

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER Maple Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 515 South Maple Street Eaton, OH 45320	

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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review and staff interview, the facility failed to ensure money from a resident fund account (RFA) was returned in a timely manner following the resident's discharge. This affected one (#60) out of the three residents reviewed for resident fund accounts. The facility census was 52.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #60 revealed an admitted [DATE] with medical diagnoses of schizophrenia, chronic obstructive pulmonary disease, asthma, hypertension, and anemia. Review of the medical record for Resident #60 revealed a discharge date of [DATE].</p> <p>Review of the medical record for Resident #60 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/07/23, which indicated Resident #60 had moderate cognitive impairment and required supervision with toileting, bathing, bed mobility and transfers.</p> <p>Review of the RFA statement for Resident #60 revealed a balance of \$50.87 on 12/01/23. Review of the RFA statement revealed the balance was refunded to Resident #60 on 02/09/24 and the RFA was closed.</p> <p>Interview on 11/05/24 at 1:08 P.M. with Business Office Manager (BOM) #215 confirmed Resident #60 was discharged from the facility on 11/20/23 and the resident's RFA remaining balance was not disbursed until 02/09/24. BOM #215 confirmed Resident #60 had transferred to another facility where she remained as a resident for at least six weeks after discharge. BOM #215 stated the facility did not have a policy for RFA.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158172.</p>

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure staff followed infection control procedures during medication administration. This affected one (#51) out of the two residents observed for medication administration. The facility census was 52.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of Parkinson's disease, arthritis, hypertension, anxiety, heart failure, and depression.</p> <p>Review of the medical record for Resident #51 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/24/24, which indicated Resident #51 had moderate cognitive impairment and was independent with eating and bed mobility, required supervision with toileting and transfers, and required partial/moderate staff assistance with bathing.</p> <p>Review of the medical record for Resident #51 revealed a physician order dated 02/27/23 for Carbidopa-Levodopa 25-100 milligram (mg) one tablet by mouth four times per day, an order dated 02/28/23 for glucosamine 400 mg one tablet by mouth daily and Primidone 50 mg one tablet by mouth three times per day, an order dated 10/11/24 for Buspar 5 mg one tablet by mouth three times per day, an order dated 01/07/24 for hydroxyzine 25 mg one tablet by mouth two times per day, and an order dated 02/06/24 for Coreg 3.125 mg one tablet by mouth two times per day.</p> <p>Observation on 11/05/24 at 8:25 A.M. revealed Registered Nurse (RN) # 202 prepare Resident #51 medications for administration. The observation revealed RN #202 place carbidopa-levodopa, glucosamine, Primidone, Buspar, hydroxyzine, and Coreg tablets into his bare hands prior to placing medications into a medication cup. The observation revealed RN #202 observed Resident #51 consume the medications.</p> <p>Interview on 11/05/24 at 9:06 A.M. with RN #202 confirmed he had not performed hand hygiene before or after medication administration and that he placed Resident #51's medications into his bare hands prior to administration.</p> <p>Review of the facility policy titled, Medication Administration, stated only persons licensed by the State to prepare, administer and document the administration of medications may do so. The policy stated the medications must be administered in accordance with the orders, including any required time frame. The policy also stated staff shall follow established facility infection control procedures (i.e. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable.</p> <p>The deficiency was based on incidental findings discovered during the course of this complaint investigation.</p>