STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365557	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Gardens Rehabilitiation and Nursing Center	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, review of a facility self-reported incident (SRI), staff and legal guardian interviews, and policy review, the facility failed to implement their abuse policy by ensuring a resident's legal guardian and physician were notified of an allegation of potential sexual abuse. This affected one (#12) out of the three residents reviewed for abuse. The facility census was 53. Findings include: 1. Review of the medical record for the Resident #12 revealed an admitted [DATE] with medical diagnoses of multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), dementia, Depression, and peripheral vascular disease (PVD). The medical record revealed a discharge of date 11/11/24. Review of the medical record for Resident #12 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/21/24, which indicated Resident #12 had moderate cognitive impairment and was dependent for all activities of daily (ADL's) except required set-up with eating. The MDS revealed Resident #12 was non-ambulatory. Review of the medical record for Resident #12 revealed no documentation related to Resident #51 being found in her room and allegation of possible sexual abuse. Review of the medical record for Resident #12 revealed no documentation to support the legal guardians or physician were notified of the allegation of sexual assault. 2. Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of COPD, anxiety, congestive heart failure, schizoaffective disorder, and chronic ischemic heart disease. Review of the medical record for Resident #51 revealed a quarterly MDS, dated [DATE], which indicated Resident #51 was cognitively intact and was independent with all ADL's except required supervision with bathing. Review of the medical record for Resident #51 revealed a nurses' note dated 11/07/24 at 11:08 A.M. stated Resident #51 continued 15-minute checks due to being in a female room unsupervised. The resident has stayed in room thus far today. (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

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility SRI dated 11/11/24 revealed on 11/06/24 there was an allegation of potential sexual abuse by Resident #51 towards Resident #12. Review of the SRI revealed the investigation was ongoing and a conclusion had not been made. Review of the statement written by State tested Nursing Assistant (STNA) #115 stated when he walked into Resident #12's room he witnessed Resident #51 on top of Resident #12's bed leaning over with one leg on her bed and his pants halfway off his bottom. The statement by STNA #115 continued to state when Resident #51 noticed STNA #115 he told the STNA not to tell anybody that he saw him in the room. The statement concluded that STNA ran out of the room to get two nurses to redirect Resident #51 back out. Interview on 11/13/24 at 10:19 A.M. interview with Registered Nurse (RN) #166 confirmed she worked on 11/06/24 and during report around 7:10 P.M. State tested Nursing Assistant (STNA) #115 came to the nurses' station and informed her Resident #51 was found in Resident #12's room and STNA #115 had concerns that something inappropriate had occurred. RN #166 stated when she entered Resident #12's room she observed Resident #51 sitting in his wheelchair and he was observed pulling Resident #12's sheet up to cover her abdominal region. RN #166 stated she had Resident #51 leave Resident #12's room immediately. RN #166 stated she asked Resident #12 if Resident #51 had touched her inappropriately and Resident #12 denied being touched by Resident #51 and stated she felt safe in the facility but also stated she did not want Resident #51 to enter her room again. RN #166 stated she asked permission from Resident #12 to look underneath her sheet and was given authorization to do so. RN #166 stated she observed Resident #12's brief to be loose and slightly opened. RN #166 stated she again asked Resident #12 if she had been sexually assaulted to which Resident #12 denied. RN #166 stated the incident was very suspicious to her, so she called the Director of Nursing (DON) around 7:25 P.M. and notified her concern for possible sexual abuse. RN #166 stated the Administrator arrived at the facility between 8:00 P.M. and 8:30 P.M. and both the Administrator and RN #166 interviewed Resident #12 who repeated that she had not been sexually assaulted and stated she felt safe in the facility. RN #166 confirmed she did not notify Resident #12's Legal Guardian or physician of the concern of possible sexual assault. Interview on 11/13/24 at 10:50 A.M. with Administrator stated he was notified on 11/06/24 by the DON of a concern for possible sexual abuse of Resident #12 by Resident #51. Administrator stated he went to the facility and interviewed Resident #12 who denied any sexual assault. Administrator stated he interviewed STNA #115 who stated he found Resident #51 in Resident #12's room with his knee up on Resident #12's bed and that Resident #51 told STNA #115 not to say anything. Administrator stated STNA #115 immediately left and went to get the nurse. Administrator confirmed the incident occurred on 11/06/24 but confirmed the SRI was not reported until 11/11/24. Administrator confirmed an investigation began immediately and the investigation into the SRI was still in progress. Administrator stated Resident #51 was put on 15-minute staff checks on 11/06/24 and was changed to one-on-one supervision on 11/07/24 and had remained on one-on-one supervision since 11/07/24. Interview on 11/13/24 at 10:55 A.M. with DON confirmed the medical record for Resident #12 revealed no documentation related to concern for possible sexual abuse or that Resident #12's legal guardian or physician were notified of the incident. Interview on 11/13/24 at 11:35 A.M. with Resident #12's legal guardian stated the facility notified both he and Resident #12's mother of the concern for possible sexual assault involving the resident on 11/11/24. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated revised 11/01/19, stated the facility would investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident or Misappropriation of Resident property, including injuries of unknown sources. The policy stated if a third party is accused or suspected (not a staff member) the facility would take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation and /or referring the matter to the appropriate authorities. The policy stated the Resident Representative, and the attending physician should be notified of the incident. The policy stated documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and Resident Representative, and any treatment provided. This deficiency represents non-compliance investigated under Complaint Number OH00159734.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on review of the medical record reviews, review of a facility self-reported incident (SRI), staff interviews, and policy review, the facility failed to report an allegation of potential sexual abuse to the Ohio Department of Health in a timely manner. This affected one (12) out of the three residents reviewed for abuse. The facility census was 53. Findings include: 1. Review of the medical record for the Resident #12 revealed an admitted [DATE] with medical diagnoses of multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), dementia, Depression, and peripheral vascular disease (PVD). The medical record revealed a discharge of date 11/11/24. Review of the medical record for Resident #12 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/21/24, which indicated Resident #12 had moderate cognitive impairment and was dependent for all activities of daily (ADL's) except required set-up with eating. The MDS revealed Resident #12 was non-ambulatory. Review of the medical record for Resident #12 revealed no documentation related to Resident #51 being found in her room and allegation of possible sexual abuse. 2. Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of COPD, anxiety, congestive heart failure, schizoaffective disorder, and chronic ischemic heart disease. Review of the medical record for Resident #51 revealed a quarterly MDS, dated [DATE], which indicated Resident #51 was cognitively intact and was independent with all ADL's except required supervision with bathing. Review of the medical record for Resident #51 revealed a nurses' note dated 11/07/24 at 11:08 A.M. stated Resident #51 continued 15-minute checks due to being in a female room unsupervised. The resident has stayed in room thus far today. Review of a facility SRI dated 11/11/24 revealed on 11/06/24 there was an allegation of potential sexual abuse by Resident #51 towards Resident #12. Review of the SRI revealed the investigation was ongoing and a conclusion had not been made. Review of the statement written by State tested Nursing Assistant (STNA) #115 stated when he walked into Resident #12's room he witnessed Resident #51 on top of Resident #12's bed leaning over with one leg on her bed and his pants halfway off his bottom. The statement by STNA #115 continued to state when Resident #51 noticed STNA #115 he told the STNA not to tell anybody that he saw him in the room. The statement concluded that STNA ran out of the room to get two nurses to redirect Resident #51 back out. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 10:19 A.M. interview with Registered Nurse (RN) #166 confirmed she worked on 11/06/24 and during report around 7:10 P.M. STNA #115 came to the nurses' station and informed her Resident #51 was found in Resident #12 ' s room and STNA #115 had concerns that something inappropriate had occurred. RN #166 stated when she entered Resident #12 ' s room she observed Resident #51 sitting in his wheelchair and he was observed pulling Resident #12 ' s sheet up to cover her abdominal region. RN #166 stated she had Resident #51 leave Resident #12 ' s room immediately. RN #166 stated she asked Resident #12 if Resident #51 had touched her inappropriately and Resident #12 denied being touched by Resident #51 and stated she felt safe in the facility but also stated she did not want Resident #51 to enter her room again. RN #166 stated she asked permission from Resident #12 to look underneath her sheet and was given authorization to do so. RN #166 stated she observed Resident #12 ' s brief to be loose and slightly opened. RN #166 stated she again asked Resident #12 if she had been sexually assaulted to which Resident #12 denied. RN #166 stated the incident was very suspicious to her, so she called the Director of Nursing (DON) around 7:25 P.M. and notified her concern for possible sexual abuse. RN #166 stated the Administrator arrived at the facility between 8:00 P.M. and 8:30 P.M. and both the Administrator and RN #166 interviewed Resident #12 who repeated that she had not been sexually assaulted and stated she felt safe in the facility. Interview on 11/13/24 at 10:50 A.M. with Administrator stated he was notified on 11/06/24 by the DON of a concern for possible sexual abuse of Resident #12 by Resident #51. Administrator stated he went to the facility and interviewed Resident #12 who denied any sexual assault. Administrator stated he interviewed STNA #115 who stated he found Resident #51 in Resident #12's room with his knee up on Resident #12's bed and that Resident #51 told STNA #115 not to say anything. Administrator stated STNA #115 immediately left and went to get the nurse. Administrator confirmed the incident occurred on 11/06/24 but confirmed the SRI was not reported until 11/11/24. Administrator confirmed an investigation began immediately and the investigation into the SRI was still in progress. Administrator stated Resident #51 was put on 15-minute staff checks on 11/06/24 and was changed to one-on-one supervision on 11/07/24 and had remained on one-on-one supervision since 11/07/24. Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated revised 11/01/19, stated if the event that caused the allegation involved an allegation of abuse or serious bodily injury, it should be reported to the Ohio Department of Health immediately, but no longer than 24 hours from the time the incident/allegation was made know to the staff member. This deficiency represents non-compliance investigated under Complaint Number OH00159734.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, review of a facility self-reported incident (SRI), staff interview, and policy review, the facility failed to ensure staff intervened when a concern was identified regarding potential resident to resident sexual abuse. The affected one (#12) out of three residents reviewed for abuse. The facility census was 53. Findings include: 1. Review of the medical record for the Resident #12 revealed an admitted [DATE] with medical diagnoses of multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), dementia, Depression, and peripheral vascular disease (PVD). The medical record revealed a discharge of date 11/11/24. Review of the medical record for Resident #12 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/21/24, which indicated Resident #12 had moderate cognitive impairment and was dependent for all activities of daily (ADL's) except required set-up with eating. The MDS revealed Resident #12 was non-ambulatory. Review of the medical record for Resident #12 revealed no documentation related to Resident #51 being found in her room and allegation of possible sexual abuse. 2. Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of COPD, anxiety, congestive heart failure, schizoaffective disorder, and chronic ischemic heart disease. Review of the medical record for Resident #51 revealed a quarterly MDS, dated [DATE], which indicated Resident #51 was cognitively intact and was independent with all ADL's except required supervision with bathing. Review of the medical record for Resident #51 revealed a nurses' note dated 11/07/24 at 11:08 A.M. stated Resident #51 continued 15-minute checks due to being in a female room unsupervised. The resident has stayed in room thus far today. Review of a facility SRI dated 11/11/24 revealed on 11/06/24 there was an allegation of potential sexual abuse by Resident #51 towards Resident #12. Review of the SRI revealed the investigation was ongoing and a conclusion had not been made. Review of the statement written by State tested Nursing Assistant (STNA) #115 stated when he walked into Resident #12's room he witnessed Resident #51 on top of Resident #12's bed leaning over with one leg on her bed and his pants halfway off his bottom. The statement by STNA #115 continued to state when Resident #51 noticed STNA #115 he told the STNA not to tell anybody that he saw him in the room. The statement concluded that STNA ran out of the room to get two nurses to redirect Resident #51 back out. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 10:19 A.M. interview with Registered Nurse (RN) #166 confirmed she worked on 11/06/24 and during report around 7:10 P.M. STNA #115 came to the nurses' station and informed her Resident #51 was found in Resident #12's room and STNA #115 had concerns that something inappropriate had occurred. RN #166 stated when she entered Resident #12's room she observed Resident #51 sitting in his wheelchair and he was observed pulling Resident #12's sheet up to cover her abdominal region. RN #166 stated she had Resident #51 leave Resident #12's room immediately. RN #166 stated she asked Resident #12 if Resident #51 had touched her inappropriately and Resident #12 denied being touched by Resident #51 and stated she felt safe in the facility but also stated she did not want Resident #51 to enter her room again. RN #166 stated she asked permission from Resident #12 to look underneath her sheet and was given authorization to do so. RN #166 stated she observed Resident #12's brief to be loose and slightly opened. RN #166 stated she again asked Resident #12 if she had been sexually assaulted to which Resident #12 denied. RN #166 stated the incident was very suspicious to her, so she called the Director of Nursing (DON) around 7:25 P.M. and notified her concern for possible sexual abuse. RN #166 stated the Administrator arrived at the facility between 8:00 P.M. and 8:30 P.M. and both the Administrator and RN #166 interviewed Resident #12 who repeated that she had not been sexually assaulted and stated she felt safe in the facility. RN #166 confirmed STNA #115 left Resident #12 alone in her room with Resident #51 while he went to get staff assistance. Interview on 11/13/24 at 10:50 A.M. with Administrator stated he was notified on 11/06/24 by the DON of a concern for possible sexual abuse of Resident #12 by Resident #51. Administrator stated he went to the facility and interviewed Resident #12 who denied any sexual assault. Administrator stated he interviewed STNA #115 who stated he found Resident #51 in Resident #12's room with his knee up on Resident #12's bed and that Resident #51 told STNA #115 not to say anything. Administrator stated STNA #115 immediately left and went to get the nurse. Administrator confirmed the incident occurred on 11/06/24 but confirmed the SRI was not reported until 11/11/24. Administrator confirmed an investigation began immediately and the investigation into the SRI was still in progress. Administrator stated Resident #51 was put on 15-minute staff checks on 11/06/24 and was changed to one-on-one supervision on 11/07/24 and had remained on one-on-one supervision since 11/07/24. Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated revised 11/01/19, stated the facility would investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident or Misappropriation of Resident property, including injuries of unknown sources. The policy stated if a third party is accused or suspected (not a staff member) the facility would take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation and /or referring the matter to the appropriate authorities. This deficiency represents non-compliance investigated under Complaint Number OH00159734.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff and resident interviews, and review of the Resident Assessment Instrument (RAI) 3.0 manual, the facility failed to ensure a comprehensive person-centered care plan was updated with current interventions. This affected one (#51) out of the three residents reviewed. The facility census was 53. Findings include: Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, congestive heart failure, schizoaffective disorder, and chronic ischemic heart disease. Review of the medical record for Resident #51 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #51 was cognitively intact and was independent with all ADL's except required supervision with bathing. Review of the medical record for Resident #51 revealed no documentation to support a comprehensive person-centered care plan was developed for behavioral concerns with the interventions of 15-minute checks or one on one supervision. Review of the facility document titled 15-minute check sheet, dated 11/06/24, revealed Resident #51 was started on 15-minute staff checks on 11/06/24 at 7:45 P.M. until 11/07/24 at 5:45 P.M. Review the facility staffing from 11/06/24 to 11/12/24 revealed staff had been scheduled to provide Resident #51 with one-on-one supervision 24 hours per day. Interview on 11/13/24 at 8:38 A.M. with State tested Nursing Assistant (STNA) #147 stated Resident #51 had been put on one-on-one supervision after an allegation that Resident #51 had inappropriately touched a female resident. STNA #147 stated she had worked 11/07/24, 11/09/24 and 11/12/24 and provided the one-on-one supervision for Resident #51 for day shifts. Interview on 11/13/24 at 8:45 A.M. with Licensed Practical Nurse (LPN) #134 confirmed Resident #51 was put on 15-minute checks on 11/06/24 and then was put on one-on-one supervision on 11/07/24. LPN #134 stated Resident #51 was put on one-on-one supervision to ensure he did not enter any female resident rooms. Interview on 11/13/24 at 8:47 A.M. with Resident #51 confirmed he was found in a female resident's room on 11/06/24 and had been under staff supervision she that incident. Resident #51 denied any allegation of abuse. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 10:50 A.M. with Administrator stated he was notified on 11/06/24 by the Director of Nursing (DON) of a concern for possible sexual abuse of Resident #12 by Resident #51. Administrator stated he went to the facility and interviewed Resident #12 who denied any sexual assault. Administrator stated he interviewed STNA #115 who stated he found Resident #51 in Resident #12's room with his knee up on Resident #12's bed and that Resident #51 told STNA #115 not to say anything. Administrator stated STNA #115 immediately left and went to get the nurse. Administrator confirmed he initiated a Self-Reported Incident (SRI) and an investigation into the allegation. Administrator stated Resident #51 was put on 15-minute staff checks on 11/06/24 and was changed to one-on-one supervision on 11/07/24 and had remained on one-on-one supervision since 11/07/24. Interview on 11/13/24 at 10:55 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #51 did not contain documentation to support Resident #51's comprehensive person-centered care plan included the one-on-one supervision by staff effective 11/07/24. Review of the RAI 3.0 manual, dated October 2023, page 4-8 stated the comprehensive care plan is an interdisciplinary (IDT) communication tool which must include measurable objectives and time frames. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI manual stated the care plan must be reviewed, and revised, periodically, and the services provided or arranged must be consistent with each resident's written plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00159734.