STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	11/21/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00394244 and IN00393266. Complaint IN00394244 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F692. Complaint IN00393266 - Unsubstantiated due to lack of evidence. Survey dates: November 18 and November 21, 2022. Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 83 SNF: 7 Total: 90 Census Payor Type: Medicare: 5 Medicaid: 64 Other: 21 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 22, 2022.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 12/18/22.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Executive Director	12/16/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure appropriate assistive devices were used to prevent a fall for 1 of 3 residents reviewed for accidents. (Resident C) Finding includes: The record for Resident C was reviewed on November 18, 2022 at 10:24 a.m. Diagnoses included, but were not limited to, difficulty walking, unsteadiness on feet, and repeated falls. A physician's order, dated 10/05/2022, indicated Resident C was to use a full body mechanical lift with two staff members for transfers. A progress note, dated 10/21/22 at 8:52 p.m., indicated "...While assisting resident from the toilet and standing her up...Resident was lowered to the ground after her knees gave out 2 staff members assisted her from the toilet and off the floor...No injuries were noted...." During an interview, on 11/21/22 at 9:34 a.m., the Director of Nursing (DON) indicated staff should have used the full body mechanical lift to transfer Resident C which was the reason the resident was lowered to floor when she was unable to sustain her weight during a transfer with one staff and no assistive device. The DON indicated staff were to follow physician's orders.	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident C no longer resides in the facility **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;** - Education to be provided via inservicing by 12/16/22. Education to include the Fall Management program and mechanical lifts, are in place per the plan of care -All residents have potential to be affected by the alleged deficient practice. -All residents who are at risk for falls with mechanical lifts were reviewed by DNS/designee to ensure mechanical lifts were in place based on resident's care plan. **What measures will be put into place and what systemic changes will be made to**	12/16/2022

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	A facility policy related to following physician's orders was requested. The policies on physician's orders were provided, by the DON on 11/21/22, but did not cover following physician's orders. During an interview, on 11/21/22 at 11:38 a.m., the DON indicated the facility did not have any other policies addressing transferring residents or following physician's orders, it was basic nursing. This Federal tag relates to Complaint IN00394244. 3.1-45(a)(2)		**ensure that the deficient practice does not reoccur;** - Education to be provided via inservicing by 12/16/22. Education to include the Fall Management program and mechanical lifts are in place per the plan of care - Facility will implement daily rounds to ensure residents that utilize mechanical lifts are in place per plan of care. - Facility to provide on going training and skills validations for mechanical lifts, as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the Mechanical Lift Transfers CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to keep accurate fluid intake records for 1 of 1 resident reviewed for a fluid restriction. (Resident C) Finding includes: The record for Resident C was reviewed on November 18, 2022 at 10:24 a.m. Diagnoses included, but were not limited to, congestive heart failure, dyspnea (difficulty breathing), and hypertension. A physician's order, dated 10/28/22, indicated Resident C was to be on a fluid restriction of 1.5 liters (a day).	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident C no longer resides at the facility **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;** - All residents with fluid	12/18/2022

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	A care plan, dated 08/15/22, indicated "...Resident is on a fluid restriction...Record intake...." The Medication and Treatment Administration Record was reviewed. There was not documentation of the fluid intake on the night shift on 11/04, 11/05 and 11/06/22. There were no total fluid intakes tallied for the night shift on 11/04, 11/05 and 11/06/22. During an interview, on 11/21/22 at 10:50 a.m., RN 1 indicated the nurses are responsible for totaling fluid restrictions and documenting the intakes and daily totals in the Medication Administration Record. During an interview, on 11/21/22 at 10:55 a.m., RN 2 indicated all staff were to track fluids when a resident was on a fluid restriction, but a resident did have the right to request extra fluid. They would then need to be educated. The night shift did the final totals for the daily fluid restrictions. During an interview, on 11/21/22 at 12:08 p.m., the Director of Nursing indicated the Medication and Treatment Administration Records should be signed off and documented accurately. A current facility policy, "Hydration Management," dated as revised 11/2017 and provided by the Director of Nursing on 11/21/22 at 11:39 a.m., indicated "...24 hour fluid totals will...be calculated for those residents on a fluid restriction...." This Federal tag relates to Complaint IN00394244. 3.1-46(b)		restrictions have the potential to be affected by the alleged deficient practice - All future residents with order for fluid restrictions have the potential to be affected by the alleged deficient practice - An Inservice will be completed by 12/18/22 educating staff on keeping accurate fluid intake records **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** - An Inservice will be completed by 12/18/22 educating staff on keeping accurate fluid intake records - All fluid restriction orders will be reviewed in the daily clinical meeting to ensure nursing staff and IDT are keeping accurate fluid intake records and to ensure resident are receiving fluid intake per physician's order. - **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed**	

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			- The DNS/designee will be responsible for the completion of the Fluid Restrictions CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	