STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165346	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Village	345 Parrott St Aplington, IA 50604

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed (Resident #8 and #16). The facility documented the residents received insulin during the look back period when they did not. The facility reported a census of 32. Findings include: 1. Resident #8's MDS assessment dated [DATE] included a diagnosis of type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). The MDS reflected Resident #8 received one insulin injection during the lookback period. Resident #8's February 2025 Treatment Administration Record (TAR) lacked an order for insulin. The TAR included an order for Ozempic (an injectable medication to treat type 2 diabetes mellitus) 1 milligram (MG) subcutaneous (administered under the skin) solution once per week. 2. Resident #16's MDS assessment dated [DATE] included a diagnosis of type 2 diabetes mellitus. The assessment reflected Resident #16 received one insulin injection during the lookback period. Resident #16's January 2025 TAR lacked an order for insulin. The TAR included an order for Ozempic 1 MG subcutaneous solution once per week. During an interview on 2/19/25 at 10:46 AM, Staff A, Licensed Practical Nurse (LPN), acknowledged Resident #8 and Resident #16 had a diagnosis of type 2 diabetes mellitus. Staff A reported Resident #8 and #16 received ozempic. Staff A acknowledged Ozempic is a diabetic medication and is not classified as insulin. During an interview on 2/19/25 at 10:49 AM Staff B, Registered Nurse (RN)/Assistant Director of Nursing (ADON), with Staff C, RN / MDS Coordinator present, acknowledged the 2 residents most recent MDS documented they received 1 injection during the look back period. Staff B reported Resident #8 and Resident #16 received Ozempic every Friday. Staff B confirmed Ozempic is not an insulin. On 2/19/25 at 4:41 PM the Administrator acknowledged the facility followed the Resident Assessment Instrument (RAI) manual for completion of the MDS.

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on observation, clinical record review, and staff interviews, the facility failed to develop and implement behavioral health concerns on the Care Plan for 1 of 1 resident sampled (Resident #2). The facility reported a census of 32 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified he had short- and long-term memory problems and had severely impaired cognitive skills for daily decision making. He could recall the staff names and faces. The assessment indicated he had inattention continuously present, and it didn't fluctuate. He experienced other behavioral symptoms not directed towards (examples physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) others daily. The MDS included diagnoses of epilepsy (seizure disorder), psychotic disorder (mental health disorder), chronic pain and severe intellectual disabilities. Throughout a continuous observation on 2/17/25 at 1:35PM till 2:10 PM observed Resident #2 sitting in the black recliner in the south common area picking at the hole in the foot rest. Saw Resident #2 pulling foam out and putting it on the floor. The hole size look approximately 4 inches around. During the observation, witnessed 3 other residents also sitting in the day room. Observed the staff walked by several times and the nurses stood around the office right next to the day room as Resident #2 continued to pick and pull foam out. No staff stopped to redirect or try interventions to stop his behavior. Observation on 2/17/25 at 3:53 PM saw Resident #2 sitting in black recliner in the south common area. Resident #2 had his fingers in the opening on the foot rest with cushion material on the floor. During a continuous observation on 2/19/25 at 7:00 AM until 8:08 AM witnessed Resident # 2 sitting in the black recliner in the south common area with his feet flat on the floor. He had his right hand picking at the open area on the foot rest. At the time a housekeeper vacuumed the common area as other numerous staff members passed through the common area without redirecting Resident #2 with his picking behavior. At the time 2 other residents sat in the common area. Resident #2's Care Plan lacked documentation about his picking behavior and/or interventions to prevent it. The Care Plan Focuses with a Goal target date of 4/7/25 a. Directed staff to offer snacks during periods of anxiety or behaviors to assisting with calming Resident #2. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Indicated Resident #2 enjoyed activities such as games (likes to play catch and throw a ball, stuffed monkey or stuffed bull); independent (enjoys relaxing in recliner in the south-needs assistance with operating the T.V. to turn it on/off and select channels/enjoys [NAME] movies, and sports like football); music (staff to sit resident out for musical activities-likes to sit in the back so can leave easily if wants to/seems to enjoy listening to music in the south lounge); reading (seems to enjoy listening to short stories read to them); van rides (staff to ensure resident has helmet on to promote safety). Resident has diagnosis of severe intellectual disability, and can only communicate by sounds and gestures. c. Documented Resident #2 had an alteration in communication related to impaired cognition form severe intellectually disability and aphasia (inability to speak). They will make facial expressions, noises, and even hit staff to get their attention. i. The Intervention instructed if he became anxious or restless staff are to attempt to provide one-on-one (1:1), diversional activity, take them for a van ride, or walk with him. During an interview on 2/19/25 at 1:05 PM the Director of Nursing (DON) reported the facility didn't do anything to address Resident #2's picking behaviors and making a hole in the footrest while in the recliner. She reported he owned the recliner and he picked at it but the hole has not been as big of a hole as it is at that time. She reported he tried to do it in other recliners as well so the staff brought out his own to the common area. She reported if someone gave him something to hold in his hands he just throws it. She didn't know for sure if Resident #2' s picking is due to not meeting his needs or if it is just a behavior. In an interview on 2/19/25 at 2:29 PM the Administrator reported they didn't have a policy specific to behaviors.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, policy review, resident, and staff interviews, the facility failed to offer or ensure a resident received dental services for 1 of 1 resident reviewed for dental services (Resident #1). The facility reported a census of 32 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included a diagnoses of dental caries (cavities). The Nutrition Assessment completed 9/2/24 documented both dentures in good condition with no chewing or swallowing issues. The Nutrition Assessment completed 12/9/24 by the Dietitian documented Resident #1 had full upper and lower dentures but they didn't have their lower ones due to them being broken. Resident #1 reported some chewing but no swallowing issues. Resident #1 requested a dental appointment. During an interview on 2/17/25 at 3:55 PM Resident #1 reported the staff dropped his bottom denture when cleaning them and it broke. He reported he still didn't have new ones or the current one repaired yet because staff said they can't get him to a dentist. In an interview on 2/19/25 at 2:25 PM Staff D, Licensed Practical Nurse (LPN), reported Resident #1's bottom dentures are broken but they didn't know for how long. Staff D reported she didn't know if he had an appointment to see a dentist. In an interview on 2/19/25 at 2:28 PM Staff A, LPN, reported she knew about Resident #1's broken bottom denture, but she didn't know how they got broke. She added the facility has tried to get him into a dentist but they didn't take his insurance. Staff A didn't know for sure how long Resident #1's dentures were broken. On 2/19/25 at 2:30 PM the Director of Nursing (DON) reported Resident #1 had 2 sets of bottom dentures but she didn't know if they both fit. She reported she didn't know when or how his denture broke. During an interview on 2/19/25 at 2:35 PM the Administrator reported she didn't know about Resident #1's broken dentures but would look into it. In an interview on 2/19/25 at 3:10 PM the Administrator reported she didn't know before about Resident #1's broken dentures. She reported the Office Manager made calls to dentists but hit road blocks with them not taking his insurance. As of the first of the year Resident #1 had new insurance so they planned to call around to see if a dentist would take his new insurance. She verbalized she called Corporate about his broken dentures to find out if they should pay for them due to the staff dropping them. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 9:00 AM the Administrator reported the facility would pay to fit Resident #1's dentures. The facility policy titled Dental Services revised April 2023 instructed if the resident's dentures are damaged, the facility will promptly (within 3 days) refer the resident and if not, they must provide documents showing what the facility did to ensure the resident could still eat and drink while waiting for dental services. In addition, they must indicate the extenuating circumstances that led to the delay. The policy added if the dentures got damaged by staff then the facility is responsible to pay for the dentures.