

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Maple View Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 856 Maple St Rocky Hill, CT 06067	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #62) reviewed for accidents, the facility failed to provide adequate supervision during toileting to prevent a fall for a resident who was identified with severely impaired cognition and at high risk for falls. The findings include: The hospital admission history & physical form dated 8/2/25 at 10:33 PM identified Resident #62 had a history of atrial fibrillation, dementia, and congestive heart failure. Resident #62 was hypotensive with a blood pressure of 83/55 mm/Hg (normal range 120/80 mm/Hg). After intravenous (IV) fluids were administered, the resident's blood pressure was 112/64 mm/Hg. Resident #62 was disoriented, cachectic and was not in acute distress. Resident #62 had a chest x-ray with results indicating pneumonia. Resident #62 had received antibiotic and intravenous (IV) fluids in the emergency room. Resident #62 had been admitted to the hospital for acute kidney injury and pneumonia. Resident #62 was last seen by the home health aide at night at his/her home and then was found on the floor the next morning at his/her home. Resident #62 was admitted to the facility on [DATE] with diagnoses that included history of falling, dizziness, giddiness, pain, muscle weakness, hypotension, heart failure, atrial fibrillation, and severe dementia with anxiety. The care plan dated 8/6/25 identified Resident #62 had potential for fall with/without injury due to: weakness and history of fall at home. Interventions included appropriate footwear (non-skid socks, non-slip soles on shoes/sneakers) when mobilizing in wheelchair. The admission MDS dated [DATE] identified Resident #62 had severely impaired cognition, required substantial/maximal assistance with toileting hygiene, toilet transfer, required extensive assistance with one-person physical assistance with transfer and toilet use. The occupational therapy Discharge summary dated [DATE] - 9/2/25 identified on 9/2/25, Resident #62 required partial/moderate assistance with toilet hygiene and toilet transfers. Additionally, required assistance of one for all activity of daily living (ADL'S) and toilet transfers. The reportable event form dated 8/24/25 at 3:15 AM identified Resident #62 was observed lying on his/her back on the floor next to his/her bed. An RN assessment and neurological check were performed with no injuries noted. The APRN and the resident representative were notified. An investigation was initiated. Interventions included low bed with floor mats. The fall evaluation form dated 8/24/25 identified Resident #62 was at high risk for falls. Resident #62 was confused at all times, had unsteady gait and balance, and does not use an assistive device for mobility. The task list report dated 8/24/25 identified Resident #62 was at high risk for falls. The reportable event form dated 9/6/25 at 8:15 PM identified Resident #62 was placed on the toilet in the bathroom by NA #1 and Resident #62 got up and fell. Resident #62 was alert and confused and transferred with one staff assistance with rolling walker. RN assessment and neurological check were performed with no injuries noted. The APRN, the resident representative were notified and an investigation was initiated. Intervention included to educate NA #1 not to leave Resident #62 when being toileted. The revised care plan dated 9/7/25 identified Resident #62 had potential for fall with/without injury due to: weakness, history of fall at home. Interventions dated 9/6/25 identified education for NA #1 to not leave Resident #62 alone when the resident is using the bathroom. The investigation statement form by NA #1 dated 9/6/25 identified that she last saw Resident #62 at 8:15 PM when she brought the resident to the bathroom. NA #1 indicated Resident #62 had voided. NA #1 indicated she transferred Resident #62 with assist time one. NA #1 indicated she was turning down the bed linen and Resident #62 got up from the toilet and fell. The investigation statement form by LPN #2 dated 9/6/25 at 8:15 PM identified it was reported to her that Resident #62 fell in the bathroom. LPN #2 indicated she observed Resident #62 sitting on the floor near the bathroom door. Resident #62 was alert and verbal. LPN #2 indicated Resident #62 denies hitting his/her head. The summary of investigation report dated 9/6/25 identified Resident #62 had a diagnosis of dementia. NA #1 assisted Resident #62 into the bathroom and while Resident #62 was sitting on the toilet the resident got up and fell. RN assessment was performed. The changes made to the plan of care was to educate NA #1 not to leave Resident #62 in the bathroom when being toileted. The conclusion was Resident #62 had an unwitnessed fall without injury. The fall unwitnessed form dated 9/6/25 at 8:15 PM identified NA #1 toileted Resident #62 in the bathroom and while the resident was sitting on the toilet, he/she got up and fell. NA #1 was educated not to leave Resident #62 in the bathroom when being toileted. Interview and review of the clinical record with the Rehabilitation Director on 12/3/25 at 12:06 PM identified on 9/2/25 Resident #62 was a partial/moderate assistance with toilet transfers and toilet hygiene (50% - 75% of the toilet hygiene to be perform by nursing staff) The Rehabilitation</p>		