Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Park Village	776 N Union St Westfield, IN 46074

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a medication was held according to the ordered parameters and the physician was notified of blood glucose readings as ordered for 2 of 5 residents reviewed for quality of care. (Resident 7 and 6)Findings include:1. The clinical record for Resident 7 was reviewed on 9/12/25 at 8:26 a.m. The diagnoses included, but were not limited to, chronic diastolic heart failure, hypertensive heart, and chronic kidney disease with heart failure.A physician's order, dated 4/15/25 and discontinued 8/18/25, indicated to administer Entresto (a medication used to treat chronic heart failure) 49-51milligrams (mg) twice a day, with special instructions to hold the medication for a systolic blood pressure of less than 120.The Medication Administration Record (MAR), dated 7/1/25 to 7/31/25, indicated Entresto had been administered 13 times when Resident 7's systolic blood pressure was less than 120.The MAR, dated 8/1/25 to 8/18/25, indicated Entresto had been administered 5 times when Resident 7's systolic blood pressure was less than 120.During an interview, on 9/12/25 at 11:13 a.m., the Medical Records staff indicated a parenthesis on the MAR indicated the medication had been held and an asterisk on the MAR indicated the medication had been given and the nurse had documented a note with the administration. The Medical Records staff reviewed the MAR and indicated the medication should have been held according to the physician's order.During an interview, on 9/16/25 at 12:11 p.m., the Director of Nursing (DON) indicated the medication should have been held according to the physician's order.2. The clinical record for Resident 6 was reviewed on 9/11/25 at 12:21 p.m. The diagnoses included, but were not limited to, type 2 diabetes, hypertension, and mixed hyperlipidemia.A care plan, dated 8/9/19, indicated Resident 6 was at risk for adverse effects of hyperglycemia/hypoglycemia related to the use of medications for diabetes. An intervention, dated 8/9/19, indicated to document abnormal findings and notify the physician.A physician's order, dated 9/12/19, indicated to notify the physician if Resident 6's blood glucose reading was greater than 350 or below 60.The Medication and Treatment Administration Records (MAR/TAR) indicated the following:a. On 6/1/25 at 8:00 a.m., the resident's blood glucose reading was 400. The MAR/TAR indicated the physician was not notified.b. On 9/4/25 at 5:00 p.m., the resident's blood glucose reading was 360. The MAR/TAR indicated the physician was not notified.There were no progress notes or observation documentation to show the physician had been notified of the blood glucose reading according to the physician's order.During an interview, on 9/16/25 at 12:19 p.m., LPN 9 indicated if a medication had a hold parameter or instructions to notify the physician, the nurse would be responsible for verifying the medication was held or the physician was notified immediately so the nurse could get further instructions on how to proceed.During an interview, on 9/16/25 at 12:04 p.m., the Executive Director indicated the facility did not have a policy related to physician ordered hold parameters. He indicated holding medications according to the physician's order was an expectation.A current facility policy, titled Resident Change of Condition Policy, dated as revised in 11/2018 and received from the Executive Director on 9/16/25 at 12:24 p.m., indicated .all changes in resident condition will be communicated to the physician.and that appropriate, timely, and effective intervention takes place.All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly.The nurse in charge is responsible for notification of physician.3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure physician ordered medications included an appropriate supporting diagnosis and a medication included a stop date for 3 of 5 residents reviewed for unnecessary medications. (Resident 11, 5 and 13)Findings include:1. The clinical record for Resident 11 was reviewed on 9/12/25 at 10:36 a.m. The diagnoses included, but were not limited to, dementia, muscle weakness, and encounter for other specified aftercare. A review of Resident 11's obsolete diagnoses indicated a diagnosis of herpes viral infection was placed on 5/20/24 and resolved on 7/23/24. A physician's visit note, dated 7/7/25, indicated Resident 11 had been experiencing painful blisters on her bilateral thighs and vaginal area, which was a chronic issue, and had been treated in the past. The treatment plan was to initiate a topical antiviral cream for 5 days, followed by valacyclovir (an antiviral medication used to treat infections) 500 milligrams (mg) every day. The physician's note did not include instructions regarding when the medication would be stopped or supporting documentation for the duration of use. A physician's order, dated 7/7/25, indicated valacyclovir 500 mg was prescribed for the diagnosis of encounter for other specified aftercare. The medication did not include a stop date or an appropriate supporting diagnosis. During an interview, on 9/16/25 at 11:05 a.m., the Director of Nursing (DON) indicated medical records would follow up on physician's orders to ensure medications contained a supporting diagnosis and stop date. The DON indicated the diagnosis for valacyclovir was not appropriate and the medication was missing a stop date. 2. The clinical record for Resident 5 was reviewed on 9/15/25 at 10:30 a.m. The diagnoses included, but were not limited to, sepsis (a life-threatening condition where the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage), encephalopathy (a disturbance in brain function), and chronic kidney disease. A physician's order, dated 8/25/25, indicated to administer amlodipine (a medication for hypertension) 10 mg for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/26/25, indicated to administer aspirin (a medication used for fever, pain, preventing clotting and/or inflammation) 81 mg for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/26/25, indicated to administer atorvastatin (a medication used for high cholesterol) 80 mg for the diagnosis of encounter for other specified aftercare. A physician's order, dated 9/9/25, indicated to give Meropenem (an antibiotic) 2 grams in 100 milliliters of normal saline intravenously every eight (8) hours for the diagnosis of encounter for other specified aftercare. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record for Resident 13 was reviewed on 9/10/25 at 3:08 p.m. The diagnoses included, but were not limited to, psoriasis, insomnia, and anxiety. A physician's order, dated 8/14/25, indicated to give amlodipine (a medication used to treat high blood pressure) 10 mg daily for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/14/25, indicated to give aspirin 81 mg daily for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/14/25, indicated to give atorvastatin (a medication used to high cholesterol) 20 mg daily for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/14/25, indicated to give famotidine (a medication used to treat reflux) 20 mg at bedtime for the diagnosis of encounter for other specified aftercare. A physician's order, dated 8/15/25, indicated to give amantadine (a medication used to treat Parkinson's disease) 100 mg daily for the diagnosis of encounter for other specified aftercare. A physician's order, dated 9/9/25, indicated to administer Humira (a medication used to treat autoimmune disorders and inflammatory diseases) 40 mg by subcutaneous injection every other Thursday. The diagnosis used for the administration of the medication was extrapyramidal and movement disorders. During an interview, on 9/16/25 at 9:36 a.m., RN 10 indicated when staff received a medication order from the physician, the order was entered into the electronic health record (EHR). The diagnosis of Encounter for specific aftercare was a short-term diagnosis the nurses could use if the appropriate diagnosis could not be found at the time they were placing the order. The nurse would be responsible for ensuring the short-term diagnosis was changed to the correct supporting diagnosis for the medication. RN 10 indicated if a medication did not include a stop date, the nurse would contact the physician to clarify when the medication would be stopped. During an interview, on 9/15/25 at 9:27 a.m., the Infection Preventionist indicated the diagnosis for the antibiotic Meropenem and the immunosuppressant Humira did not have correct diagnoses. Medications needed to have appropriate diagnoses. During an interview, on 9/16/25 at 11:37 a.m., the DON indicated the facility did not have a policy regarding medications with supporting diagnoses or stop dates. A current facility policy, titled Medication Regimen Reviews and Pharmacy Recommendations, dated as last revised on 10/2018 and received by the Executive Director on 9/16/25, indicated .the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimized adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician, Medical Director, and Director of Nursing. 3.1-48(a)(2) 3.1-48(a)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure staff wore Personal Protective Equipment (PPE) properly, wore the appropriate PPE when entering an isolation room, preformed hand hygiene, and changed gloves during a dressing change for 3 of 7 residents reviewed for infection control. (Resident 57, 34 and 5)Findings include:1. During a random observation, on 9/10/25 at 9:53 a.m., CNA 4 was observed to put on a protective gown, mask, and gloves outside of Resident 57's room. The gown was not tied at the neck. She then entered the room which had a sign posted to indicate it was a droplet/contact isolation room. The sign indicated to put on a gown and to tie the gown.During an interview, on 9/10/25 at 10:11 a.m., CNA 4 indicated the sign did indicate she should have tied her gown.During a random observation, on 9/11/25 at 8:48 a.m., CNA 3 was observed to put on a gown, mask, and gloves and enter Resident 57's room. She was not observed to put on the eye protection required for droplet precautions. During an interview, on 9/11/25 at 8:52 a.m., CNA 3 indicated she did not wear eye protection, and she should have applied the Personal Protective Equipment indicated on the sign posted.The clinical record for Resident 57 was reviewed on 9/11/25 at 8:53 a.m. The diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus without complications, and cough.A physician's order, dated 9/10/25, indicated Resident 57 was in isolation due to having an active infection with highly transmissible or epidemiologically significant pathogens which had been acquired by physical contact or airborne or droplet transmission. The type of isolation required would be contact/droplet related to a cough.A care plan, dated 9/10/25, indicated the resident had a need for isolation related to infectious diseases: cough.2. During an observation of catheter care, on 9/12/25 beginning at 1:31 p.m., Resident 34 was observed in bed. CNA 6 filled a wash basin with water, set the basin on the bedside table with the clean linen, put on a protective gown, and then put on gloves. She was not observed to perform hand hygiene prior to donning her gloves. During an interview, on 9/12/25 at 1:37 p.m., CNA 6 indicated she did not use hand sanitizer or perform hand washing after touching items in the resident's environment and she should have performed hand hygiene prior to putting on her gloves.3. During an observation of wound care, on 9/15/25 beginning at 10:35 a.m., RN 8 and LPN 7 put on PPE. LPN 7 was observed to remove a dressing from the right buttock area of Resident 5 and discarded it. LPN 7 cleaned the area on the right buttock with wound cleaner and a clean 4 by 4 dressing. After cleaning the area, she discarded the 4 by 4. She was not observed to change her gloves or perform hand hygiene prior to continuing. She opened the packaging for sterile cotton tip applicators and the Santyl (an ointment used to remove dead or damaged tissue to promote healing of wounds) she had removed from a plastic bag. LPN 7 then applied the Santyl to the wound and discarded the applicator. She then opened an emulsion dressing (a nonadherent gauze mesh), folded it in half and applied the dressing to the wound. The area was then covered with a dressing. LPN 7 then removed her gloves, discarded the gloves, and washed her hands with soap and water. During an interview, on 9/15/25 at 9:21 a.m., the Infection Preventionist indicated hand hygiene was to be performed after touching items in the resident's environment. Gowns were to be tied at the neck, and the back, masks and face shields were to be used (as indicated by isolation type), and hand hygiene was to be completed before donning gloves and after removing gloves.A current facility document, titled ISOLATION DROPLET/CONTACT PRECAUTIONS, indicated .wear all PPE listed below. The PPE listed on the sign was gown, N95 respirator, eye protection, and gloves. The sign was posted outside the room of Resident 57.A current facility procedure, titled Dressing Change Clean Technique (Incision or Wound), dated as revised in 7/2025 and received from LPN 7 on 9/12/25 at 10:50 a.m., indicated .Remove old dressing from resident and put directly in trash receptacle . Remove gloves and discard .Perform hand hygiene and put on new gloves A current facility policy, titled Hand Hygiene Policy, dated as revised 12/2021 and received from the Executive Director on 9/16/25 at 8:47 a.m., indicated .5 Moments of hand hygiene - a term that describes the hand hygiene opportunities that prevent infection transmission linked to healthcare activities.Before touching a resident.Before Clean/Aseptic procedure.After touching resident surroundings.Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications.Before moving from work on a soiled body site to a clean body site on the same resident.Indication for Hand-rubbing but not limited to.Before and after removing glove.A current facility policy, titled Standard and Transmission-Based Precautions (Isolation) Policy, dated as last revised 2/2025 and received from the Executive Director on 9/16/25 at 8:47 a.m., indicated. Change gloves during care and perform hand hygiene if hands move from a contaminated site to a