

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: 366139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interview, review of a facility self reported incident form, and review of a facility job description, the facility failed to ensure staff implemented the assistance devices necessary to prevent accidents. This affected one resident (#35) of five sampled residents. The facility census was 34. Findings include: Review of the closed medical record for Resident #35 revealed an admission date of 05/22/26 and diagnoses including chronic obstructive pulmonary disease, diabetes, malignant neoplasm of the endometrium, and history of fracture of T11-T12 vertebrae. Review of the admission five day Minimum Data Set assessment revealed a brief interview for mental status score of 14, indicating intact cognition. It further documented the resident required supervision only with transfers and walking 10 feet. Review of a facility self reported incident form revealed on 06/01/26 Resident #35 was being transported to an appointment by Activities staff #23 in the facility van when a car pulled out in front of them. Activities staff #23 had to brake suddenly and Resident #35 came forward out of her wheelchair landing on her knees at approximately 8:45 A.M. The van was pulled over to the side of the road where Activities staff #23 opened the door to find the resident already attempting to get back into her wheelchair. Resident #35 stated she was fine, did not hit her head, and requested to continue on to her appointment so she got there on time. After the appointment, Resident #35 was returned to the facility and Activities staff #23 then reported the incident to nursing staff upon arrival (approximately 11:00 A.M.). The resident was assessed and determined to have abraded/bruised knees (right worse than left). X-rays were obtained and were negative for acute fractures. Upon questioning, Activities Staff #23 could not remember fastening the resident's seat belt upon leaving for the appointment. Interview with the Director of Nursing on 06/17/26 at 8:00 A.M. confirmed Resident #35 fell out of her wheelchair while being transported in the facility van to an appointment by Activities staff #23 on 06/01/26. She stated Activities staff #23 was also the Transportation Director. She confirmed Activities staff #23 did not notify nursing staff or 911 when the incident occurred on the van, and should have. She confirmed the resident should have been assessed for injury by medical personnel prior to getting up after falling out of the wheelchair. She confirmed the resident did not have a seatbelt on at the time of the incident and Activities staff #23 did not know if she had applied the required seat belt upon leaving the facility. Review of the undated job description for the position of transportation revealed the primary purpose of the position was to safely transport residents to medical appointments and recreational activities. The deficiency was corrected on 06/10/26 after the facility implemented the following corrective actions: On 06/01/26 Resident #35 was assessed for injuries by the Director of Nursing and Assistant Director of Nursing at 11:30 A.M. after returning to the facility from her appointment. On 06/01/26 X-rays of both knees and cervical, thoracic, and lumbosacral were completed for Resident #35 with no acute fractures noted. The physician was notified of the results on 06/01/26 with no new orders. On 06/01/26 all staff were trained on post fall interventions to include reporting immediately to nursing/calling 911 during transport and having resident assessed prior to moving resident off of the floor. Between 06/01/26 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 06/10/26, all staff who transport residents were re-trained on transportation safety by the Maintenance Director, including operation of security straps and safety/seatbelts with return demonstration. On 06/01/26 transportation staff was educated by the Director of Nursing to include clinical personnel to accompany on transports and at least two staff will document that the wheelchair is secured in the van and the resident is secured by seatbelt while being transported in the van. On 06/01/26 weekly audits of the van were started to ensure proper function, including seatbelts. This was being conducted by the Director of Maintenance. To be done weekly for four weeks then monthly for three months. On 06/02/26 a 30 day look back audit was completed by the Director of Nursing to identify any issues with previous transports. No other issues were identified besides Resident #35. On 06/02/26 the facility began audits of each transport by the facility to assess for proper seatbelt use by two staff prior to the resident being transported which was to continue for three months. On 06/03/26 weekly audits of all falls began by the Director of Nursing to determine if fall protocols were followed, including proper notification and timely assessment. To be done weekly for four weeks then monthly for three months. On 06/04/26 Activities staff/Transportation Director #23 was terminated from the facility. There were no identified accidents with resident transports between 06/02/26 and 06/17/26, the time of the onsite complaint investigation. This deficiency represents non-compliance investigated under Complaint Number 3032438.		