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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Gardens Rehabilitiation and Nursing Center	515 South Maple Street Eaton, OH 45320

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on medical record review, observation, interview, review of training competency records, review of the manufacturers guidelines, facility record review, policy review, and review of current Occupational Safety and Health Administration (OSHA) guidance, the facility failed to ensure glucometers were cleaned after use. This affected one (Resident #60) out of two residents observed for glucometer use. In addition, the facility failed to maintain documentation of annual fit testing for staff for a respirator required for respiratory protection when working with Coronavirus Disease 2019 (COVID-19) positive residents. This had the potential to affect all 64 residents who resided in the facility. The facility census was 64.Findings included:1. Review of the medical record revealed the facility admitted Resident #60 on 03/07/25. Diagnoses included type two diabetes mellitus. Review of Resident #60's Care Plan Report, included a focus area initiated 03/11/25, that indicated the resident had diabetes mellitus. Interventions directed staff to monitor blood sugar levels. During an observation of medication pass for Resident #60 on 02/25/26 at 6:16 A.M., Licensed Practical Nurse (LPN) #02 performed a blood glucose test with a result of 144 milligrams per deciliter (mg/dL). The LPN #02 placed the used glucometer on the top of the medication cart, removed their gloves, performed hand hygiene, and documented the results of the test. LPN #02 then placed the glucometer into the top drawer of the medication cart. LPN #02 had not cleaned the glucometer prior to placing in the top drawer of the medication cart. Interview at the time of the observation LPN #02 stated she was not told she had to clean the glucometer.During an interview on 02/27/26 at 11:19 A.M., the Assistant Director of Nursing (ADON), who also served as the Infection Preventionist (IP), stated she expected that multiuse equipment, including glucometers, were cleaned and disinfected after each use. During an interview on 02/27/26 at 11:33 A.M., LPN #03 stated she worked with and trained LPN #02 on how to complete a fingerstick glucose check, clean the glucometer, and then reviewed the cleaning procedure. She stated LPN #02 had demonstrated competency during their training.During an interview on 02/27/26 at 1:05 P.M., the Director of Nursing (DON) stated she expected the glucometers were cleaned per the manufacturer's instructions. The DON stated she had immediately provided re-education to LPN #02 on the morning of 02/25/2026 following the medication pass observation.Review of a Competency Assessment Obtaining a Fingerstick Glucose Level for LPN #02, specified, Always ensure that the blood glucose meters intended for reuse are cleaned and disinfected between resident uses. The document further specified, Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The competency was checked as demonstrated and signed by the Observer/Trainer, LPN #03 on 02/23/26.Review of a facility policy titled, Obtaining a Fingerstick Glucose Level, revised 10/2011, specified, 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.Review of the manufacturer guideline revealed The [name of manufacturer] Multi Blood Glucose Monitoring System instructions for use, undated, specified, The meter should be cleaned and disinfected after use on each patient. The [name of manufacturer] Multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The policy also specified, The cleaning (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedure is needed to clean dirt, blood, and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens.2. Review of an undated Nursing Phone Roster revealed a list of 80 current employees from all departments.During interviews on 02/27/26 between 6:30 PM. and 7:00 P.M., four nurses, Registered Nurse (RN) #07, Licensed Practical Nurse (LPN) #03, #08, and #09, four Certified Nurse Aides (CNA) #10, #11, #12, and #13, the Dietary Manager [DM], two Dietary Aides (DA) #14, and DA #15, the Admissions Director, and Housekeeper #16, all stated they had been fit tested in 2025.During an interview on 02/27/26 at 5:00 P.M., the DON stated they would look for the fit testing documentation. During an interview on 02/27/26 at 6:34 P.M., the ADON/IP stated she and Central Supply Medical Records (CS/MR) #05 were responsible for performing fit testing for staff. She stated that fit testing was performed upon hire, annually, and with any significant changes. The ADON/IP stated that the fit documentation should be maintained, but she found no documentation for 2025.During a follow-up interview on 02/27/26 at 6:50 P.M., the DON stated the Nursing Phone Roster provided at the start of the survey was a current list of employees. The DON stated she expected fit testing documentation for employees to be maintained and readily available.Review of a facility policy titled, Mask Fitting Policy and Procedure, revised 05/28/2020, indicated, The purpose of this policy is to follow OSHA Standards 1910.134 for mask fit testing for those employees that may come in contact with an airborne pathogen in home or facility settings. This testing will be conducted at the time of hire then annually moving forward.Review of the 1910 Occupational and Safety Health Standards Subpart: 1910 Subpart 1 Personal Protective Equipment - Standard Number: 1910.134, titled, Respiratory protection, indicated the following:- 1910.134(f)(2) - The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter.- 1910.134(m)(2)(ii) - Fit test records shall be retained for respirator users until the next fit test is administered.This deficiency represents noncompliance investigated under Complaint Number 2725949.

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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 observation, interview, and facility policy review, the facility failed to ensure two of four medication carts were locked when not within the line of sight of facility staff. This had the potential to affect all 64 residents who resided in the facility. The facility census was 64.Findings Included:During an observation and concurrent interview on 02/25/26 at 6:01 A.M., at the nurse's station on the 300 Hall, a medication cart and a treatment cart, located between the Minimum Data Set (MDS) office and the nursing station, were observed unlocked. There were no staff members in the hallway where the carts were located. Three staff were observed in an adjacent hallway walking away from the carts. At 6:08 A.M., Licensed Practical Nurse (LPN) #01 returned to the nursing station. LPN #01 stated the carts should have been locked when not in use. Medications in the medication cart included lisinopril (used to treat high blood pressure), Amlodipine (used to treat high blood pressure and coronary artery disease), and glipizide (used to treat type two diabetes).During an interview on 02/27/26 at 11:19 A.M., the Assistant Director of Nursing, who also served as the Infection Preventionist, stated she expected medication carts to always be locked when not in use.During an interview on 02/27/26 at 1:05 P.M., the Director of Nursing stated she expected medication carts to be locked if the nurse could not see the drawers and supervise the cart.Review of a facility policy titled, Storage of Medications, revised April 2007, specified, 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerator, carts, and boxes. [sic]) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Any malfunctioning medication storage, especially secure/locked carts or containers must be reported immediately to prevent medications diversion and provide safety for patient's medications.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on medical record review, observation, resident and staff interview, and facility policy review, the facility failed to ensure foods were served per resident preference. This affected one (Resident #44) out of five residents reviewed for food preferences. The facility census was 64. Findings included:Review of the medical record revealed the facility admitted Resident #44 on 01/19/26. Diagnoses included hyperlipidemia, gastro-esophageal reflux disease (GERD), adult failure to thrive (FTT), atherosclerotic heart disease (AHD), ascites, and depression. Review of a Diagnosis Report indicated Resident #44 also had diagnoses that included protein calorie malnutrition (PCM), cirrhosis of the liver, type 2 diabetes mellitus (DM2), and hyperlipidemia. Review of Resident #44's Care Plan Report included a problem statement that indicated the resident had nutritional problems related to severe PCM, cirrhosis of the liver, DM2, hyperlipidemia, GERD, adult FTT, and AHD. Interventions directed staff to provide and serve diet as ordered and monitor/record intake for each meal. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/30/2026, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS also indicated Resident #44 ate independently after the tray was set up by staff. During an interview on 02/23/26 at 11:36 A.M., Resident #44 stated they were served beans sometimes, which was a food the resident disliked, was recorded as a food the resident did not like and populated on the tray tickets from dietary services. Resident #44 stated that when beans were received, the resident ate around the beans. During a concurrent observation and interview on 02/24/26 at 12:15 P.M., Resident #44 was observed with their lunch meal, which included a bowl of baked beans. Resident #44 did not eat the baked beans and stated, I don't like beans and they know it. Interview on 02/24/26 at 12:22 P.M. with Certified Nurse Aide (CNA) #04 revealed she provided a lunch tray to Resident #44 that day and that she looked at the tray ticket to make sure the resident received the correct diet. CNA #04 stated she did not see on the tray ticket that the resident did not like beans, but she should have noticed that and offered Resident #44 an alternative to the baked beans. During an interview on 02/25/2026 at 8:20 A.M., the Dietary Manager (DM) stated that on admission to the facility, Resident #44 provided a list of foods the resident did not like, including beans, and Resident #44 was consistent in that the resident did not like beans. The DM stated that when beans were on the menu, Resident #44 should receive a different vegetable. The DM further stated that Resident #44 should have received double carrots instead of beans for lunch on 02/24/26, and if beans were provided it was because staff may not have paid attention to the tray ticket.During a telephone interview on 02/25/26 at 10:20 A.M., the Registered Dietitian (RD) revealed that if a resident expressed food preferences, those preferences should be communicated to the DM, who would update the tray ticket. The RD stated food preferences should be listed on the tray ticket and honored. During an interview on 02/27/26 at 11:20 A.M., the Administrator stated that during admission and throughout the resident's stay, the staff asked residents about preferences. That information was entered into the facility's tray ticket system, and any likes/dislikes were printed on the tray ticket. The Administrator stated that if the tray ticket listed a dislike, staff should not serve it but should serve the resident something comparable. The Administrator stated that he expected dietary staff to honor resident requests. During an interview on 02/27/26 at 11:45 A.M., the Regional Director of Clinical Operations stated she expected the facility to follow what the patient wanted to eat and provide an alternative for items expressed as a dislike.Review of a facility policy titled, Resident Food Preferences, revised July 2017, indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. The policy further indicated, 1. Upon the resident's admission (or within forty eight (48) hours after his/her admission) the Dietician or dietary staff will identify a resident's food preferences. 2. When possible, staff will interview the resident (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. The Dietician and nursing staff, assisted by the Physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. The policy continued, 7. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. and 9. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. This deficiency represents noncompliance investigated under Complaint Number 2718114.