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	04/02/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, record review, staff interviews, resident interviews, Ombudsman electronic communication, and policy review, the facility failed to provide sufficient staff to meet residents' needs. This affected three residents (#24, #28, and #30) of three residents reviewed for personal care needs and had the potential to affect all 33 of 33 residents in the facility. Findings include: 1. Record review revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including unspecified dementia and hypertension. Review of a nursing note dated 03/13/25 at 4:32 P.M. by Director of Nursing (DON) revealed she was made aware Resident #30 was outside, when she went outside to check, the first floor nurse was with Resident #30. Resident #30 had wandered out the side door with construction workers because she wanted to take a walk. Resident #30 was immediately assessed and had no injuries, she was taken back into the facility, and her wander-guard was checked and working properly. All wander-guards were checked and working properly. The elopement assessment was updated. Review of an Elopement Evaluation dated 03/14/25 at 12:41 P.M. by the DON revealed Resident #30 did not have a history of eloping while at home, she did have a behavior pattern of wandering, she wanders aimlessly, and wandering behavior was likely to affect the safety of herself/others. Resident #30's wandering was likely to affect the privacy of others and she was a recent admission. She had an elopement score of seven. Interview on 03/20/25 at 2:09 P.M. with Certified Nursing Assistant (CNA) #304 revealed she was concerned because Resident #30 eloped in the previous week and the DON lied to her husband. CNA #304 stated there are not enough staff in the facility to meet the needs of residents because the unit she is assigned to, she has 22-25 residents by herself and when she requests additional help, she is told the nurse is considered help. CNA #304 stated there was a time where she and the nurse were caring for a resident in their room and they heard the door alarms go off and a resident had made it into a stairwell because there was no one to provide additional supervision. CNA #304 stated most of the residents on her unit require the use of a hoyer lift, which requires two staff to operate. CNA #304 stated there are times call lights go unanswered for an extended period of time due to lack of staff. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/20/25 at 4:01 P.M. with Registered Nurse (RN) #355 revealed she was working on 03/13/25 when Resident #30 left the building unsupervised. RN #355 stated she was downstairs and two agency staff and an agency nurse were working upstairs, the alarms began to go off. The aide downstairs had to go upstairs and check both doors because the agency staff did not. RN #355 stated she was approached a few minutes later by an agency aide who asked, is that a resident?. RN #355 stated she saw Resident #30 about 50 yards away from the building in a grassy area between the driveway and the trees near the road. RN #355 stated she took off running to get to Resident #30. RN #355 stated the elopement was not witnessed, but since the alarms for the stairwells had gone off, the resident had likely walked down the stairs and out the side staff exit, which did not lock or have an automatic locking system for residents wearing wander-guards. RN #355 stated the DON took care of documentation for the incident. Interview on 03/20/25 at 4:10 P.M. with CNA #395 revealed when Resident #30 got out of the facility, the construction workers were already gone, so they did not let her out. CNA #395 stated Resident #30 wandered out alone because the staff entrance does not lock, so once someone is in the stairwell, they are able to leave. CNA #395 stated she was in a resident room on the first floor, when she came out she was told to check the stairwells because the alarms were going off. CNA #395 stated she walked upstairs and turned off the alarm and told the agency staff the alarm was due to a wander-guard. CNA #395 stated when she came back downstairs, RN #355 had Resident #30 back in the building. Interview on 03/27/25 at 2:36 P.M. with the DON revealed when Resident #30 eloped, she made it to the end of the parking lot. DON stated the construction workers saw her leave the building. The DON stated Resident #30's family was notified, she was assessed and she was wearing a functioning wander-guard. The DON stated there was another resident having a medical emergency at the time of the incident, so all upstairs staff were in the other residents room and did not hear the alarms. Interview on 03/27/25 at 3:18 P.M. with CNA #404 revealed she is agency staff. CNA #404 stated she and the agency nurse were in a room with a resident having a medical emergency, but she was not sure where the other agency aide was. CNA #404 stated due to the room being on the opposite end of the hallway, they were not able to hear the door alarming and the doors open after being pushed for 15 seconds. CNA #404 stated Resident #30 could only have been outside for about five or six minutes because she was found by the other agency aide (CNA #416) when she went outside for break. CNA #404 stated the facility does not have enough staff because the second floor has about six residents who require a hoyer lift and they have one aide working the floor. CNA #404 stated the aide who works downstairs is supposed to come up to help, but doesn't have time to very often. CNA #404 stated the DON does help when she can due to call-offs. Interview on 03/27/25 at 3:23 P.M. with CNA #416 revealed she was headed outside to her break when she saw an older lady outside who did not look right. CNA #416 stated the lady was walking towards the street, stopped, then sat down in the grass. CNA #416 went back inside and grabbed RN #355 to ask if it was a resident, then RN #355 began running to the lady and told CNA #416 to get the DON. CNA #416 stated she is agency staff and it was her first time working at the facility and she did not realize the resident was missing from the second floor where she had been working. CNA #416 stated she was in a room with CNA #404 and a nurse with a resident who was having a medical emergency so she did not see or hear Resident #30 leave. 2. Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including dementia and hypertension. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an email from Ombudsman #101 dated 03/20/25 at 10:04 A.M. revealed she had investigated and verified complaints related to call lights taking greater than 30 minutes and up to three hours to get assistance from staff. Interview on 03/20/25 at 2:09 P.M. with Certified Nursing Assistant (CNA) #304 revealed she had three residents on the unit, including Resident 28, who had excoriated bottoms due to delayed incontinence care. CNA #304 stated there are not enough staff in the facility to meet the needs of residents because the unit she is assigned to, she has 22-25 residents by herself and when she requests additional help, she is told the nurse is considered help. CNA #304 stated there was a time where she and the nurse were caring for a resident in their room and they heard the door alarms go off and a resident had made it into a stairwell because there was no one to provide additional supervision. CNA #304 stated most of the residents on her unit require the use of a hoyer lift, which requires two staff to operate. CNA #304 stated there are times call lights go unanswered for an extended period of time due to lack of staff. Interview on 03/20/25 at 4:10 P.M. with CNA #395 revealed there is absolutely not enough staff to meet resident needs and there were several residents upstairs with raw butts and Resident #28 stays bright red. Interview on 03/24/25 at 8:02 A.M. with CNA #304 revealed she would have to get an aide from the first floor to assist her with Resident #28's incontinence care because she required a two-person assist. CNA #304 confirmed Resident #28 did not have incontinence care yet since her arrival at 6:05 A.M. Interview on 03/24/25 at 8:04 A.M. with CNA #150 revealed she had worked all night on the second floor. CNA #150 stated she last provided incontinence care to Resident #28 at about 5-5:15 A.M. Observation on 03/24/25 at 8:05 A.M. of incontinence care for Resident #28 revealed the skin on the resident's front perineal and groin area was red. Both aides, CNA #304 and #150, stated the redness was typical for Resident #28 and barrier cream was applied after incontinence care. Resident #28's buttocks was also reddened and there was a pinpoint open area to her coccyx, which CNA #304 and #150 confirmed. Both aides also confirmed there is one aide upstairs and one aide downstairs. Interview on 03/27/25 at 2:36 P.M. with DON revealed she completes the schedules and it is based on PPD of 2.5. The DON stated she does aim for 2.75 contact hours per resident to account for acuity. The DON stated there were ten residents on the first floor and 22 on the second floor. The DON stated if staff are busy, management will step in to assist as needed. The DON confirmed she had spoken with Ombudsman #101 and was informed it took up to one hour for a call light to be answered, but was unaware of a call light going unanswered for three hours. Interview on 03/27/25 at 3:45 P.M. with Resident #24 revealed she was upset because she had her call light turned on for staff to remove her lunch tray, but no one had come yet. Resident #24 stated lunch was over hours ago and the tray should already be removed because it takes up space in her room. Resident #24's call light was not on during the interview. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a policy dated 08/2024 titled Staffing revealed the facility should provide sufficient staffing numbers with the skills necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Staffing numbers and the skill requirements are determined by the needs of the residents. This deficiency represents non-compliance investigated under Complaint Number OH00163080.

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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.	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** 47985 Based on record review, review of the administrator's job description, observations, review of the facility vendor and supplier bills, and interviews, the facility failed to ensure the facility was administered in a manner that enabled it to use it's resources effectively and efficiently including compliance with all financial obligations for the delivery of care to attain and maintain the highest practicable well being of each resident. This affected 33 of 33 residents residing in the facility. Findings included: 1. Review of information received from an anonymous complainant on 03/18/25 revealed the facility owed over $10,000 for their water bill, but due to it being a nursing facility the water department was either unable to or refused to issue a shut off notice. a .)Review of an invoice dated 04/06/24 from Stockmeister (plumbing, heating, and cooling repair company) revealed the facility owed $110 at the time of receipt for a service call related to the garbage disposal not working. Review of an invoice dated 04/24/24 from Stockmeister revealed the facility owed $2,427.63 for miscellaneous services at the time of receipt. Services included materials, tools, and labor to replace approximately 20 feet and one inch of galvanized pipe which was leaking in the basement ceiling above the water heaters with one inch copper pipe and press fittings. Review of an invoice dated 04/25/24 from Stockmeister revealed the facility owed $706.25 for the water heater tripping the breakers and not functioning correctly. The payment was due at the time of receipt. Review of an invoice dated 12/30/24 from Stockmeister revealed the facility owed $241.25 for the dishwasher drain being clogged. The payment was due at the time of receipt. Review of an invoice dated 12/30/24 from Stockmeister revealed the facility owed $190 due to the hot water tank having a low gas pressure warning being repaired. The payment was due at the time of receipt. Review of an invoice dated 12/30/24 from Stockmeister revealed the facility owed $918.76 for repairs to a floor drain backing up in basement. The payment was due at the time of receipt. Review of an invoice dated 12/30/24 from Stockmeister revealed the facility owed $660.43 for repairs to a heater in room [ROOM NUMBER]. The payment was due at the time of receipt. Review of an invoice dated 12/30/24 from Stockmeister revealed the facility owed $477.50 for repairs to water in the basement and the kitchen drain which was not draining properly. Payment was due at the time of receipt. (continued on next page)

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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 invoice dated 01/20/25 from Stockmeister revealed the facility owed $1,941.11 for repairs to a circulating pump for the water heater. The payment was due at the time of receipt. Review of an invoice dated 02/12/25 from Stockmeister revealed the facility owed $351.50 for repairs to heating unit and starting the boiler. Payment was due at the time of receipt. Review of an invoice dated 02/13/25 from Stockmeister revealed the facility owed $458.50 for repairs to a toilet in room [ROOM NUMBER]. Payment was due at the time of receipt. Review of an invoice dated 02/13/25 from Stockmeister revealed the facility owed $2,586.85 for repairs to a water leak on the main line in the basement. Payment was due at the time of receipt. Review of an invoice dated 02/13/25 from Stockmeister revealed the facility owed $1,061.48 for repairs for sewage backing up into drains in the basement. Payment was due at the time of receipt. Review of an invoice from 02/13/25 from Stockmeister revealed the facility owed $320.60 due to replacing a one-inch valve in basement. Payment was due at the time of receipt. Review of an invoice from 02/13/25 from Stockmeister revealed the facility owed $1,160.50 for a gas leak on 02/08/25. The carbon monoxide detectors were going off. The gas company checked for leaks, there were none. The gas company red-tagged the boiler and said the boiler was the issue and it was unsafe to run. Everything was turned back on and the pilot lights were re-lit. Everything was working properly at the time of services. Payment was due upon receipt. The total of the invoices came to $13,612.36. Interview on 03/20/25 at 12:32 P.M. with Stockmeister Representative (SR) #722 revealed the facility had several open invoices which were not paid. SR #722 stated payment is due at the time of receipt or within 30 days. SR #722 stated the facility is often behind on payments, but due to it being a nursing facility, they will not refuse services. b.) Interview on 03/20/25 at 9:11 A.M. with Water Department Representative (WDR) #717 revealed the facility owed $10,848.92 for their water bill which was over due. The WDR #717 stated the last payment made was $1,608.89 in December 2024. The WDR #717 stated the water department bills monthly. The WDR #717 stated the facility had been in arrears for a while because they pay a little bit at a time. The WDR #717 stated the facility was in arrears since 04/2024 and the amount continually goes up. The WDR #717 stated the facility used 460,000 gallons of water in 03/2025 which was a lot of water totaling to approximately $5,000 worth of water in one month. The WDR #717 stated she has called and left messages for someone at the facility and has received no call back. The WDR #717 stated they are not allowed to turn off the water because it is a nursing facility. c.) Interview on 03/20/25 at 12:24 P.M. with Fire Chief (FC) #713 revealed the fire department had to respond to the facility twice in 02/2025: once for a potential gas leak which ended up being due to the boiler and once due to the sprinkler system being down due to the boiler not working. FC #713 stated when they responded to the first incident on 02/08/25, the facility was unable to find a report regarding the boiler because it needed services but there was a deficiency with the bill. There was a tag dated 08/12/24 which stated boiler needs serviced. The assumption was the person who services the boiler left the tag there without telling anyone due to nonpayment. (continued on next page)

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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.	Interview on 03/20/25 at 1:37 P.M. with Licensed Practical Nurse (LPN) #380 revealed she was made aware the boiler has been tagged out for nonpayment and it would not be repaired until the company received payment. On 03/20/25 at 3:21 P.M., observation and interview with Maintenance Staff (MS) #338 revealed the boiler is still out of service. Interview on 03/27/25 at 8:47 A.M. with Director of Nursing (DON) revealed she was not able to confirm or deny anything related to billing because she does not take care of billing. The DON stated she would let the surveyor know who to talk to regarding bills, but the DON did not ever provide a contact person to the surveyor. Review of an undated document titled Job Description for Administrator revealed it is the responsibility of the Administrator to ensure the building and grounds are maintained in good repair, ensure the facility is maintained in a clean and safe manner for resident comfort and convenience by assuring necessary equipment and supplies are maintained to perform such duties and services, and ensure adequate supplies and equipment are on hand to meet the day-to-day operational needs of the facility and residents. Additionally, the administrator should assist in the establishment and maintenance of an adequate accounting system that reflects the operating cost of the facility, review and interpret monthly financial statements, keep abreast of the economic condition and situation and make adjustments as necessary to assure the continued ability to provide quality care. This deficiency represents non-compliance investigated under Complaint Number OH00163810. This deficiency is evidence of continued non-compliance from the survey dated 02/19/25.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47985 Based on record review and interview, the facility failed to ensure resident medical record documentation was accurate and not falsified. This affected three residents (#24, #26, and #28) of three sampled residents reviewed for accurate medical records. Findings included: Review of medical records for Residents #24, #28, and #26 revealed the director of nursing (DON) entered notes on 02/08/25 which stated Resident assessed noted no signs or symptoms of dizziness, nausea, headache, shortness of breath, confusion, or chest pains. Vital signs obtained and within normal limits. Family and MD (medical director) notified. Interview on 03/20/25 at 10:15 A.M. with the DON revealed she was on the phone with a nurse manager during the time of the gas leak incident (on 02/08/25), but she did not come to the facility. The nurse manager who was at the facility was who completed resident assessments on paper regarding the incident. Interviews on 03/20/25 with Licensed Practical Nurse (LPN) #380 and Registered Nurse (RN) #355 at 1:21 P. M. revealed they did not look into it, but did hear the DON had entered false assessments into the resident notes regarding an incident she was not in the building for. Interview on 03/27/25 at 8:47 A.M. with the DON confirmed she entered resident assessments into notes. The DON confirmed she did not complete the assessments and she was not in the facility when the nurse who completed the assessments was physically in the building. This deficiency represents non-compliance investigated under Complaint Number OH00163080.

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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** 47985 Based on observation, policy review, and interview, the facility failed to ensure the facility provided a safe, sanitary and comfortable environment for residents. This affected 33 of 33 residents residing in the facility. Findings included: Continuous observations on 03/20/25 from 8:39 A.M. to 8:49 A.M. revealed trash throughout the yard, parking lot and woods surrounding the facility. Trash including plastic grocery bags, cigarette butts, and Styrofoam food containers. There was an empty flower pot with three inches of standing water and a Styrofoam container in it with a black mold-like substance. There was a sidewalk next to the building leading to the back where the resident smoking area is. At the back corner of the building, there was a hole which appeared to be created from a water drip. The drop off into the hole was approximately three feet and the hole was starting to go underneath the sidewalk. There was no hand rail for the residents to use. Interview on 03/20/25 at 1:37 P.M. with Licensed Practical Nurse (LPN) #380 revealed she had concerns about a section of the ceiling in the laundry room in the basement falling in, the handrail off the back porch was loose and you cannot put weight on it, there was a crack in the concrete out front, a large hole near the sidewalk at the back corner of the building from a water drip and the sidewalk goes over it a little bit. LPN #380 stated some residents' wheelchairs are right at the edge of the sidewalk near the hole. LPN #380 stated there is a slab of concrete which raises up on the sidewalk when the ground expands due to cold weather. LPN #380 stated there is a large area of mold in the laundry room and there had been mold behind the nurses station but they just put new trim right over top of it. Interview and observations on 03/20/25 at 2:09 P.M. with Certified Nursing Assistant (CNA) #304 revealed she was concerned about an area in the laundry room by the dryers due to mold and the ceiling, filters not being cleaned in units causing them to stop working, the grab bars in the upstairs shower room were loose, the drain was broken, the shower was dirty and covered with mildew. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility tour completed with Maintenance Staff (MS) #338 on 03/20/25 starting at 3:21 P.M. revealed the laundry room had a six-foot long span of wall which was covered with a black mold-like substance, an area on the ceiling approximately four feet by four feet was collapsing in; the boiler room was observed and the boiler was out of service; the first floor shower room was observed with a sharps container overflowing with razors, there were three missing tiles on the shower floor as well as a broken drain; the shower had a build up of grime and mildew on the walls and floors in the grout; the second floor shower room had loose grab bars around the toilet, a missing drain, mildew streaks on the shower walls and floors; room [ROOM NUMBER] had a missing transition strip; a call light in room [ROOM NUMBER] (which was empty) was not working; the back porch, used only by staff, was unstable and wobbling; there was trash throughout the property including plastic bags, Styrofoam containers, and cigarette butts; a large hole next to the sidewalk from a water drip starting to corrode under the sidewalk. MS #338 confirmed all findings and stated he has made multiple efforts to make repairs in the facility but has not been provided with payment for tools and supplies required for improvements. Interview on 03/27/25 at 9:09 A.M. with LPN #380 revealed corporate staff came to the facility and attempted to improve the second floor nurses' station by adding a wooden trim. The trim was observed to have splinters at the far right side, the screws were sharp, and the left corner piece had fallen off leaving a sharp edge. LPN #380 also showed concern over a door handle which falls off when you grab it, leading into a room [ROOM NUMBER]. Interview on 03/27/25 at 10:15 A.M. with Corporate Nurse #101 regarding the trim revealed she felt the trim, but when asked if she had any concerns, she walked away without answering. Interview on 03/27/25 at 10:39 A.M. with MS #338 revealed he had concerns with the trim that was applied to the nurses' station because the edges were sharp and a piece had already fallen off. MS #338 stated he has a cut from the trim and showed a cut on her right, middle knuckle. MS #338 stated he was sent upstairs and instructed to remove the trim. Review of an undated policy titled Quality of Life- Homelike Environment revealed residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to extent possible. This deficiency represents non-compliance investigated under Complaint Number OH00163080. This deficiency is evidence of continued non compliance from the survey dated 02/19/25.