

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Maple Hills Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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:  366139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Maple Hills Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of a facility self-reported incident (SRI), and staff interview, the facility failed to ensure pre-operative laboratory testing was completed for a resident that was scheduled to have a surgical procedure performed to address kidney stones. This affected one (Resident #38) of two residents reviewed for pre-operative surgical procedures. Findings include: Review of Resident #38's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included acute pyelonephritis (a bacterial infection of the kidney), unspecified hydronephrosis (swelling of one or both kidneys due to the backup of urine often caused by a blockage in the urinary tract such as from kidney stones), and calculus of kidney (kidney stones). Review of Resident #38's progress notes revealed a nurse's note dated 10/03/25 at 10:27 A.M. by Licensed Practical Nurse (LPN) #113 that indicated the resident was complaining of lower abdominal discomfort. She had pallor (an unnatural lightness of the skin or mucous membranes often due to reduced blood flow or fewer red blood cells signaling conditions like anemia or shock) and her skin was clammy. The on-call physician was notified and a new order was received for the resident to be sent to the emergency room (ER) for an evaluation. A nurse's progress note dated 10/04/25 at 1:19 A.M. revealed the resident had been admitted to the hospital. She did not return to the facility until 10/15/25. Review of Resident #38's hospital records for her hospitalization between 10/03/25 and 10/15/25 revealed the resident was seen by urology while in the hospital for flank pain and taken to the operating room (OR) for further management. A cystoscopy (a medical procedure where a thin, lighted scope was used to look inside the urethra and bladder to diagnose or treat urinary issues like pain, bleeding, or blockage) was performed in the OR on 10/08/25 with ureteral stent removal, ureteroscopy, laser lithotripsy, ureteroscopic renal evacuation, and stent replacement. She was diagnosed with left urolithiasis, staghorn calculus (kidney stone) and developed septic shock post procedure. The hospital progress note indicated urology would need the rest of the stone burden addressed and urology was holding off at that time. Review of Resident #38's After Visit Summary (AVS) for the hospital stay 10/03/25 through 10/15/25 revealed the resident had two appointments scheduled under the What's Next section on the AVS. On 10/28/25, she had a Cystolithotripsy with laser, ureteroscopy, steerable ureteral stone evacuation, and stent insertion scheduled. She also had another procedure with the urologist scheduled for 11/11/25 at 2:15 P.M. The latter did not specify what the procedure was planned on 11/11/25. Review of Resident #38's physician's orders revealed a telephone order had been received on 10/25/25 at 10:48 A.M. for a urinalysis (U/A) with a culture and sensitivity (C&amp;S) to be collected for lab 10/27/25. The order indicated it must be done before surgery on 10/28/25. The resident's medical record was absent for any evidence of the U/A being completed as ordered and there was nothing documented in the resident's progress notes about her going out on 10/28/25 for her scheduled appointment. Further review of Resident #38's physician's orders revealed a telephone order had been received on 11/04/25 at 3:33 P.M. for a U/A and C&amp;S being ordered for the following morning. The resident was indicated to have surgery on 11/11/25. Review of the U/A and C&amp;S collected on 11/04/25 at 3:18 P.M. revealed the culture results were received on 11/07/25 (Friday) at 2:44 P.M. The culture results showed mixed pathology with greater than or equal to three organisms being isolated indicating probable contamination. There was instructions to contact the laboratory within 48 hours if identification was clinically indicated. Resident #38's medical record was absent for any evidence of the facility contacting the lab as instructed or to contact the urologist's office, who ordered the lab pre-operatively prior to her planned surgical procedure on 11/11/25, on 11/07/25 for further instructions. Review of a nurse's progress note by Registered Nurse (RN) #115 on 11/10/25 at 3:58 P.M. revealed the nurse made several calls to the urologist's office at the hospital where Resident #38 was supposed to have her procedure performed at to check on the schedule for surgery. She received a message earlier at 3:55 P.M. from the urologist's office that if they did not have the urine culture results within 30 minutes the resident was not going to be able to have her surgical procedure done on 11/11/25. Review of a nurse's progress note dated 11/11/25 at 1:35 P.M. indicated the previous U/A sample was contaminated and a new order was received for a U/A and C&amp;S to be drawn on Wednesday 11/12/25. Resident #38 had been seen by her advanced level provider on 11/11/25 for hematuria (blood in urine) and dysuria (pain upon urination). That specimen was collected on 11/11/25 at 11:20 P.M. Review of a nurse's</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Maple Hills Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Maple Hills Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the facility's cycle menu, review of food temperature logs, staff interview, and policy review, the facility failed to ensure residents received food that was procured from their food service supply company and was prepared in the facility's kitchen to ensure proper food handling and preparation to safe guard it from possible food-borne illnesses. This affected eight (Resident #5, #6, #11, #20, #22, #24, #31, and #35) out of 36 residents who resided in the facility. Findings include: Review of the facility's cycle menu for Week #1 of the Spring and Summer Menu revealed the scheduled meal for lunch on 09/16/25 included chicken tortilla rice bowl as the main entree. They were also having seasoned black beans, corn, and a Mexican Wedding Cookie. The cycle menu did not include an alternate meal choice, other than what was on the facility's alternate/ always available menu. Review of a food temperature log for the meals served on 09/16/25 revealed the dietary staff obtained hot food temperatures of the food items served for the lunch meal. Temperatures were obtained for the main entree chicken tortilla rice bowl and for the black beans and creamed corn. Lasagna was included under the miscellaneous category despite it not being one of the food items on the cycle menu. There was no temperature recorded for the lasagna to show the dietary staff checked to ensure it was at the proper temperature before being served to residents. On 12/16/25 at 10:25 A. M., an interview with Certified Nursing Assistant (CNA) #121 revealed she used to work in the facility's kitchen, but was now working as a nursing assistant. She reported several months ago that she made lasagna in her home and brought it in to the residents to eat. She initially denied knowledge of any staff ever doing that and did not think that was something they were able to do. It was not until she was directly asked, if she had cooked lasagna at home and brought in to the residents, that she admitted doing so. The residents had requested it as their special meal for the month and she could not tell them no. She stated she made a big old pan of it. She was told by the facility's previous Director of Nursing (DON) that she shouldn't do that, but did it anyway. On 12/16/25 at 10:56 A.M., an interview with RN #115 revealed there was one time that the residents asked for something special to be made for one of their meals. A staff member volunteered and brought in a lasagna that had been cooked at home for the residents. She confirmed CNA #121 was the staff member that brought the lasagna in and all residents that wanted it ate it. She was not sure what the facility's policy was on food brought in from outside sources. They allowed residents to do it (have food brought from home) and residents also had the right to order out for food from nearby restaurants, so she did not see what the difference was. On 12/16/25 at 12:34 P.M., an interview with Licensed Practical Nurse (LPN) #130 revealed there was one occasion a couple of months ago, when a staff member brought food in for the residents. It was a lasagna tray that had been cooked at home by CNA #121. She questioned if that was permitted to be done, but was told that someone there at the time had approved it. She had always been taught that no outside food could be brought in and shared with the residents. On 12/16/25 at 1:23 P.M., an interview with CNA #125 revealed she was aware of the special meal that was provided to the residents in the past couple of months or so. The residents picked what special meal they wanted each month. CNA #121 made two great big pans of lasagna at home and served it to the residents in the facility. She went into the kitchen and told the dietary staff they were not allowed to do that, but was told it had been approved. She then went to the Administrator, who told her that it had been approved and she was the one that approved it. The Administrator told her it was no different than the residents ordering out for food. She told the Administrator it was different, as those local restaurants the residents ordered food from were still inspected by the local health department and the aide's home where the lasagna was made was not inspected. On 12/16/25 at 3:08 P.M., an interview with Dietary Manager #108 revealed she had been the facility's Dietary Manager since March 2025. She was off the day a staff member cooked lasagna at home and brought into the facility for the residents. She did not find out about it until after it had already happened. She stated once she was aware, she put a stop to outside food being brought in, after that. It was not something the staff were able to do. Her dietary staff were not permitted to bring any outside food into the kitchen. The food they served had to come from the food service supply company the facility contracted with. She heard previous talk that an aide was talking about doing that, but nothing had been decided. She did an education with all her dietary staff during their next scheduled meeting that her rules and the State's rules were not to bring any outside food into the kitchen. She reported the residents had requested lasagna, as part of their special meal request during their Resident Council meeting. They usually prepared those special</p>		