSC 19.3.5.8 tice could affect 20 residents,			Executive Director or designe		
	_				has been completed to ensure	e all	
	staff and visitors ex	titing the facility.			means of egress are being		
	Findings:				maintained		
	rinuings.				How the corrective action(s)		
	Rased on observati	ons during a facility tour and			How the corrective action(s) will be monitored to ensure		
		Maintenance Supervisor on			deficient practice will not	nie.	
		11:50 a.m. and 3:15 p.m., the			-		
					recur, i.e., what quality assurance program will be p	+	
	corridor between resident rooms 312 & 314					ut	
	contained a large table which extended into the corridor. The aforementioned table was free				into place? A Maintenance audit to	ol.	
		ed to the wall or floor.			ensuring corridors are	υı,	
	standing, not affixe	a to the wan of 11001.			continuously maintained free	of all	
	1		1		i continuousiv maintaineu liee (JI AII I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPI			COMPL	ETED
		155199	B. WING			11/14/	2022
			СТ	DEET A	DDDEGG CITY CTATE ZID COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP COD NION ST		
MADLE	PARK VILLAGE				IELD, IN 46074		
IVIAFLE	ANN VILLAGE		٧٧	LOTFI	IELD, IN 40074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	ΔG	DEFICIENCY)		DATE
	The finding was acknowledged at the time of				obstructions, will be completed	Ł	
		at the exit conference with			monthly for one year with resu	Its	
		tor and Maintenance			reported to the Quality Assura	nce	
Supervisor present.				Performance Improvement (Q	API)		
	3.1-19(b)				Committee overseen by the		
					Executive Director. If a thresh		
					of 95% is not achieved, an act		
					plan will be developed to ensu		
					compliance. Any non complia	nce	
					with staff will result in staff		
					education and up to disciplinar	гу	
					action		
14 0074	NEDA 404						
K 0271	NFPA 101	-14					
SS=E	Discharge from Ex						
Bldg. 01	Discharge from Ex						
	-	arranged in accordance with					
		vel walking surface meeting					
		7.1.7 with respect to for and shall be maintained					
	-	s. Additionally, the exit					
		a hard packed all-weather					
	travel surface.	a hard packed all-weather					
	18.2.7, 19.2.7						
		on and interview, the facility	K 0271		What corrective action(s) wil		12/14/2022
		f 8 exit discharges had a level	K 02/1		be accomplished for those	'	12/14/2022
		ere free of obstructions, and			residents found to have beer	,	
	-	packed all-weather travel			affected by the deficient	•	
		ce with CMS Survey and			practice?		
		05-38. This deficient practice			· There will be a new		
		dents and staff using the			concrete ramp installed to the		
	Breezeway North E	xit.			street by 12/14/22		
	•		1		How will you identify other		
	Findings include:			- 1	residents having the potentia	al	
	-			- 1	to be affected by the same		
	Based on observation	ons during a facility tour and			deficient practice and what		
		Maintenance Supervisor on		- 1	corrective action will be take	n?	
11/14/22 between 11:50 a.m. and 3:15 p.m., t		1:50 a.m. and 3:15 p.m., the exit	1		· No residents were affect	ted	
	discharge described	as the Breezeway North Exit,	1		by the alleged deficient practic	ce.	
	was uneven. Where	e the sidewalk sloped and	1		· All residents, visitors, st		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLE	
		155199	B. W	ING	11/14/		2022
NAME OF P	PROVIDER OR SUPPLIEF		-		ADDRESS, CITY, STATE, ZIP COD	_	
MADIE	PARK VILLAGE				JNION ST FIELD, IN 46074		
	Г				ILLD, IN 40074		
(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)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION urking lot, a fence has been	+	TAG			DATE
		generator which obstructs the			have the potential to be affect by the alleged deficient practic		
	1	at all other points the sidewalk			by the alleged delicient practic	Je	
	_	ximately 6 inches before			What measures will be put in	nto	
	stepping down to th	-			place or what systemic		
		visor agreed that the sidewalk			changes you will make to		
	_	arking lot at the point where			ensure that the deficient		
		ting access and the facility did			practice does not recur?		
	not have a complete level walking surface that was free of obstructions leading to the common way at this exit location.						
					staff will be inserviced by	-	
					the Executive Director/designe		
					on level walking surfaces, are		
	The finding was acknowledged at the time of				of obstructions, and construct		
	discovery and again at the exit conference with				hard packed all-weather trave	1	
		etor and Maintenance			surface and the regulatory		
	Supervisor present.				standard indicated by this		
	2.1.10/1-)				requirement by 12/14/22.		
	3.1-19(b)				The Maintenance		
					Supervisor/designee will make		
					environmental rounds daily to ensure facility exits remain cle		
					of obstructions.	iai	
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not	-	
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					· A Maintenance audit to	ol,	
					ensuring corridors are		
					continuously maintained free		
					obstructions, will be completed		
					monthly for 6 months with res	I	
					reported to the Quality Assura		
					Performance Improvement (Q	API)	
					Committee overseen by the	ا	
					Executive Director. If a thresh		
					of 95% is not achieved, an act	I	
					plan will be developed to ensu		
1	l		ı		compliance. Any non complia	IIICE	

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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 11/14/2022					
	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0293 SS=E Bldg. 01	accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6 1. Based on observed facility failed to ensure the clearly identified as states any door, pass neither an exit nor a located or arranged mistaken for an exit that reads as follow sign shall have the high, with a stroke word EXIT below the is an approved exist practice could affect Findings include: Based on observation interview with the 11/14/22 between 1 door identified as the illuminated exit sign on the door, there we will the reads as follows.	less than 30 occupants exit travel is obvious.) ation and interview, the sure the 200 North Exit was a facility exit. LSC 7.10.8.3.1 sage, or stairway that is a way of exit access and that is so that it is likely to be at shall be identified by a sign so NO EXIT. The NO EXIT word NO in letters 2 inches width of 3/8ths inch, and the he word NO, unless such sign ting sign. This deficient	K 0293	with staff will result in staff education and up to disciplinal action What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Remove "Not an Exit" Sat the end of the 200 hall and install a "Not and Exit" Sign or memory courtyard door. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take No residents were affect by the alleged deficient practic. All residents, visitors, st have the potential to be affected by the alleged deficient practic. What measures will be put in	I 12/14/2022 In Sign In the late of the december of the decem		

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courtyard. This condition creates confusion

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place or what systemic

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155199	B. W.	ING		11/14/	2022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					JNION ST		
MAPLE I	PARK VILLAGE			WESTE	FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· · · ·	DATE
	regarding the abilit	y to escape/evacuate the			changes you will make to		
	facility via the afor	rementioned door. Based on			ensure that the deficient		
	interview at the time of the observations, the Maintenance Supervisor was unsure if the exit was a required exit and was also unsure why the "not an exit" signage was on the door.				practice does not recur?		
					· The Maintenance		
					Supervisor will be inserviced	by	
					the Executive Director/design	ee	
	The finding was ac	knowledged at the time of			on the regulatory standard		
	discovery and again at the exit conference with				indicated by this requirement	by	
	the Executive Director and Maintenance Supervisor present.				December 14, 2022		
					 A Maintenance audit to 	ool	
					will be completed monthly for	one	
	2. Based on observ	ation and interview, the facility			year to ensure all exit signage	e is	
	failed to ensure 1 of 1 courtyard doors to the				meeting the regulatory		
	outside of the facil	ity was not mistaken as a			requirements		
	facility exit. LSC	7.10.8.3.1 states any door,			 A visual inspection by t 	:he	
	passage, or stairwa	y that is neither an exit nor a			Executive Director or designe	ee	
	way of exit access	and that is located or arranged			has been completed to ensur	e all	
	so that it is likely to	o be mistaken for an exit shall			exit signage is meeting the		
	be identified by a s	ign that reads as follows: NO			regulatory requirements		
	EXIT. The NO EX	ATT sign shall have the word NO					
	in letters 2 inches h	nigh, with a stroke width of					
		e word EXIT below the word					
		gn is an approved existing			How the corrective action(s))	
		t practice could affect 25			will be monitored to ensure	the	
	residents in the Me	emory Care area.			deficient practice will not		
					recur, i.e., what quality		
	Findings include:				assurance program will be p	out	
					into place?		
		ons during a facility tour and			· A Maintenance audit to		
		Maintenance Supervisor on			ensuring exit signage is meet	-	
		11:50 a.m. and 3:15 p.m., in the			the regulatory requirements,	will	
		leading to the courtyard the			be completed monthly for 6		
		courtyard was not an exit door			months with results reported	to	
		ot posted with a "NO EXIT"			the Quality Assurance		
	_	erview at the time of the			Performance Improvement (C	QAPI)	
	observation, the Maintenance Supervisor stated				Committee overseen by the		
		t an exit to the public way and			Executive Director. If a thres		
		courtyard door did not have a			of 95% is not achieved, an ac		
	"NO EXIT" sign posted and he believed it was				plan will be developed to ens	ure	

PRINTED: 12/13/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIEI	₹	776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	once there but had The finding was ac discovery and again	knowledged at the time of at the exit conference with ctor and Maintenance		compliance. Any non compliar with staff will result in staff education and up to disciplinar action	nce
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2. enclosed as haza	int is protected in NFPA 96, Standard for ol and Fire Protection of sing Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited ance with 18.3.2.5.2, sopen to the corridor in ents with 30 or fewer with the conditions under 1.5.3, or so in smoke compartments extients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not			
	through 19.3.2.5.8 Based on observation failed to ensure state the UL 300 hood sy 96, 11.1.4 states ins	n 18.3.2.5.4, 19.3.2.5.1	K 0324	What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice?	

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posted conspicuously in the kitchen and shall be

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The Dietary Manager and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155199	B. W	ING		11/14/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2					
MADIE					JNION ST		
WAPLE F	PARK VILLAGE			WESTE	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
	reviewed with empl	loyees by management. This			kitchen staff have been		
	deficient practice co	ould affect staff in the kitchen			re-educated on the use of the	UL	
	and 25 residents in	the dining room.			300 hood system in the kitche	n.	
					Training included the instruction		
	Findings include:				for manually operating the fire		
	8				extinguishing system.		
	Based on observation	ons during a facility tour and			· The sign was removed		
		Maintenance Supervisor on			How other residents having		
	11/14/22 between 11:50 a.m. and 3:15 p.m., the				potential to be affected by th		
		UL 300 hood system and a			same deficient practice will b		
	K-class fire extinguisher with posted instructions.				identified and who corrective		
	Instructions were also placed near the UL 300				action(s) will be taken?	•	
	Hood Pull stating, "in the event of a grease fire,				No residents were affect	rted	
	under the hood, first use the K-Class fire				by the alleged deficient practi		
	extinguisher. If the K-Class doesn't extinguish the				· All residents, visitors, st		
	fire, then use the UL 300 Suppression system by						
		Based on interview, the facilities			have the potential to be affect		
		cook was asked; what is the			by the alleged deficient practic	æ	
	-	there was a grease fire					
	-	_			NA/hat was assumed will be must im-	.4	
		d. The employee responded			What measures will be put in	ito	
		e hood for some switch. The			place or what systemic		
		identify the location of either			changes will be made to		
	-	ne K Class extinguisher. The			ensure that the deficient		
	_	visor acknowledged the			practice does not recur?	1	
	-	additional training would be			The Dietary Manager a	na	
	_	sign over the UL 300 Pull			dietary staff were provided		
	station would need	to be removed.			in-service training on the use		
	TE1 (" 1' '				the UL 300 hood system in the	9	
	-	knowledged at the time of			kitchen, in the event of a fire,		
		at the exit conference with			Training included the instruction		
		etor and Maintenance			for manually operating the fire		
	Supervisor present.				extinguishing system, education		
					completed by December 14, 2		
	3.1-19(b)				· There is a posting of the		
					instructions on how to manual	ly	
					operate the fire extinguishing		
					system.		
					· The Executive		
					Director/designee will monitor		
					kitchen staff training and in-se	rvice	
	i		1				ı

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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2022
	PROVIDER OR SUPPLIE	R	776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGELITORY	R ESC IDENTITIVO IN ORNEXTION		to ensure compliance. A Maintenance audit to will be completed monthly for months to ensure Dietary staff understand the use of the UL a hood system in the event of a How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be printo place? A Maintenance audit too will be completed monthly, to ensure staff understand the use the UL 300 hood system in the complete of the comple	ol 6 300 fire the ut ol se of
K 0351 SS=F	NFPA 101 Sprinkler System	Installation		event of a fire and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (Quanthly meeting for 6 months QAPI is overseen by the Executive Director. Any non compliance with staff will result staff education and up to disciplinary action.	API)
Bldg. 01	Spinkler System 2012 EXISTING Nursing homes, a by construction ty throughout by an sprinkler system 13, Standard for Systems.				

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, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155199	B. W	ING		11/14/	2022
	PROVIDER OR SUPPLIER PARK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, 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
	protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation did not provide adea department connect for the Inspection, 13.7 Fire Edition, 13.7 Fire Edition, 13.7 Fire Efire department corquarterly to verify to (1) The fire department and accessible. (2) Couplings or sw rotate smoothly. (3) Plugs or caps are (4) Gaskets are in position (5) Identification signal (6) The check valve (7) The automatic doperating properly. (8) The fire department place and operating This deficient praction interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation interview with the Measure sprint in the second conservation in the second co	res are permitted to be inkler protection in specific or local regulations prohibit where are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers that as required by NFPA 13, and the closet does not exceed sprinkler coverage covers that as required by NFPA 13, and the compact of the coverage covers that as required by NFPA 13, and the coverage covers that as required by NFPA 13, and the coverage covers that as required by NFPA 13, and the coverage covers that as required by NFPA 13, and the coverage covers that as required by NFPA 13, and the coverage for 1 of 1 fire in the coverage for 1 of	K 0		What corrective action(s) will be accomplished for those residents found to have beer. Installed new directional FDC signs How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. No residents were affected by the alleged deficient practic. All residents, visitors, sthave the potential to be affected by the alleged deficient practic by the alleged deficient practic. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervisor will be inserviced by the regulatory standard	n l l l l l l l l l	12/14/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIER PARK VILLAGE		776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	Eastward side of the facility is on the opposite building. The facility identification sign of responders entering the front Westward location in the rear.	the facility parking lot from side of the facility to the FDC Based on interview at the time		indicated by this requirement December 14, 2022. A Maintenance audit to will be completed monthly, to ensure the FDC directional signage is in place	
	acknowledged there directing responders parking lot to the Fl of the building. The make it difficult for	Maintenance Supervisor was no identification sign s entering the main front DC on the rear Eastward side is deficient practice would responding fire personnel to DC attached the facility.		How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? A Maintenance audit to will be completed monthly, to	the
	discovery and again	knowledged at the time of at the exit conference with tor and Maintenance		ensure the FDC directional signage is in place and the re of the monitoring will be revied during the Quality Assurance Performance Improvement (Comonthly meeting for 6 months QAPI is overseen by the Executive Director. Any non compliance with staff will resustaff education and up to disciplinary action.	wed PAPI) S,
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and tes secure location are	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, Iting are maintained in a Index of the control of the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199				COMPLETED	
		155199	B. WI	NG		11/14/2022
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, 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	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	b) Who provided	<u> </u>				
	c) Water system supply source					
	coverage for any automatic sprinkle	, and NFPA 25	V 0	252	What corrective estimate) will	12/14/2022
	Based on observation and interview, the facility failed to ensure sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall		K 03	555	What corrective action(s) will be accomplished for those residents found to have been	
					 Sprinkler heads in the kitchen were already on order are to be replaced 12/14/22 	and
	be installed in the c up-right, pendent, o	orrect orientation (e.g., or sidewall). Furthermore, at			How will you identify other	
		tler that shows signs of any of be replaced: (1) Leakage (2)			residents having the potention to be affected by the same	aı
	_	cal Damage (4) Loss of fluid in			deficient practice and what	
		responsive element (5)			corrective action will be take	en?
	_	g unless painted by the			No residents were affer	
		rer. This deficient practice			by the alleged deficient practi	
	could affect 5 staff.				· All residents, visitors, s	taff
	Findings include:				have the potential to be affect by the alleged deficient praction	I
	Based on observation	ons during a facility tour and			What measures will be put in	nto
		Maintenance Supervisor on			place or what systemic	
		1:50 a.m. and 3:15 p.m., the			changes you will make to	
		ne kitchen near the dishwasher			ensure that the deficient	
		or showed signs of loading.			practice does not recur?	
	This finding was ac					
	Maintenance Super				· The Maintenance	
		ated he was aware of the issue			Supervisor will be inserviced by	-
	and that they were s	scheduled to be replaced.			the Executive Director/designe	ee
					on the regulatory standard	
		knowledged at the time of			indicated by this requirement	
l	I discovery and agair	at the exit conference with	I		December 14 2022	

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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIER PARK VILLAGE	1	776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF the Executive Direc	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION tor and Maintenance	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) A Maintenance audit to	DATE
	Supervisor present. 3.1-19(b)			will be completed monthly, to ensure sprinkler heads are no covered in dust or showing sig of loading.	
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place? A Maintenance audit to will be completed monthly, to ensure sprinkler heads are not covered in dust or showing sign of loading and the results of the monitoring will be reviewed do the Quality Assurance Performance Improvement (Quantity meeting for 6 monthst QAPI is overseen by the Executive Director. Any non compliance with staff will results staff education and up to disciplinary action.	ut ol t gns ne uring (API)
K 0363 SS=E Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistin	corridor openings in other losures of vertical openings, s areas resist the passage made of 1 3/4 inch wood or other material ag fire for at least 20 fully sprinklered smoke			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/14/2022		
	PROVIDER OR SUPPLIEF		776 N	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary apply the door apply to auxiliary apply the door apply to auxiliary apply to auxiliary apply the door apply to auxiliary apply the door apply to auxiliary apply to auxiliary apply the door apply the door apply the auxiliary apply the auxili	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire sor frames in window Parts 403, 418, 460, 482, AS details of doors such as the steel of such as the such					
	facility failed to ens would resist the pas practice could affec	ration and interview, the sure 2 of over 30 corridor doors sage of smoke. This deficient at 8 residents.	K 0363	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice?	en		
	Findings include:			The holes at the handle the doors has been fixed.	es or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155199	B. WI	ING		11/14/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			JNION ST		
MADIF	PARK VILLAGE				FIELD, IN 46074		
IVIALLLI	- ANN VILLAGE			WESTI	1LLD, 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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observations during a facility tour and				· Adjusted the latch and		
		Maintenance Supervisor on			replaced the hinge to the Activ	vities	
		11:50 a.m. and 3:15 p.m., the			door		
	_	doors had holes which			How will you identify other		
	penetrated complet	ely through the door:			residents having the potential	al	
					to be affected by the same		
		through the door above the			deficient practice and what		
	1 ~	in the corridor door to resident			corrective action will be take		
	room 105.				No residents were affe		
	D) + 1/0 : 1 1 1				by the alleged deficient practi		
		through the door above the			All residents, visitors, si		
	_	in the corridor door to the			have the potential to be affect		
	Social Services Off	fice.			by the alleged deficient praction	ce	
	TI (* 1'	1 11 1 41 4 6					
		knowledged at the time of			What measures will be put in	nto	
		n at the exit conference with		place or what systemic			
		ctor and Maintenance			changes you will make to		
	Supervisor present.				ensure that the deficient		
	2 December of the com	ration and interview the			practice does not recur?		
		vation and interview, the sure 1 of over 30 corridor doors			The Maintenance	~	
	-	t to closing and latching into			Supervisor will be inserviced to the Executive Director/design	-	
	_	would resist the passage of			on the regulatory standard	ee	
		ent practice could affect 2 staff			indicated by this requirement		
	and 5 residents in t				December 14, 2022.		
	dia 3 residents in t	ne delivities died.			·Maintenance		
	Findings include:				Supervisor/designee complete	29	
					preventative maintenance tas		
	Based on observati	ons during a facility tour and			TELs system which includes		
		Maintenance Supervisor on			testing fire doors, and submit	s	
		11:50 a.m. and 3:15 p.m., the			completion to the ED during		
		e activities area failed to close			monthly QAPI meeting.		
		into the door frame.			A Maintenance audit to	ol	
	·				will be completed monthly, to		
	The finding was ac	knowledged at the time of			ensure there are no holes of t	he	
	_	n at the exit conference with			doors near the handles and th		
		ctor and Maintenance			activities door latches correctl		
	Supervisor present.					•	
	· ·						
	3.1-19(b)				How the corrective action(s)		

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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	01	(X3) DATE SURVEY COMPLETED 11/14/2022		
		776 N	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
			will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? A Maintenance audit to will be completed monthly, to ensure there are no holes of the doors near the handles and the activities door latches correct and the results of the monitor will be reviewed during the Quality Assurance Performant Improvement (QAPI) monthly meeting for 6 months, QAPI overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinate action.	out ol he ne ly ing ce / is		
Barrie Subdivision of Buil Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that re Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of o provides a minimu for swinging or hor 19.3.7.6, 19.3.7.8,	Iding Spaces - Smoke arriers are 1-3/4-inch thick d-core doors or of esists fire for 20 minutes. We plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors. 19.3.7.9	К 0374	What corrective action(s) wi	II 12/14/2022		
	PROVIDER OR SUPPLIER PARK VILLAGE SUMMARY SIMPLE (EACH DEFICIENT REGULATORY OR PROVIDER OF PROVIDER O	PROVIDER OR SUPPLIER PARK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	PROVIDER OR SUPPLIER PARK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C. IDENTIFYING INFORMATION REGULATORY OR I.S.C. IDENTIFYING INFORMATION Will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place? A Maintenance audit to will be completed monthly, to ensure there are no holes of the doors near the handles and it will be completed monthly will be reviewed during the Quality Assurance Performan Improvement (QAPI) monthly meeting for 6 months, QAPI overseen by the Executive Director. Any non compliance with staff will result in staff education and up to discipline action. NFPA 101 Subdivision of Building Spaces - Smoke Barrier Subdivision of Building Spaces or of construction that resists fire for 20 minutes. Norrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 11/14/2022					
	PROVIDER OR SUPPLIEF		776 N U	STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	would restrict the n 20 minutes. LSC 1 barriers shall comp 8.5.4.1 requires doc the opening leaving necessary for prope practice could affect Findings include: Based on observation interview with the 1 11/14/22 between 1 of smoke barrier do and (2) near the cle did not close complianterview during the Executive Director barrier doors did not The finding was aci discovery and again	f 5 sets of smoke barrier doors novement of smoke for at least 9.3.7.8 requires doors in smoke ly with LSC Section 8.5.4. LSC ors in smoke barrier shall close gonly the minimum clearance or operation. This deficient of 24 residents. This deficient of 24 residents. This deficient of 3:15 p.m., the set fors (1) near resident room #101 an utility area on the 200 Hall, detely and latch. Based on the time of observations, the acknowledged these smoke of close completely and latch. The set of		be accomplished for those residents found to have been affected by the deficient practice? Door had already been ordered and set to be replace 12/14/22 How will you identify other residents having the potentit to be affected by the same deficient practice and what corrective action will be take. No residents were affe by the alleged deficient practice. All residents, visitors, so have the potential to be affected by the alleged deficient practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervis will be inserviced on the regul standard indicated by this requirement by December 14, 2022. Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes testing doors, and submits completic the ED during monthly QAPI meeting. A Maintenance audit to will be completed monthly, to ensure the smoke barrier doo close completely and latch	d al en? cted ice. taff red ce nto or atory		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 11/14/2022
	PROVIDER OR SUPPLIE	R	776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place? A Maintenance audit too will be completed monthly, to ensure the smoke barrier doors close completely and latch and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	ıt I S III Y
K 0511 SS=E Bldg. 01	complies with NF Code, electrical v complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.1. Based on obser facility failed to en corridors were seen personnel. NFPA Energized parts of enclosed as specific specified in 230.62	d Electric gas or related gas piping PA 54, National Fuel Gas wiring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 vation and interview, the sure all electrical panels in the ured from non-authorized 70, 2011 edition states 230.62 service equipment shall be ed in 230.62(A) or guarded as	K 0511	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The panel has been lock. The wires have been removed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED
		155199	B. W	ING		11/14/2022
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u></u>
NAME OF I	PROVIDER OR SUPPLIEF	R			UNION ST	
MADIE	PARK VILLAGE				FIELD, IN 46074	
IVIAPLE	PARK VILLAGE			WEST	-IELD, IN 40074	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	so that they will no	t be exposed to accidental			How will you identify other	
	contact or shall be	guarded as in 230.62(B).			residents having the potential	al
	(B) Guarded. Energ	gized parts that are not enclosed			to be affected by the same	
	shall be installed or	n a switchboard, panelboard, or			deficient practice and what	
	control board and g	guarded in accordance with			corrective action will be take	n?
		Where energized parts are			 No residents were affe 	cted
	guarded as provided	d in 110.27(A)(1) and (A)(2), a			by the alleged deficient practi	ice.
	_	or sealing doors providing			· All residents, visitors, s	taff
	access to energized	parts shall be provided. This			have the potential to be affect	ed
	deficient practice co	ould affect staff and 12			by the alleged deficient praction	ce
	residents.					
					What measures will be put in	nto
	Findings include:				place or what systemic	
					changes you will make to	
		ons during a facility tour and			ensure that the deficient	
		Maintenance Supervisor on		practice does not recur?		
		1:50 a.m. and 3:15 p.m., two			·The Maintenance Supervis	or
	-	the 200 hall near resident room			will be inserviced by the Exec	utive
	216 were unlocked	when tested.			Director/designee on the	
					regulatory standard indicated	-
	_	knowledged at the time of			this requirement by Decembe	r 14,
		n at the exit conference with			2022.	
		ctor and Maintenance			Maintenance Supervisor	
	Supervisor present.				completes preventative	
		and the second			maintenance tasks via TELs	
		vation and interview, the			system which includes checki	-
		sure 1 of 1 electrical boxes in			electrical wiring and outlets, a	
		maintained in a safe operating			submits completion to the ED	
		.5.1.1 requires utilities comply			during monthly QAPI meeting	
		LSC 9.1.2 requires electrical			A Maintenance audit to	OI
		ent to comply with NFPA 70,			will be completed monthly, to	
		Code. NFPA 70, 2011 Edition,			ensure the electrical panels at	
		c) states junction boxes shall be			locked and there are no expos	seu
	_	ers compatible with the box and ditions of use. Where used,			wires in the riser room	
		comply with the grounding			How the come of the cost of the	
	could affect 3 staff.	0.110. This deficient practice			How the corrective action(s) will be monitored to ensure	
	could affect 3 staff.	•				ine
	Finding in 1 1				deficient practice will not	
	Findings include:		- 1		recur, i.e., what quality	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/14/2022	
	PROVIDER OR SUPPLIER		776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	interview with the M 11/14/22 between 1 sprinkler riser area of receptacle that had a from the bottom. The support and had 3 w Maintenance Superwhy the wire was excondition. The finding was ack discovery and again the Executive Direct Supervisor present. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include the alarm signal and seconditions. Fire drand unexpected the conditions, at least The staff is familial aware that drills alar outine. Where draware that drills are outine. The staff is familial aware that drills are outine. Where draware that drills are outine. Where draware that drills are outine. The staff is familial aware that drills are outine. Where draware that drills are outine. Where draware that drills are outine. The staff is familial aware that drills are outine. Where draware that drills are outine. Where draware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. Where draware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine. The staff is familial aware that drills are outine.	9.7.1.7 riew and interview, the facility e drills or documented on all second quarter shifts. drills shall be conducted aft to familiarize facility	K 0712	assurance program will be pinto place? A Maintenance audit to will be completed monthly, to ensure the electrical panels at locked and there are no exposivires in the riser room and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI in overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinate action. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance	re sed e e

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Event ID:

X82D21

Facility ID: 000106

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>01</u>	COMPLETED	
		155199	B. WING		11/1	4/2022
		1	ст	REET ADDRESS, CITY, STATE	ZIP COD	
NAME OF F	PROVIDER OR SUPPLIE	ER		6 N UNION ST	, 211 001	
MAPLE	PARK VILLAGE			ESTFIELD, IN 46074		
	, and village					1
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREI	CROSS-REFERENCED I	O THE APPROPRIATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TA			DATE
		ministrative staff) with the		Director/designee		
	"	ency action required under		to do fire drills per		
		QSO-20-31 1135 temporary		regulations movin	ig forward	
		eu of a physical fire drill, a				
		tation training program related		How other reside	_	
		plan, which considers current		potential to be at	-	
	· -	, is acceptable. The training will		same deficient p		
		s, including existing, new or		identified and wh		
		rees, on their current duties, life		action(s) will be		
		and the fire protection devices			ts were affected	
		rea. This deficient practice		by the alleged de	•	
	affects all staff and	d residents.			s, visitors, staff	
				have the potential to be		
	Findings include:			by the alleged de	ficient practice	
	Rased on record re	eview and interview with the		What measures v	will be put into	
		ervisor on 11/14/22 between		place or what sy	-	
	_	:50 a.m., the facility was missing		changes will be		
		a completed fire drill for all three		ensure that the d		
		econd quarter of 2022. Based		practice does no		
	_	e time of record review, the		·The Maintenan		
		ervisor agreed there were		will be inserviced	•	
	_	and staff has not been trained in		Director/designee	•	
	_	cedures for the second quarter		regulatory standa		
		at the Maintenance Director		this requirement b	•	
	_	eriod likely did not complete fire		2022.	-, 5000501 11,	
	drills.	,		·Maintenance S	Supervisor	
				completes prever	3	
	The finding was a	cknowledged at the time of		maintenance task		
	_	in at the exit conference with		system which incl		
		ector and Maintenance		and submits com		
	Supervisor presen			during monthly Q		
	' ' '			· Maintenand	-	
	3.1-19(b)			Director/designee		
	3.1-51(c)			to do fire drills per		
				regulations movin		
					•	
				How the correcti	ve action(s)	

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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CO A. BUILDING B. WING	B. WING 11/14/2022				
	PROVIDER OR SUPPLIER		776 N	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0741 SS=F Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the intermediate. (2) In health care of smoking is prohibit prominently placed secondary signs we smoking shall not	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable the gases, or oxygen is at in any other hazardous area shall be posted with D SMOKING or shall be the ternational symbol for no occupancies where the ted and signs are at all major entrances, with language that prohibits		will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be into place? A Maintenance audit to will be completed monthly, to ensure the fire drills are comper state regulations and the results of the monitoring will reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplination.	put pol poleted pe y is e		

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Event ID:

X82D21

Facility ID: 000106

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155199	B. W	ING		11/14/2022	
NAME OF I	DROWIDED OF CLIRIC IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	X.			JNION ST		
MAPLE F	PARK VILLAGE			WESTF	FIELD, IN 46074		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEFEREN		DATE
	responsible shall	ent of 18.7.4(3) shall not					
	. ,	patient is under direct					
	supervision.	autom le unuer un est					
	•	oncombustible material and					
		be provided in all areas					
	where smoking is	permitted.					
	' '	ers with self-closing cover					
		n ashtrays can be emptied					
		vailable to all areas where					
	smoking is permit	ted.					
	18.7.4, 19.7.4	on and interview the facility	K 0	741	What corrective action(s) wil		12/14/2022
	Based on observation and interview, the facility failed to ensure 3 of 3 smoking areas and 1 of 1		I K U	/ 4 1	be accomplished for those		12/14/2022
		were maintained by disposing			residents found to have been	า	
	_	etal or noncombustible			affected by the deficient	-	
	_	closing cover devices. This			practice?		
	deficient practice co	ould affect all residents.		. The Cigaret		е	
			been cleaned up in the identified		ed		
	Findings include:				areas		
	Based on observation	ons during a facility tour and			How other residents having t	the	
	interview with the l	Maintenance Supervisor on			potential to be affected by th		
	11/14/22 between 1	1:50 a.m. and 3:15 p.m., the			same deficient practice will b	ре	
	following was obse				identified and who corrective	•	
		ntenance Shop Entrance there			action(s) will be taken?		
	_	ette butts disposed on the			No residents were affect		
	ground in the grave				by the alleged deficient practi		
	· /	e Smoking Area there were atts disposed on the ground in			All residents, visitors, st		
		nd in and around the leaves			have the potential to be affected by the alleged deficient practic		
	near the area.	na m and around the leaves			by the aneged denoterit practic		
		the FDC sign, there were over			What measures will be put in	nto	
	20 cigarette butts o				place or what systemic		
		doom, there were over 100			changes will be made to		
	cigarette butts on th	ne ground in the gravel and			ensure that the deficient		
	near the building.				practice does not recur?		
					· staff will be inserviced b	-	
		knowledged at the time of			the Executive Director/designe	ee	
	discovery and again	n at the exit conference with			on non smoking areas and		l

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X82D21 Facility ID: 000106

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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		A. BUILDING B. WING	01	COMPLETED 11/14/2022				
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 PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
		tor and Maintenance		smoking areas are maintained disposing cigarette butts in a metal or noncombustible conta with a self closing cover device. The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility non smoking ar smoking areas are maintained cigarette butts are disposed in metal or noncombustible conta with a self closing cover device will be monitored to ensure to deficient practice will not recur, ie., what quality assurance program will be printo place? A Maintenance audit too will be completed monthly, to ensure facility non smoking ar smoking areas are maintained cigarette butts are disposed in metal or noncombustible conta with a self closing cover device and the results of the monitoric will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for one year, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinatication.	ainer e and I and I and ainer e the ut ol I and and ainer e ng ce			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

X82D21

Facility ID: 000106

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED			
		155199	B. WING 11/14/2022				
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.						
	interview; the facilit documentation of el testing at all residen review in accordance Health Care Faciliti 6.3.4.1.3 states rece hospital-grade at pa locations where dee	ectrical outlet receptacle t rooms was available for the with NFPA 99. NFPA 99, the Code, 2012 Edition, Section	K 0914	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The electrical testing of receptacles has been completed and documented on the proper forms	n ted		

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Event ID:

X82D21 Facility ID: 000106

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155199		B. W	B. WING 11/14/2022				
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>	
NAME OF PROVIDER OR SUPPLIER					JNION ST		
MAPLE PARK VILLAGE					FIELD, IN 46074		
IVIAFLE	-ARK VILLAGE			WEST	-IELD, IN 40074		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	hs. NFPA 99, Health Care			How other residents having	the	
	· ·	12 Edition, Section 6.3.4.1.1			potential to be affected by the	ie	
		le receptacles testing shall be			same deficient practice will I	be	
	_	tial installation, replacement or			identified and who corrective	e	
	_	vice. Section 6.3.3.2,			action(s) will be taken?		
		in Patient Care Rooms requires			 No residents were affe 		
		ty of each receptacle shall be			by the alleged deficient practi	ice.	
		l inspection. The continuity of			· All residents, visitors, s		
		it in each electrical receptacle			have the potential to be affect		
		Correct polarity of the hot and			by the alleged deficient praction	ce	
		s in each electrical receptacle					
		and retention force of the			What measures will be put in	nto	
		each electrical receptacle			place or what systemic		
		be receptacles) shall be not less			changes will be made to		
		ounces). Section 6.3.4.2.1.2			ensure that the deficient		
		m, the record shall contain the			practice does not recur?		
		areas tested, and an indication			·The Maintenance Supervis	or	
		e met, or have failed to meet,			will be inserviced by the Exec	utive	
	-	quirements of this chapter.			Director/designee on the		
	This could affect al	ll residents.			regulatory standard indicated by		
					this requirement by Decembe	r 14,	
	Findings include:				2022.		
					·Maintenance Supervisor		
		view, observation and			completes preventative		
		Maintenance Supervisor on			maintenance tasks via TELs		
		10:00 a.m. and 11:50 a.m., an			system which includes checki	-	
	1	inspection and testing electrical			electrical wiring and outlets, a		
	-	or the facility within the most			submits completion to the ED		
		th period was not available for			during monthly QAPI meeting		
		nterview at the time of record			· Maintenance		
		nance Supervisor stated that			Director/designee will make s	ure	
		cation his assistant began the		to do electrical testing of			
	electrical testing but according to documentation			receptacles per state regulations		ons	
	it was not completed. The most recent complete				moving forward		
	documentation of receptacle testing was dated 04/28/21. Based on observations with the						
	_	visor during a tour of the					
		nt sleeping room had multiple			How the corrective action(s)		
	-	es installed at resident bed			will be monitored to ensure	the	
locations.				deficient practice will not			

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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		A. BU	A. BUILDING <u>01</u> COM			survey .eted /2022			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
K 0920 SS=E Bldg. 01	discovery and again the Executive Direct Supervisor present. 3.1-19(b) NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care roother UL standard	ent - Power Cords and ent - Power Strips and ent - Power Strips in conity are only ent electrical equipment les that have been elified personnel and meet elified			recur, ie., what quality assurance program will be pinto place? A Maintenance audit to will be completed monthly to ensure electrical testing of receptacles per state regulation and the results of the monitor will be reviewed during the Quality Assurance Performant Improvement (QAPI) monthly meeting for one year, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinate action.	ons ing ce / s			

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Event ID:

X82D21

Facility ID: 000106

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155199	B. WING 11/14/2022				/2022	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074					
(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 APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the Medical Records office. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on		K 0	K 0920 What corrective action be accomplished for to residents found to have affected by the deficiency practice? The power strip for removed from the Medicoffice The phone charger resident room 222 has removed		n en	12/14/2022	
					How other residents having to potential to be affected by the	ie		
		1:50 a.m. and 3:15 p.m., in the			same deficient practice will be identified and who corrective			
		ffice a power strip was being			action(s) will be taken?	-		
		crowave oven (high power			· All residents, visitors, st	aff		
	draw equipment).	-			have the potential to be affect			
					by the alleged deficient praction	ce		
	_	knowledged at the time of						
		at the exit conference with			What measures will be put in	nto		
		etor and Maintenance			place or what systemic			
	Supervisor present.				changes will be made to ensure that the deficient			
	2. Based on observa	ation and interview, the facility			practice does not recur?			
		ver strips in a resident room			The Director of			
	•	363A or 60601-1. Patient care			Maintenance, and staff were			
	_	s a space, within a location			provided in-service training on Life			
		amination and treatment of			Safety from Fire and the 2012			
	patients, extending	6 feet beyond the normal			Edition of the National Fire			
		chair, table, treadmill, or other			Protection Association (NFPA)		
device that supports the patient during				101 to include information				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLI	ETED	
		155199	B. WING		11/14/2	11/14/2022	
		<u> </u>		TDEET	DDDESC OITY CTATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP COD		
					INION ST		
MAPLE F	PARK VILLAGE		l v	WESIF	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		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	I	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)	' ⁻	DATE
	examination and tre	eatment. A patient care vicinity			regarding extension cords and		
	extends vertically to	7 feet 6 inches above the			surge protectors, by December		
	,	t practice affects 3 resident.			14, 2022		
		•			The Maintenance		
	Findings include:				Director/designee will monitor	the	
	C				facility to ensure continued		
	Based on observation	ons during a facility tour and			compliance with power cords a	$_{and}$ \mid	
		Maintenance Supervisor on			extension cord requirements.		
		1:50 a.m. and 3:15 p.m., resident			· A visual inspection by the	ne l	
		g a power strip for resident's			Maintenance Director/designe		
	•	equipment items including a			has been completed to ensure		
		Plugged into the same power			surge protectors and extension		
		Il IV machine which was in use			cords have been removed and		
	for patient care.				needed replaced with hospital		
	To patient care.				grade surge protectors.		
	The finding was acl	knowledged at the time of			staff will be inserviced b	v	
		at the exit conference with			the Executive Director/designe	·	
		etor and Maintenance			on power strips and proper us		
	Supervisor present.				· The Maintenance	-9-	
	1 1				Supervisor/designee will make	,	
	3.1-19(b)				environmental rounds daily to		
	()				ensure facility power strips are	,	
					being used correctly.		
					g		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not	-	
					recur, ie., what quality		
					assurance program will be p	_{ut}	
					into place?		
					· A Maintenance audit to		
					will be completed monthly, to	[
					ensure continued compliance	_{with}	
					power cords and extension co		
					requirements and the Executiv		
					Director will monitor the facility		
					ensure continued compliance		
				ensure continued compliance	VVILII		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

X82D21

Facility ID: 000106

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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICINE & MEDICINE SERVICES							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155199	B. WING		11/14/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 776 N UNION ST WESTFIELD, IN 46074				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		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	
				power cords and extension co requirements, for 6 months w results reported to the Quality Assurance Performance Improvement (QAPI) Committo overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinal action	ee		

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