STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366139	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Hills Skilled Nursing & Rehabilitation	31054 State Route 93 North McArthur, OH 45651

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observation, record review, review of the Administrator job description and personnel file and interview, the facility failed to employ a qualified administrator to ensure the facility was effectively and efficiently administered to allow all residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being and to ensure staff were knowledgeable of who the administrator was. This had the potential to affect all 34 residents residing in the facility. Findings Include: On [DATE] between 10:45 A.M. and 12:41 P.M. interviews with Certified Nursing Assistant (CNA) #216, Licensed Practical Nurse (LPN) #223, and Registered Nurse (RN) #220 revealed none of the staff knew who the current facility Administrator was. The staff revealed they were not familiar with Interim Administrator (IA) #260 or Administrator #275. During the interview with the CNA, the CNA revealed she had not met IA #260 or Administrator #275. She stated she was aware there had been a new administrator hired but had not yet been introduced. The CNA revealed she had not been provided with any education related to who she should report to should she need an Administrator. During the interview with the LPN, the LPN indicated if there was a concern or issue, she would go to the Director of Nursing (DON); however, the LPN revealed she did not know who to contact if for some reason the issue involved the DON. The staff interviewed denied any contact information or chain of command information being available for staff. An interview on [DATE] at 11:14 A.M. with IA #260 via telephone and Administrator #275 revealed Administrator #275 identified herself as the facility incoming Administrator. However, during the conversation, Administrator #275 revealed she was not a Licensed Nursing Home Administrator (LNHA) in the State of Ohio. On [DATE] at 11:05 A.M. interview with the Director of Nursing (DON) revealed IA #260 started in the facility on [DATE] and worked between this facility and a sister facility. Then Administrator #275's first day working at the facility as the Administrator was on [DATE]. Administrator #275 was the only administrator present/working in the facility on [DATE] when the survey investigation started. Review of Administrator #275's application dated [DATE] revealed the applicant's address was in [NAME] Virginia. Administrator #275 was hired as the facility Administrator on [DATE] with a start date on [DATE]. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of an Administrator offer letter dated [DATE] revealed Administrator #275 was offered an Administrator position on [DATE] with a start date on [DATE]. On [DATE] at 2:47 P.M. a telephone interview with Director of Operations (DOO) #270 revealed she was responsible for hiring the facility Administrator. DOO #270 confirmed she was aware Administrator #275 did not have a current Licensed Nursing Home Administrator's license (LNHA) in the State of Ohio at the time she was hired. However, DOO #270 stated Administrator #275 was working under the supervision of IA #260 (who was licensed in the State of Ohio as an LNHA). DOO #270 confirmed Administrator #275 was on-site at the facility on [DATE] and [DATE] without IA #260 present. Concerns investigated during the onsite investigation related to administrative oversight were identified related to the facility boiler system as noted: Review of the boiler inspection dated [DATE] revealed Certificate of Operation expired: The Certificate of Operation is expired due to either a non-passed inspection within the last 12 months or non-payment of fees. Please contact the Division of Industrial Compliance support staff within 30 days of this order. Observation on [DATE] at 11:58 A.M. of the boiler room revealed the boiler had a red tag on it dated [DATE]. Boiler needs serviced was written on the tag. There was no further evidence of attempts by the facility to follow up on the expired Certificate of Operation for the boiler until [DATE], following surveyor intervention. On [DATE] at 2:47 P.M. during the interview with DOO #270, the DOO confirmed the boiler was not certified for use in [DATE] and stated this was due to unpaid fees from 2018. However, DOO #270 revealed she was not aware of the issue prior to the surveyors entering the facility to investigate a complaint related to the boiler. DOO #270 confirmed it was the Administrator's responsibility to ensure bills/invoices were paid in a timely manner. Review of the undated Administrator Job Description revealed the primary purpose of the position was to direct the day-to-day functions of the facility in accordance with federal, state, and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Furthermore, duties included to ensure the building and grounds are maintained in good repair. Ensure that the facility was maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies were maintained to perform such duties and services. Keep abreast of the economic condition and situation and make adjustments as necessary to assure the continued ability to provide quality care. Qualifications included the individual must possess a current, unencumbered Nursing Home Administrator's license or meet the licensure requirements of this State. This deficiency is an incidental findings identified during the investigation of Complaint Number OH00162507.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observation, record review, facility policy review and staff interview, the facility failed to ensure all essential mechanical equipment (boiler) was maintained in a functional and safe operating condition. The had the potential to affect all 34 residents residing in the facility. Findings Include: Review of the boiler inspection dated [DATE] revealed Certificate of Operation expired: The Certificate of Operation is expired due to either a non-passed inspection within the last 12 months or non-payment of fees. Please contact the Division of Industrial Compliance support staff within 30 days of this order. Observation on [DATE] at 11:58 A.M. of the boiler room revealed the boiler had a red tag on it dated [DATE]. Boiler needs serviced was written on the tag. There was no further evidence of attempts by the facility to follow up on the expired Certificate of Operation for the boiler until [DATE], following surveyor intervention. On [DATE] at 1:17 P.M. information provided via email from Regional Maintenance (RGM) #208 revealed the boiler failed inspection in [DATE] due to unpaid fees from 2018. On [DATE] at 2:47 P.M. interview with Director of Operations (DOO) #270 confirmed the boiler was not certified for use in [DATE] and stated this was due to unpaid fees from 2018. However, DOO #270 revealed she was not aware of the issue prior to the surveyors entering the facility to investigate a complaint related to the boiler. DOO #270 confirmed it was the Administrator's responsibility to ensure bills/invoices were paid in a timely manner. Review of the facility policy, Resident Environmental Quality, dated ,d+[DATE], revealed the facility would be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. The deficiency represents non-compliance investigated under Complaint Number OH00162507.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observation, record review, facility policy review and interview, the facility failed to maintain a safe, functional and comfortable environment for all residents and failed to timely address an alarming carbon monoxide detector to ensure resident safety. This had the potential to affect all 34 residents residing in the facility. The facility census was 34. Findings Include: Review of the Fire Department Run Report dated 02/08/25 revealed the fire department was dispatched to the facility at 9:10 A.M. for a possible gas or carbon monoxide (CO) leak at the facility. There was no gas detected on the first floor of the facility but upon entering the basement, the multi-gas meter started alarming with carbon monoxide level at 87 parts per million (ppm) (normal/average levels 0.5-5.0 ppm). Evacuation and ventilation procedures were started. The gas was shut off at the meter by the fire department. Gas and CO level began falling rapidly once the gas was shut off and normal readings were restored. The facility's HVAC company isolated the boiler. The residents and staff were cleared to return into the building once normal readings were maintained. The Maintenance Director was instructed not to use the boiler under any circumstances until it had been inspected and/or repaired by a boiler technician and also inspected and approved b the Ohio Department of Commerce State Boiler Inspector. One worker was transported to the hospital due to possible exposure to CO and natural gas. Interview on 02/12/25 at 11:42 A.M. with Maintenance Director (MD) #206 revealed he was called in to the facility on [DATE] at approximately 8:00 A.M. by the floor nurse due to the carbon monoxide detector in the boiler room alarming. MD #206 arrived at the facility at approximately 8:30 A.M. and residents were already being evacuated from the facility. The Fire Department arrived at the facility and were directed to the boiler room. MD #206 stated the boiler was supposed to be serviced but it was not serviced by the HVAC company. They just turned it on. MD #206 was responsible for testing carbon monoxide detectors but had not been keeping any documentation of the tests he conducted. MD #206 stated the Fire department and the gas company shut down the boiler quickly and shortly after allowed residents and staff to return inside the building. There was no evidence of any carbon monoxide on the first or second floors where the residents resided, it was only found in the basement. Observations during the initial tour on 02/12/25 from 11:58 A.M. to 12:30 P.M. revealed the boiler had a red tag dated 08/12/24 with the written indication, boiler needs serviced. The boiler was also tagged by the local gas company dated 02/08/25 that stated, Danger. The boiler was not currently in use and was being serviced by the facility's Heating, Ventilation, and Air Conditioning (HVAC) company. There was a carbon monoxide detector observed inside the boiler room. The detector was tested and was in good working condition. Observations of resident rooms on the first and second floor revealed the rooms were supplied heat through packaged terminal air conditioning (PTAC) units. There were not any carbon monoxide detectors observed on the first or the second floors of the facility. Interview on 02/12/25 at 12:30 P.M. with MD #206 confirmed there were not any CO detectors installed on the first or second floors where residents resided. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/12/25 at 2:34 P.M. with Housekeeping Aide (HKA) #204 revealed she had arrived to the facility approximately one hour before her shift started, at approximately 6:00 A.M. HKA #204 stated as soon as she arrived she heard an alarm going off in the basement. HKA #204 and HKA #210 found the alarm was in the boiler room. HKA #210 informed the floor nurse. Two nurses changed the batteries in the CO detector and it stopped alarming for ten to 15 minutes and then started alarming again. The nurse was notified again of the alarm going off. HKA #204 stated then the fire department was called and everyone was evacuated out into the parking lot until it was cleared. HKA #210 was transported to the emergency room (ER) due to feeling light headed, dizzy, and short of breath. She was treated in the ER for about three hours with 100% oxygen and was told she had carbon monoxide poisoning. There were not any residents who were transported to the hospital that she was aware of. HKA #204 stated approximately two hours and 30 minutes had passed between when the detector was first alarming and when the fire department was contacted. Interview on 02/12/25 at 4:14 P.M. with HKA #210 revealed he arrived for his shift at approximately 5:30 A. M. on 02/08/25. Upon arriving he heard an alarm sounding in the basement but was not able to determine exactly where it was coming from until HKA #204 arrived at approximately 6:00 A.M. and found the alarm was coming from the boiler room. The floor nurse on the first floor was notified. Two nurses changed the batteries in the detector and it did stop alarming for approximately ten to 15 minutes but then started alarming again. The floor nurse was notified again. HKA #210 stated then the building was evacuated to the parking lot until the fire department and the gas company confirmed it was safe to return inside the building. HKA #210 reported having a headache and was evaluated by the paramedics but declined to go to the hospital. Interview on 02/12/25 at 4:48 P.M. with Licensed Practical Nurse (LPN) #214 confirmed she started her shift at approximately 6:00 A.M. on 02/08/25. LPN #214 first notified MD #206 at approximately 8:00 A.M. that a CO detector was alarming in the boiler room. MD #206 did not answer and LPN #214 attempted again at approximately 8:30 A.M. At approximately 8:50 A.M., LPN #214 notified the Assistant Director of Nursing (ADON) who instructed to call the fire department. LPN #214 attempted to call the fire department but there was no answer so she then dialed 911 at approximately 9:00 A.M. The dispatcher instructed LPN #214 to start evacuating the building. By approximately 10:00 A.M., the fire department and other companies who had responded had assessed and cleared the building to be safe and the residents and staff were allowed to go back inside. LPN #214 stated she and another nurse changed the batteries in the CO detector in the boiler room between 6:30 A.M. and 7:00 A.M. and the beeping stopped. LPN #214 stated she was not notified again that the alarm was going off again until approximately 8:00 A.M. Review of the boiler inspection reports revealed the facility's boiler had been red tagged due to non-payment of fees from 2018 at the time of the inspection on 08/12/24. The inspection did not indicate there was any need for repairs to be made to the boiler at that time. Review of facility undated policy titled Emergency Preparedness Program, revealed within zero to two hours, the facility should initiate the Incident Briefing of all appointed staff. Include the following: nature of the problem and safety of staff, residents, and visitors. Review of the facility policy titled Resident Environmental Quality, dated 08/2023 revealed the facility would be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The deficiency represents non-compliance investigated under Complaint Number OH00162507.