STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365350	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Knoll Village	11100 Springfield Pike Cincinnati, OH 45246

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff provided timely incontinence care. This affected two (Residents #15 and #16) of three residents reviewed for call light response. The facility census was 66 residents. Findings include: Review of the medical record for Resident #15 revealed an admission date of 02/16/24 with diagnoses including cerebral infarction, diabetes, and depression. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 08/06/25 revealed the resident had no cognitive impairments and required substantial assistance to total dependence on staff for activities of daily living (ADLs). Review of the medical record for Resident #16 revealed an admission date of 01/06/23 with diagnoses including dementia, depression, and Barrett's esophagus. Review of the MDS assessment for Resident #16 dated 09/05/25 revealed the resident had no cognitive impairment and was dependent of staff for ADLs. Observation on 09/22/25 from 3:05 P.M. until 3:25 P.M. revealed Residents #15 and #16's call lights were sounding. Staff did not respond to the call lights. Interview on 09/22/25 at 3:25 P.M. with Resident #15 confirmed he had activated his call light because he needed assistance with being changed. Interview on 09/22/25 at 3:26 P.M with Resident #16 confirmed she had activated her call light because she needed to be changed as she was soiled and had diarrhea. Observation on 09/22/25 at 3:34 P.M. revealed Certified Nursing Assistant (CNA) #25 entered Resident #15's room and turned off his call light without providing care. Interview on 09/22/25 at 3:36 P.M. with CNA #25 confirmed she had been off the unit on a lunch break and had just returned. CNA #25 confirmed she was unaware no one had been available to answer the call lights from 3:05 P.M. to 3:25 P. M. Review of the facility policy titled Supporting Activities of Daily Living undated revealed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. This deficiency represents noncompliance investigated under Complaint Number 2580344 and and Complaint Number 135097 (OH00161949) and Complaint Number 1395096 (OH00161797) and Complaint Number 1395095 (OH00160987.)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on medical record review, staff interview, and review of the facility policy, the facility staff failed to safely and properly position a resident in bed during incontinence care in order to prevent falls. This affected one (Resident #10) of three residents reviewed for falls. The facility census was 66 residents.Findings include:Review of the medical record for Resident #10 revealed an admission date of 03/07/10 with diagnoses including dementia, depression, and cerebrovascular disease. Review of the care plan for Resident #10 dated 10/31/22 revealed the resident had a self-care deficit secondary to multiple diagnoses including Alzheimer's disease with severe cognitive impairment and aphasia. Resident #10 was dependent on staff for all areas of care. Review of the care plan for Resident #10 dated 11/16/22 revealed the resident was incontinent of bowel and bladder and staff were to check and change the resident regularly.Review of the incident note for Resident #10 dated 07/30/25 at 5:50 A.M. revealed Resident #10 fell out of bed while Certified Nursing Assistant (CNA)#35 was providing incontinence care. CNA had reached for a clean brief, and the resident fell out of bed. No injuries were noted at the time of the fall, and the resident was to have two caregivers present during incontinence care in the future. Review of the progress note for Resident #10 dated 07/30/25 at 12:26 P.M. revealed the resident had developed bruises to the left arm since the fall and the physician gave an order for x-rays which were negative. Review of a written statement regarding Resident #10's fall on 07/30/25 per CNA #35 dated 07/30/25 revealed when the aide was changing Resident #10, the resident rolled out of the bed and onto the floor. Review of a written statement regarding Resident #10's fall on 07/30/25 per Licensed Practical Nurse (LPN) #51 dated 07/30/25 revealed CNA #35 notified her that Resident #10 had fallen out of bed during peri-care. The nurse observed Resident #10 lying on the floor on her back to the left side of the bed. CNA #35 stated she laid Resident #10 on her side and while the aide was reaching for the clean brief at the end of the bed the resident rolled out of the bed and onto the floor. There were no injuries noted at the time of the fall. Review of the incident note for Resident #10 dated 07/31/25 at 12:25 P.M. revealed the Interdisciplinary Team (IDT) met to review the resident's fall on 07/30/25. CNA #35 had rolled Resident #10 onto her right side in the bed to provide incontinent care. CNA #35 stated she was grabbing for the incontinence brief at the end of the bed and trying to open it when Resident #10 rolled out of bed on to the floor on 07/30/25 at 5:50 A.M. Resident #10 had x-rays completed to left arm, bilateral hips, pelvis, and spine with no fractures. Resident #10 did sustain bruises to her left elbow and forearm. A new intervention to prevent further falls was for the facility to have two staff people assist with incontinence care.Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 08/18/25 revealed the resident had severe cognitive impairment and was dependent on staff for completing activities of daily living (ADLs.)Interview on 09/22/25 at 4:07 P.M. with CNA #25 confirmed when providing care, you should never roll a resident away from you because they could roll off the bed.Interview on 09/23/25 at 3:20 P.M. with CNA #35 confirmed while she was providing incontinence care to Resident #10 the bed was raised and she rolled the resident on her right side, which was away from the aide, and then the resident rolled out of bed.Review of an online clinical resource titled Turning Patients Over in Bed: Medline Plus Medical Encyclopedia undated at: https://medlineplus.gov/ency/patientinstructions/000426.htm#:~:text=Standing%20with%20one%20foot%20ahead,the%20person's%20hip%20toward%20you revealed the following steps should be followed when turning a resident in bed: explain to the resident what you are planning to do so they know what to expect, encourage the person to help if possible, stand on the opposite side of the bed the resident will be turning towards, move the patient towards you, step around to the other side of the bed, ask the resident to look towards you (this will be the direction in which the person is turning.)This deficiency represents noncompliance investigated under Master Complaint Number 2587988 and Complaint Number 1395095 (OH00160987.)