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	05/11/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, and facility policy review, the facility failed to safely and properly position a resident during incontinence care. Actual harm occurred on 04/08/26 when Certified Nurse Assistant (CNA) #525 rolled Resident #10 in bed away from her and the resident fell onto the floor sustaining a closed fracture of left femur and a laceration of upper forehead which required sutures. This affected one (Resident #10) of one resident reviewed for falls. The facility census was 68 residents. Findings include: Review of the medical record for Resident #10 revealed admission date of 05/22/23 with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus type two, and morbid obesity. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 01/14/26 revealed the resident was cognitively intact, was dependent on staff assistance with toileting and hygiene, required substantial/maximal assistance for rolling left and right from lying position on back, and was dependent for transfer to and from bed to chair. Review of the fall risk evaluation for Resident #10 dated 01/14/26 revealed the resident was at high risk for falls. Review of the health status note for Resident #10 dated 01/27/26 written by MDS Registered Nurse (RN) #350 revealed the resident frequently required two staff members for hygiene and mobility. Review of the progress note for Resident #10 dated 04/08/26 at 6:18 P.M. written by Licensed Practical Nurse (LPN) #435 revealed CNA #525 reported Resident #10 had rolled out of bed while staff were providing care. Resident #10 was found lying flat on his stomach between the wall and the bed with a bleeding laceration above his eye. Resident #10 was sent to the hospital via 911 for further evaluation and treatment. Review of a written statement regarding Resident #10's fall dated 04/08/26 by LPN Supervisor #400 revealed the after the aide reported rolling the resident away from her and out of bed the nurse educated CNA #525 that she should be rolling residents towards her and not away from her when assisting residents in bed. Review of the hospital summary report for Resident #10 dated 04/14/26 revealed the resident was admitted to hospital on [DATE] following the fall out of bed and was treated for left distal femur fracture and head laceration which required sutures. During an interview on 5/04/26 at 1:28 P.M., Resident #10 stated an aide rolled him out of bed on 04/08/26 when she was providing incontinent care. Resident #10 stated he was rolled over the right (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	side of the bed and the caregiver was on the opposite side of the bed when she rolled him. Resident #10 stated that because of the fall he broke his left leg and received stitches to a laceration on his forehead. During an interview on 05/05/26 at 9:50 A.M., CNA #525 verified on 04/08/26 when she was providing incontinence care to Resident #10, she rolled the resident away from her, and the resident continued to roll over and fell off the bed landing on the floor. During an interview on 5/05/26 at 10:42 A.M., the Director of Nursing (DON) stated the best practice for rolling a resident while providing care to residents in bed was to roll a resident towards the caregiver to lower the chance for falls. During an interview on 05/05/26 at 11:55 A.M., LPN Supervisor #400 stated the best practice was to roll a resident towards the caregiver for bed mobility if there was only one care giver present. During an interview on 05/07/26 at 10:06 A.M., MDS RN #350 verified she made the health status note dated 01/27/26 documenting Resident #10 frequently required two staff for hygiene and mobility. MDS RN #350 confirmed she interviewed staff that provided care to Resident #10, and they stated Resident #14 often required the assistance of two staff. Review of the undated facility policy titled Fall Program Policy/Procedure revealed the facility's goal was to minimize resident risk for falling and sustaining injury without compromising functional mobility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility policy, the facility failed to store and prepare food in a sanitary manner to prevent contamination and spoilage. This had the potential to affect all residents except for one (#68) that did not consume food from the kitchen due to a diet of nothing by mouth. The facility census was 68 residents. Findings include: 1.Observation on 05/04/26 at 9:43 A.M. with Executive Chef (EC) #6051 revealed the walk- freezer in the main kitchen located in the basement revealed it contained the following items: a box of strawberry pastries opened and exposed to air, two bags of undated dinner rolls, a box of pork chops opened and exposed to air. Interview on 05/04/26 at 9:43 A.M. with EC #605 confirmed the undated and open-to-air items in the walk-in freezer.2. Observation on 05/05/26 at 11:44 A.M. of the main kitchen with Dietary General Manager (DGM) #610 revealed in the revealed there was food debris and several gnats flying above the floor drain on the ground in front of the industrial sized cooking appliances as staff were cooking. Interview on 05/05/26 at 11:44 A.M. with DGM #610 confirmed the food debris and gnats to the grate in the main kitchen. 3. Observation on 05/06/26 from 10:09 A.M. with EC #605 revealed the walk-in freezer in the main kitchen contained a box of cheese manicotti that was not properly sealed and a box of cookie dough opened and exposed to air. Interview on 05/06/26 at 10:09 A.M. with EC #605 confirmed the opened and exposed to air items in the walk-in freezer. Review of the facility policy titled Food and Supply Storage revised January 2026 revealed the procedure was to cover, label and date unused portions and open packages.Review of the facility policy titled Pest Control revised January 2025 revealed the food and nutrition services department should be free of all rodents and insects.

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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 residents received adequate grooming and nail care. This affected two (Residents #44 and #70) of two residents reviewed for activities of daily living (ADLs). The facility census was 68 residents. Findings include: 1. Review of the medical record for Resident #44 revealed an admission date of 04/01/22 with diagnoses including dementia, traumatic subdural hematoma and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #44 dated 03/16/26 revealed the resident had severe cognitive impairment and was required maximal assistance with grooming and hygiene. Review of the care for Resident #44 dated 10/31/22 revealed Resident #44 had a self-care performance deficit. Interventions included staff were to assist with and perform ADLs as needed. Observation on 05/04/26 at 11:49 A.M. revealed Resident #44 had facial hair to the chin approximately one inch in length. Observation on 05/05/26 at 8:24 A.M. with the Director of Nursing (DON) revealed Resident #44 had facial hair to the chin approximately one inch in length. Interview on 05/05/26 at 8:35 A.M. with the DON confirmed staff should have shaved Resident #44's facial hair. 2. Review of the medical record for Resident #70 revealed an admission date of 10/22/25 with diagnoses including atrial fibrillation, malignant neoplasm of skin and protein-calorie malnutrition. Review of the MDS assessment for Resident #70 dated 04/24/26 revealed the resident had moderate cognitive impairment and required maximal staff assistance with personal hygiene. Review of the care plan for Resident #70 dated 10/22/25 revealed the resident had an ADL self-care performance deficit. Interventions included staff were to check nail length and trim and clean on bath day and as necessary. Observation 05/04/26 at 10:41 A.M. revealed Resident #70's fingernails were long and had an unidentified brown substance under the nails. Interview on 05/04/26 at 10:42 A.M. with Resident #70 confirmed she would like to have her fingernails cut and cleaned. Observation on 05/05/26 at 8:25 A.M. with the DON revealed Resident #70's fingernails were long and had an unidentified brown substance under the nails. Interview on 05/05/26 at 8:26 A.M. with the DON confirmed staff should have cut and cleaned Resident #70's fingernails. Review of the facility policy titled Activities of Daily Living undated revealed residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure insulin vials were properly labeled and stored. This affected two (Residents #2 and #25) of 17 residents with medications stored in the Three North medication cart. The facility census was 68 residents. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 01/14/25 with diagnoses including diabetes mellitus type two and chronic kidney disease. Review of the physician's orders for Resident #2 revealed an order dated 06/08/25 for Lantus insulin 10 units at bedtime. Review of the Medication Administration Record (MAR) for Resident #2 dated April 2026 revealed the resident received Lantus insulin daily from 04/23/26 through 04/30/26. Review of the MAR for Resident #2 dated May 2026 MAR revealed the resident received Lantus insulin daily from 05/01/26 through 05/04/26. Observation of the Three-North medication cart on 05/05/26 at 2:00 P.M. with Licensed Practical Nurse (LPN) #435 revealed Resident #2's Lantus insulin vial was dated on 03/26/26. Interview on 05/05/26 at 2:00 P.M. with LPN #435 verified Resident #2's Lantus insulin vial should have been discarded on 04/23/26, 28 days from the date it was removed from the refrigerator and placed on the medication cart. 2. Review of the medical record for Resident #25 revealed an admission date of 04/21/26 with diagnoses including diabetes mellitus type two and congestive heart failure. Review of the physician's orders for Resident #25 revealed an order dated 04/28/25 for Lantus insulin 20 units at bedtime. Review of the MAR for Resident #25 dated April 2026 revealed the resident received Lantus insulin 04/28/26, 04/29/26 and 04/30/26. Review of the MAR for Resident #25 dated May 2026 MAR revealed the resident #25 received Lantus insulin from 05/01/26 through 05/04/26. Observation of the Three-North medication cart on 05/05/26 at 2:00 P.M. with LPN #435 revealed Resident #25's Lantus insulin injector-pen was not dated when placed on the medication cart. Interview on 05/05/26 at 2:00 P.M. with LPN #435 verified Resident #25's Lantus insulin injector-pen should have been dated when removed from the refrigerator and placed on the medication cart. Interview on 05/07/26 at 10:12 A.M. with the Director of Nursing verified Lantus insulin had a 28-day expiration date after opening and/or storage at room temperature, i.e. being placed on the medication cart. Review of the facility's contracted pharmacy services Product Expiration Dates document revised January 2022 revealed Lantus insulin vials and pen-injectors had a 28-day expiration date after opening and/or storage at room temperature, i.e. being placed on the medication cart. Review of the policy titled Storage of Medications undated revealed that drug containers that had missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals were to be returned to the dispensing pharmacy or destroyed.