

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/24/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of Self-Reported Incidents (SRI), interviews and facility policy review, the facility failed to ensure supervision was provided during smoke break which resulted in resident to resident abuse. This affected one resident (Resident #30) of three reviewed for abuse. The facility census was 63. Review of the medical record revealed Resident #3 had an admission date of 08/31/21 with diagnoses of alcohol induced persisting dementia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 was cognitively intact. Resident #3 did not exhibit physical or verbal behaviors. Review of the Smoking Safety Screen dated 05/05/26 revealed Resident #3 was safe to smoke with supervision. Review of the care plan revealed Resident #3 had behavior problem related to being verbally abusive to roommate and others and loud w/ staff at times. Interventions include education on successful coping and interaction strategies. Resident #3 had a care plan which documented the resident had the potential to be verbally aggressive related to dementia dated 09/03/24. The goal was for the resident to verbalize understanding of need to control verbally abusive behavior. Interventions included when the resident becomes agitated to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. Resident #3 had a care plan dated 06/15/26 that documented the resident had the potential to be physically aggressive to peers related to dementia and poor impulse control, the goal was for the resident not to harm others, interventions included when the resident becomes agitated to intervene before agitation escalates, guide away from the source of distress and engage calmly in conversation. Further review revealed Resident #3 is a smoker with interventions including supervision while smoking. Review of the medical record for Resident #30 revealed an admissions date of 11/26/25 with the most recent readmission date of 05/20/26. Diagnoses included bipolar II, borderline personality disorder, muscle weakness and repeated falls. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #30 was cognitively intact. Resident #30 did not exhibit physical or verbal behaviors. Review of the Smoking Safety Screen completed on 05/20/26 revealed Resident #30 was safe to smoke with supervision. Review of the care plan revealed Resident #30 revealed a care plan dated 02/09/26 which documented the resident exhibits verbal aggression including yelling, threatening language, insults or hostile tone towards staff and peers. Interventions include using calm non-confrontational communication. Further review revealed Resident #30 was a smoker with interventions including supervision while smoking. Review of Resident #30's progress note dated 06/14/26 at 9:00 A.M. revealed the resident was out in the designated smoking area with Laundry Aide #75. Resident #30 was asked by another Resident (#3) if she could borrow her lighter and Resident #30 stated no. The other resident called Resident #30 profane names and Resident #30 stood up and pointed at the other resident and stated that is the last time you will call me that, you call me that all the time and I'm sick of it. At this point Laundry Aide #75 came into the building to find a nurse. As reported by both residents the other resident grabbed onto Resident #30's arm and pushed her to the ground. Resident #30 had a bruise on her left knee and left inner arm. Resident #30 was helped up off her knee by Licensed Practical Nurse (LPN) #1 who was the nurse who arrived on the (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
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scene and assisted Resident #30 back into the building. Review of the Self-Reported Incident dated 06/14/26 revealed on the morning of 06/14/26, two female residents (#3 and #30) were involved in an altercation in the main courtyard. An argument started during a supervised smoke break. The supervising attendant reported both residents began arguing intensely and name calling. The attendant repeatedly requested for them to calm down when Resident #30 stood from her wheelchair and walked towards Resident #3 who was in her wheelchair. Shortly after, Resident #3 grabbed Resident #30 and allegedly knocked Resident #30 to the ground. When a nurse arrived to assist, Resident #30 was on one knee on the ground near Resident #3 who remained in her wheelchair. Resident #3 and #30 were the only two in the courtyard. The residents were separated and taken to their halls/units. Resident #30 stated she stood up from her wheelchair because she was not going to tolerate being called horrible names. She reported once she stood next to Resident #3 she was grabbed by the left arm and then shoved to the ground. Resident #30 described landing on her back, but given the evidence that seems unlikely. Resident #3 stated that Resident #30 had punched her in the face, however, no evidence (no redness or bruising) to indicate that occurred. No charges were filed or arrests made. Resident #30 complained of back pain so X-rays were obtained. The results of those X-rays revealed no damage or fractures. The allegation was unsubstantiated. Interview with the Administrator on 06/23/26 at 3:13 P.M. confirmed the altercation between Resident #3 and Resident #30 occurred towards the end of the smoke break and the two had gotten into a name calling event. The Administrator verified there was a laundry aide supervising the smoke break, but stated at the time of the incident between the two residents, the laundry aide had gone inside to get help from the nurse. Observation of smoking on 06/24/26 at 8:43 A.M. revealed two residents did not have their smoking products in the lock box. Housekeeping #80 who was supervising smoking was observed to walk away from the smoking area, around the corner, and out of sight of the smoking area to see if activities staff had the resident's smoking products. Interview with Housekeeping #80 on 06/24/26 at 9:17 A.M. revealed housekeeping staff usually supervise the first two smoke breaks of the day. Housekeeping #80 verified during smoke break the staff supervising the smoking should not leave the smoking area. Housekeeping #80 stated she thinks the facility should have a walkie in the smoking area so they can call for help when needed. Housekeeping #80 verified on this day she did have to walk away from the smoke break to retrieve smoking materials, confirming she did not have eyes on all residents during the smoke break. Interview on 06/24/26 at 9:52 A.M. with Laundry Aide #75 verified she was supervising the smoke break on 06/14/26 when Resident #30 and Resident #3 began to argue and call each other names. Laundry Aide #75 revealed she attempted to get Resident #3 to go back back in the facility, but Resident #30 began to stand up, and she (laundry Aide #75) panicked because she could not help the residents. Laundry Aide #75 stated she went inside to the front to get LPN #1 but had to go back to the living room and LPN #1 told her to get LPN #10. Laundry Aide stated LPN #10 told her to get LPN #26. Laundry Aide #75 stated at most the residents were outside alone for two minutes while she ran for help. Interview with the Director of Nursing on 06/24/26 at 11:40 A.M. verified the Resident #30's fall on 06/14/26 was not on the incident log due to it being a physical altercation incident. Interview on 06/24/26 at 1:57 P.M. with Resident #3 revealed she did not remember what exactly happened on 06/14/26, but she was satisfied the facility was keeping Resident #30 away from her. She stated her and Resident #30 now have separate smoke breaks and verified smoke breaks are always supervised. Interview on 06/24/26 at 2:44 P.M. with Certified Nursing Assistant # 43 revealed she was working the day of the altercation, and stated she has supervised smoke breaks before and never seen an altercation. CNA # 43 stated staff are supposed to have a walkie on them when they go to supervise smoke break to call for help if needed, but the facility will run low on them. Interview on 06/24/26 at 3:22 P.M. with Resident #30 revealed during the smoke break on 06/14/26, she was outside with Resident #3 and Laundry Aide #75 who was supervising the smoke break. Resident #30 stated Resident #3 had asked to use her lighter and when she refused, Resident #3 began calling her names. Resident #30 stated Laundry Aide #75 did not (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervene and went inside. Resident #30 stated she and Resident #3 were the only ones outside, and she told Resident #3 she was not going to let her keep talking to her like that. Resident #30 confirmed she stood up and was pulled to the ground by Resident #3. Resident #30 stated that she had bruising on her arm and pain in her back since the incident. Resident #30 stated that an X-ray of her back was completed with no findings. Resident #30 verified that now she had separate smoke breaks and can sign herself out to smoke as wanted. Review of the undated facility policy titled, Safe Smoking Policy revealed smoke breaks will always be supervised. This deficiency represents non-compliance investigated under Complaint Number 3050549.		