STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366191	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Nursing and Hta	400 Sexton Street Struthers, OH 44471

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review and review of facility policy the facility failed to ensure Resident #43's advance directives were accurate in the physician orders and care plan. This affected one resident (Resident #43) out of one resident (Resident #43) reviewed for advance directives. The facility census was 46. Findings included: Review of the medical record for Resident #43 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, osteoarthritis, and muscle wasting with atrophy. Review of the care plan dated 12/10/24 revealed Resident #43's advance directives indicated he was a full code. Review of the Do Not Resuscitate (DNR) Comfort Care form in Resident #43's medical record revealed on 12/13/24 Primary Care Physician (PCP) #482 signed the form indicating Resident #43 was a DNR comfort care- arrest. Review of the DNR Comfort Care form in Resident #43's medical record revealed on 12/26/24 PCP #482 changed Resident #43's advance directives from a DNR comfort care- arrest to a DNR comfort care. Review of Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had impaired cognition. Review of the April 2025 physician orders revealed Resident #43 had an advanced directive order dated 12/27/24 for a DNR comfort care- arrest. Interview on 04/08/25 at 11:49 A.M. and 12:34 P.M. with Licensed Practical Nurse (LPN)/ MDS #419 verified Resident #43's care plan was inaccurate as the care plan had identified Resident #43 as a full code and that he should have been a DNR comfort care. She also verified the physician order of DNR comfort care- arrest in the electronic medical record was also inaccurate as the physician order did not match the DNR Comfort Care form that indicated Resident #43 was to be a DNR-comfort care. (continued on next page)

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
	366191	A. Building B. Wing	04/14/2025

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/25 at 12:12 P.M. and 12:38 P.M. with the Director of Nursing (DON) verified the advanced directives were inaccurate in the care plan and physician orders. The DON verified the care plan indicated Resident #43 was a full code, the physician order in the electronic medical record indicated Resident #43 was a DNR comfort care- arrest and the DNR Comfort Care form in Resident #43's medical record indicated he was to be a DNR comfort care. The DON verified Resident #43 should have been a DNR comfort care. Review of the facility policy labeled, Advanced Directives dated January 2015 revealed advanced directives would be respected in accordance with state and facility policy. The policy revealed prior to admission the admissions coordinator, or the social service designee would provide written information regarding the right to formulate advanced directives. Any changes of an advance directive would be submitted in writing to the Administrator and/or Director of Nursing who would submit the changes to the care plan team for adjustments to the care plan. The Director of Nursing or designee would notify the attending physician of the advanced directives so that appropriate orders would be documented in the medical record and care plan.

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	366191	A. Building B. Wing	04/14/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, interview, and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers, timely identify new pressure ulcers and perform wound care using appropriate infection control practices. This affected one resident (#43) of one resident reviewed for pressure ulcers. This had the potential to affect four residents (#4, #9, #17, and #43) identified by the facility with pressure ulcers. Actual Harm occurred on 01/29/25 when Resident #43, who was dependent on staff assistance for most all activities of daily living (ADL) including toileting, and transfers, and required substantial to maximum assistance with rolling left and right in bed, was found to have an in-house acquired unstageable (full thickness tissue loss in which the actual depth of the ulcer was obscured by slough/ dead skin) pressure ulcer to his right gluteal fold (horizontal crease between the buttocks ad posterior upper thigh) per Registered Nurse (RN)/ Wound Nurse #449 as the wound bed contained 90 percent (%) slough. The facility failed to provide documented evidence of effective, comprehensive, and adequate interventions being in place to prevent the development of the pressure ulcer and to ensure the pressure ulcer was identified before being found as unstageable. Findings included: Review of the medical record for Resident #43 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, osteoarthritis, and muscle wasting with atrophy. Review of care plan dated 12/10/24 revealed Resident #43 was at risk for impaired skin integrity. Interventions included assess skin on admission, quarterly, annually and upon significant change, encourage and assist in turning and repositioning every two hours and as indicated, encourage nutrition and hydration supplements as ordered, incontinence care with barrier cream, keep linen clean, dry, and wrinkle free, keep skin clean and dry, treatments and dressings as ordered by the physician and pressure relieving cushion to wheelchair. Review of the re-admission Braden Scale (assesses risk for developing pressure ulcers) dated 12/27/24 and completed by Licensed Practical Nurse (LPN) #446 revealed Resident #43 was at high risk for developing pressure ulcers because his sensory perception was very limited, he was occasionally moist, he was bedfast, he had inadequate nutrition, he was very limited on mobility and had a problem with friction and shearing as he required moderate to maximum assistance with moving. Review of the Admission/ Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had impaired cognition and was dependent on toileting hygiene. The MDS assessment revealed during the assessment period rolling left and right and transfers were not attempted due to medical condition. He was at risk for pressure ulcers and had one unstageable pressure ulcer that was present on admission. Review of the nursing note dated 01/28/25 timed 4:36 A.M. and completed by RN #414 revealed Resident #43 had a new area to his right gluteal fold. There was no staging classification, description, and/or measurements noted per the nursing note or any other assessment form. (continued on next page)

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	366191	A. Building B. Wing	04/14/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Weekly Wound Observation Tool (documented as first observation in the note section) completed by RN/ Wound Nurse #449 and dated 01/29/25 revealed Resident #43 was found to have an unstageable pressure ulcer to his right gluteal fold that measured a length of 3.4 centimeters (cm), width of 2. 0 cm and 0.2 cm in depth. The wound bed contained 90 percent slough and 10 percent granulated tissue with moderate serosanguinous (combination of clear and blood) drainage. Primary Care Physician (PCP) #482 was notified and ordered to cleanse the wound with normal saline, pat dry, apply calcium alginate (a highly absorbent wound dressing), cover with foam dressing twice a day. The assessment revealed the pressure ulcer was present on admission. Review of an Outside Wound Clinic progress note dated 01/29/25 and completed by Wound Physician #483 revealed Resident #43 was seen in the clinic and new orders were received for the right posterior thigh (the facility identified as right gluteal fold) to cleanse with vashe (super-oxidized solution formulated to combat bacteria and facilitate wound healing), apply silver alginate (absorbent dressing with antimicrobial properties) and cover with silicone border dressing every day. Resident #43 was also seen for the pressure ulcer to his coccyx that was present on admission and a wound culture was taken of this area. There were no details including measurements or classification of the wounds in the progress note. Review of the Wound Culture completed on Resident #43's coccyx pressure ulcer obtained on 01/29/25 and resulted on 02/01/25 revealed mixed gram-negative organisms (bacteria) and rare gram-positive cocci (unique group of bacteria that cause various infections) in pairs. Review of an Outside Wound Clinic progress note dated 01/29/25 and completed by Wound Physician #483 revealed he reviewed the wound culture results for Resident #43 and ordered doxycycline (antibiotic) 100 milligram (mg) by mouth every 12 hours. The progress note revealed to continue same treatment to the right posterior thigh: cleanse with vashe, apply silver alginate and cover with silicone border dressing every day. The progress note revealed the treatment order for the coccyx remained the same: cleanse with vashe, pack with silver alginate rope, and cover with silicone border. Review of the Wound Culture completed on Resident #43's coccyx pressure ulcer obtained on 02/27/25 and resulted on 03/01/25 revealed corynebacterium striatum (opportunistic bacteria that can infect tissues, complicate wound healing and often was resistant to various antibiotics) and granulicatella adiacens (gram positive bacteria) was identified in the wound. Review of Infection Control Physician #484's progress note dated 03/02/25 revealed Resident #43's coccyx wound culture was reviewed and Ceftriaxone (antibiotic) 2,000 mg intravenously (IV) every 24 hours for 42 doses was ordered. Review of the Outside Wound Clinic progress note dated 03/13/25 and completed by Wound Physician #483 revealed Resident #43's wound care orders for his right posterior thigh was to cleanse wound with vashe, apply black foam to wound bed, cover with drape, and apply wound vacuum (negative pressure suction to help bring the wound edges together and remove fluid and dead tissue) at 125 millimeters of mercury (mmHg). The note revealed to continue IV antibiotic Ceftriaxone as ordered per Infection Control Physician #484. There were no details including measurements of the wound in the progress noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Medicare five-day MDS assessment dated [DATE] revealed Resident #43 had impaired cognition and was dependent on staff assistance with toileting hygiene and transfers. He required substantial to maximum assistance with dressing, rolling left and right and showers. He was at risk for developing pressure ulcers and had two unstageable pressure ulcers with one being present on admission. Review of the Weekly Wound Observation completed by RN/ Wound Nurse #449 and dated 04/07/25 revealed Resident #43's pressure ulcer to his right gluteal fold was now a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer that measured 3.4 cm in length, 5.2 cm in width and 4. 6 cm in depth. The wound area contained 25 % necrosis, 75 % slough and moderate serosanguinous drainage. The treatment was for a wound vacuum at 125 mmHg to the pressure area and change every Monday, Wednesday and Friday. Interview on 04/08/25 at 10:59 A.M. with RN/ Wound Nurse #449 revealed she incorrectly placed on the Weekly Wound Observation Tool dated 01/29/25 that Resident #43 was admitted with the pressure ulcer to his right gluteal fold and verified the wound was in-house acquired. RN/Wound Nurse #449 also verified the nursing note dated 01/28/25 indicated Resident #43 had a new area to his right gluteal fold but there was no documentation of staging, description or measurements per the nursing note or any other assessment form until she completed the Weekly Wound Observation Tool dated 01/29/25 and it was classified as unstageable. RN/Wound Nurse #449 revealed the pressure ulcer to Resident #43's right gluteal fold contained 90% white slough to the wound bed and she did not know why the wound was not found at an earlier stage especially with already formed slough inside the wound bed. RN/Wound Nurse #449 revealed she was aware Resident #43 refused to turn once and that after she educated him to her knowledge, he did not refuse any further. RN/Wound Nurse #449 had not relayed to LPN/ MDS #419 that Resident #43 had refused because in her opinion it was an isolated event and the education provided was effective, and he refused no longer. Interview on 04/08/25 at 11:49 A.M. and 12:34 P.M. with LPN/ MDS #419 verified on the Admission/ Medicare five-day MDS assessment dated [DATE] she had marked that rolling left and right and/or transfers were not attempted for Resident #43 due to medical condition. LPN/MDS #419 revealed she was unsure why she had marked that as she could not think of the medical condition that would have prevented Resident #43 from being turned. She revealed nobody had communicated anything to her regarding Resident #43 refusing care including turning as she would have documented that in his care plan. LPN/MDS #419 verified there was nothing in Resident #43's care plan regarding being noncompliant with care including turning and repositioning. Interview on 04/08/25 at 12:12 P.M. and 12:38 P.M. with the Director of Nursing (DON) verified Resident #43's right gluteal fold was found at an unstageable pressure ulcer with 90 % slough inside the wound bed. The DON also verified that there was no medical condition that prevented Resident #43 from being turned and the MDS assessment dated [DATE] was marked incorrectly as he was dependent on staff assistance with bed mobility and transfers. Review of the Outside Wound Clinic progress note dated 04/09/25 completed by Wound Physician #483 revealed to place wound vacuum on hold and change treatment order to cleanse the right posterior thigh with vashe, apply silver alginate and cover with silicone border. The treatment to Resident #43's coccyx was changed to cleanse with vashe, pack with silver alginate rope and cover with silicone border. The progress note revealed to continue to follow with Infection Control Physician #484. (continued on next page)

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	366191	A. Building B. Wing	04/14/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Observation of wound care on 04/10/25 at 10:26 A.M. with RN/Wound Nurse #449 and Certified Nursing Assistant (CNA) #478 revealed Resident #43 was dependent on staff assistance to turn to his side. RN/ Wound Nurse #449 had performed hand hygiene and applied gloves, gown and mask as Resident #43 was on enhanced barrier precautions. RN/Wound Nurse #449 proceeded to remove the dressings from the right gluteal fold and coccyx and disposed of them. RN/Wound Nurse #449 changed her gloves but did not wash her hands. She proceeded to pour vashe wound solution inside each wound and then took an unsterile gauze four by four and cleansed the inside of the coccyx wound and then with the same gloved hand took another unsterile gauze four by four and cleansed the inside of the right gluteal fold wound. Then, she took a sterile four by four and wiped the inside of the coccyx wound and then took a sterile four by four and wiped the inside of the right gluteal fold wound with the same gloved hands that had come in contact with both wounds. RN/Wound Nurse #449 described the right gluteal fold as a Stage IV with 90 percent necrotic tissue and 10 percent slough. RN/Wound Nurse #449 described the coccyx wound as also a Stage IV and only having 10 percent granulated tissue as majority of the wound bed contained slough. Both wounds had moderate yellow drainage with a foul smell. RN/Wound Nurse #449 proceeded with the same gloved hands to pack the coccyx wound with silver calcium rope gauze and then packed the right gluteal fold. She then took Skin Prep and wiped around both wounds (right gluteal fold and coccyx) with same gloved hand, then covered each wound with silicone border dressing. RN/Wound Nurse #449 then proceeded to doff and wash her hands. Interview on 04/10/25 at 10:49 A.M. with RN/Wound Nurse #449 verified Resident #43 had a wound culture completed of his coccyx area that indicated it was infected, and he was started on IV antibiotics on 03/02/25 for 42 doses that continued at this time. RN/Wound Nurse #449 verified the right gluteal fold had not been cultured and to her knowledge there was nothing documented that the right gluteal had an infection. RN/Wound Nurse #449 verified she had removed both dressings at the same time, changed her gloves and did not wash her hands. She verified she had cleansed each wound with the same gloved hands with vashe wound care solution and then packed each wound with the same gloved hands without washing her hands and/or changing her gloves. She verified that she then applied Skin Prep to the skin surrounding the wounds and applied the silicone border dressing with the same gloved hands. RN/Wound Nurse #449 verified there was the potential to cross contaminate the already known wound infection to the coccyx wound to the right gluteal fold wound. RN/Wound Nurse #449 verified she should have completed each wound dressing separately including cleaning the wound, packing the wound, and covering the wound and not with the same gloved hands as well as washing her hands after removing the old dressings before applying new gloves. Interview on 04/10/25 at 11:49 A.M. with the DON verified Resident #43's coccyx wound culture had come back positive indicating he had an infection and was on IV antibiotics. She verified RN/ Wound Nurse #449 should have washed her hands after removing the old dressings. The DON also verified RN/ Wound Nurse #449 should not have cleansed, packed and covered the coccyx and right gluteal fold wounds with the same gloved hands as there was a potential for cross contamination of infection especially since the coccyx wound already had a known infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366191	A. Building B. Wing	04/14/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the undated facility policy labeled, Pressure Injury Prevention revealed the purpose of the policy was to ensure the safety and well-being of the residents by minimizing the risk of pressure injuries and promote skin integrity. The policy revealed if a Braden Scale for Predicting Pressure Sore Risk was 18 or lower than preventative orders would be implemented such as turning and repositioning and elevating heels. The policy revealed proper lifting and transferring techniques would be utilized to minimize shearing and skin damage, appropriate support surfaces such as mattresses and cushions would be used to redistribute pressure and ongoing education to all staff members on pressure ulcer prevention and management. Review of the undated facility policy, Wound Care and Dressing Change revealed the purpose of the policy was to ensure consistent, safe and effective wound care to reduce the risk of infection and promote wound healing. The policy revealed the dressing change process included to perform hand hygiene and don gloves, remove old dressing carefully noting any drainage or odor, remove gloves and perform hand hygiene. The nurse was to don new gloves, cleanse wound per orders, apply new dressing as prescribed and secure dressing. There was nothing in the policy regarding the process the nurse should follow when there was more than one wound.

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	366191	A. Building B. Wing	04/14/2025

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, interview and review of facility policy the facility failed to ensure Resident #43's peripherally inserted central catheter (PICC) line (a long flexible tube usually inserted into the vein in the upper arm and passed through a larger vein near the heart to administer medications and other treatments) dressing was changed as ordered. This affected one resident (Resident #43) out of one resident (Resident #43) reviewed for intravenous (IV) therapy. Findings included: Review of medical record for Resident #43 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, osteoarthritis, and muscle wasting with atrophy. Review of undated care plan revealed Resident #43 had intravenous (IV) medications. Interventions included IV dressing change as ordered, and monitor, document and report as needed signs and symptoms of infection at the site including drainage, inflammation, swelling, redness and warmth. Review of March and April 2025 physician orders revealed the following orders all dated 03/06/25: monitor PICC line to right upper extremity for any signs of infection or infiltration every shift, Ceftriaxone (antibiotic) 2, 000 milligram (mg) intravenously (IV) every 24 hours for 42 doses due to wound infection, change PICC line dressing to right upper extremity every week (Thursday), and flush PICC line to right upper extremity before and after every antibiotic administration using the SASH method (a guideline for flushing and delivering medication to IV lines, that stands for administration of saline, medication, saline, and then heparin (blood thinner) to prevent complications and ensure safe IV line maintenance). Review of the March 2025 Treatment Administration Record (TAR) revealed the order to change Resident #43's PICC line dressing to his right upper extremity every week was not documented as completed as ordered on 03/20/25 as it was blank. There was no documentation the PICC line dressing was changed from 03/13/25 until 03/27/25. Review of Medicare five-day MDS assessment dated [DATE] revealed Resident #43 had impaired cognition and received intravenous antibiotics. Review of the April 2025 TAR revealed Resident #43's order to change the PICC line dressing to Resident #43's right upper extremity every week was documented as completed on 04/03/25 by Licensed Practical Nurse (LPN) #446. Observation on 04/09/25 at 8:35 A.M. revealed Resident #43's right upper extremity PICC line was intact with a dressing covering the PICC line dated 03/27/25. The dressing was loose to the lower left as it was peeling and folding upward. (continued on next page)

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	366191	A. Building B. Wing	04/14/2025

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 04/09/25 at 8:56 A.M. with LPN #446 verified Resident #43's right upper extremity PICC line dressing was dated 03/27/25. LPN #446 verified the dressing was supposed to be completed once a week and was scheduled to be changed 04/03/25. LPN #446 verified she had signed off in the TAR that the dressing was changed on 04/03/25 and that she did not change the dressing. LPN #446 revealed she had been sick and all the days run together so she did not know why she had documented that she had changed the dressing when she had not. LPN #446 verified the right upper extremity PICC line dressing was loose and the lower left corner of the dressing was peeling and folding upward. Interview on 04/09/25 at 9:10 A.M. with the Director of Nursing (DON) verified PICC line dressings were to be changed once a week. The DON also verified Resident #43 was the only resident currently receiving IV therapy. Review of undated facility policy labeled, PICC Line revealed the dressing over the PICC line should be changed every seven days or sooner if the dressing became wet, soiled or loose. The nurse was to document the dressing change procedure including date and any observations regarding the site including signs of infection, and condition of catheter.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on medical record review and staff interview, the facility failed to ensure pharmacy recommendations were reviewed and responded to timely from the physician. This affected one resident (#29) of five residents reviewed for unnecessary medications. The current census was 46. Findings included: Review of Resident #29 record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #29 included cerebral infarction, schizoaffective disorder, major depression, hemiplegia, anxiety disorder and chronic pain syndrome. Review of Resident #29's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed the resident had good cognition and was receiving antipsychotic, antidepressant, diuretic, and antiplatelet medication during the assessment period. Review of the physician order dated 10/28/24 revealed Risperidone oral tablet one milligram by mouth at bed time for schizoaffective disorder. Review of Resident #29's Pharmacy Drug Regimen Review sheet with dates of 04/17/24 through 03/12/25 revealed a recommendation was made to the physician on 02/18/25. Review of the Physician's Communication Form dated 02/18/25 revealed a pharmacy recommendation for a dose reduction for the psychoactive medication Risperidone one milligram tablet. Further review of Resident #29's medication record, treatment records, progress notes, and physician orders revealed there was no documentation of a response from the physician to the pharmacy or facility staff until the physician response dated 04/07/25 indicating not to reduce Risperidone. Interview on 04/08/25 at 3:04 P.M. with the Director of Nursing (DON) verified a recommendation was made by the pharmacist on 02/18/25 and the response was not timely since the psychiatrist was in the building every six weeks and the nurse practitioner more often. Review of facility policy Tapering Medications and Gradual Drug Dose Reduction, revised April 2007, revealed after medication was ordered for a resident, the staff and practitioner would seek an appropriate does and duration for each medication that also minimized the risk of adverse consequences.

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	366191	A. Building B. Wing	04/14/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on interview, observation, and policy review the facility failed to ensure physician ordered diet modification texture was followed as required. This affected one resident (#5) of three residents reviewed for diet texture. The facility census was 46. Findings included: Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included but were not limited to gastrointestinal hemorrhage, chronic kidney disease, neoplasm of parotid gland, dysphagia and cognitive communication deficit. Review of the Care Plan dated 03/10/25 revealed Resident #5 had swallowing problems related to swallowing assessment results per Modified Barium Swallow (MBS) study. Resident #5 had a potential risk of aspiration. Interventions included monitor dietary intake. Monitor, document, report as needed dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, and several attempts to swallow. Aid with meals as needed to encourage intake. Refer to speech therapist for swallowing evaluation. Resident to eat only with supervision. Review of the physician order dated 03/10/25 for Resident #5 revealed a diet order for regular diet, puree texture, and honey thick consistency for liquids. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #5 revealed a Brief Interview of Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. Resident #5 received a mechanically altered therapeutic diet, and required moderate assistance for eating meals. Review of the Speech Therapy Note dated 04/03/25 revealed Resident #5 had limited insight into current physical impairment. Resident #5 consumed honey thick liquids with no signs and symptoms of aspiration. Intervention included honey thick drinks and puree consistencies. Observation on 04/08/25 at 8:19 A.M. of the Activities Dining Room revealed Resident #5 was feeding himself breakfast that consisted of apple juice that was thick, cream of wheat, puree banana, pancakes that were of a minced consistency, sausage that was of a minced consistency, and milk that was thick. Resident #5 was observed to chew his food upon feeding himself. Interview on 04/08/25 at 8:26 A.M. with the Director of Nursing (DON), who was in the Activities Dining Room, confirmed Resident #5 was to receive puree food. Interview on 04/08/25 at 8:28 A.M. with Dietary Manager #401 verified Resident #5's breakfast was minced/chopped and not smooth. Interview on 04/08/25 at 8:29 A.M. with Resident #5 revealed he was a poor historian. (continued on next page)

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	366191	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Nursing and Hta	400 Sexton Street Struthers, OH 44471

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/25 at 12:49 P.M. with Speech Therapist #481 revealed Resident #5 was evaluated by speech therapy and was ordered a puree diet consistency and honey thick liquid consistency after a Modified Barium Swallow (MBS) test was done on 03/08/24. The puree consistency honey thick liquids was deemed the safest diet at that time to reduce the risk of choking and aspiration. Interview on 04/09/25 at 9:00 A.M. with Registered Dietitian (RD) #454 revealed Resident #5 was ordered a puree food consistency because Resident #5 was at high risk for aspiration. Review of the facility's undated policy Food Textures revealed puree diet texture was smooth, lump free and did not require chewing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, interview, and facility policy review, the facility failed to perform wound care using appropriate infection control practices. This affected one resident (#43) of one resident observed for wound care. This had the potential to affect six Residents (#4, #9, #17, #18, #31 and #43) identified by the facility with wounds requiring dressing changes. Findings included: Review of medical record for Resident #43 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, osteoarthritis, and muscle wasting with atrophy. Review of the care plan dated 12/10/24 revealed Resident #43 was at risk for impaired skin integrity. Interventions included skin assessment on admission, quarterly, annually and upon significant change, encourage and assist in turning and repositioning every two hours and as indicated, and treatments and dressings as ordered by the physician. Review of the Outside Wound Clinic progress note dated 01/29/25 and completed by Wound Physician #483 revealed Resident #43 was seen in the clinic and new orders were received for the right posterior thigh (the facility identified as right gluteal fold) to cleanse with vashe (super-oxidized solution formulated to combat bacteria and facilitate wound healing), apply silver alginate (a wound care absorbent dressing with antimicrobial properties) and cover with silicone border dressing every day. Resident #43 was also seen for a pressure ulcer to his coccyx that was present on admission and a wound culture was taken of this area. There were no details including measurements, description or classification of the wounds noted in the progress note. Review of the Wound Culture completed on Resident #43's coccyx pressure ulcer obtained on 01/29/25 and resulted on 02/01/25 revealed mixed gram-negative organisms (bacteria) and rare gram-positive cocci (unique group of bacteria that cause various infections) in pairs. Review of the Wound Culture completed on Resident #43's coccyx pressure ulcer obtained on 02/27/25 and resulted on 03/01/25 revealed corynebacterium striatum (opportunistic bacteria that can infect tissues, complicate wound healing and often was resistant to various antibiotics) and granulicatella adiacens (gram positive bacteria) was identified in the wound. Review of Infection Control Physician #484's progress note dated 03/02/25 revealed Resident #43's coccyx wound culture was reviewed and Ceftriaxone (antibiotic) 2,000 mg intravenously (IV) every 24 hours for 42 doses was ordered. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had impaired cognition and had two unstageable (full thickness tissue loss in which the actual depth of the ulcer was obscured by slough/ dead skin) pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weekly Wound Observation completed by Registered Nurse (RN)/ Wound Nurse #449 and dated 04/07/25 revealed Resident #43's pressure ulcer to his right gluteal fold was now a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer that measured 3.4 centimeter (cm) in length, 5.2 cm in width and 4.6 cm in depth. The wound area contained 25 percent necrosis, 75 percent slough and moderate serosanguinous drainage. The treatment was for a wound vacuum (negative pressure suction to help bring the wound edges together and remove fluid and dead tissue) at 125 millimeters of mercury and change every Monday, Wednesday and Friday. Review of the Outside Wound Clinic progress note dated 04/09/25 and completed by Wound Physician #483 revealed to place wound vacuum on hold and change treatment order to cleanse the right posterior thigh with vashe, apply silver alginate and cover with silicone border. The treatment to Resident #43's coccyx was changed to cleanse with vashe, pack with silver alginate rope and cover with silicone border. The progress note revealed to continue to follow with Infection Control Physician #484. Observation of wound care on 04/10/25 at 10:26 A.M. with RN/Wound Nurse #449 and Certified Nursing Assistant (CNA) #478 revealed Resident #43 was dependent on staff assistance to turn to his side. RN/ Wound Nurse #449 had performed hand hygiene and applied gloves, gown and mask as Resident #43 was on enhanced barrier precautions. RN/Wound Nurse #449 proceeded to remove the dressings to the right gluteal fold and coccyx and disposed of them. RN/Wound Nurse #449 changed her gloves but did not wash her hands. She proceeded to pour vashe wound solution inside each wound and then took an unsterile gauze four by four and cleansed the inside of the coccyx wound and then with the same gloved hand took another unsterile gauze four by four and cleansed the inside of the right gluteal fold wound. Then, she took a sterile four by four and wiped the inside of the coccyx wound and then took a sterile four by four and wiped the inside of the right gluteal fold wound with the same gloved hands that had come in contact with both wounds. RN/Wound Nurse #449 described the right gluteal fold as a Stage IV with 90 percent necrotic tissue and 10 percent slough. RN/Wound Nurse #449 described the coccyx wound as a Stage IV and only having 10 percent granulated tissue as majority of the wound bed contained slough. Both wounds had moderate yellow drainage with a foul smell. RN/Wound Nurse #449 proceeded with the same gloved hand and packed the coccyx wound with silver calcium rope gauze and then packed the right gluteal fold. RN/Wound Nurse #449 then took Skin Prep and wiped around the right gluteal fold and coccyx with same gloved hand. RN/Wound Nurse #449 then covered each wound with silicone border dressing and proceeded to doff and wash her hands. Interview on 04/10/25 at 10:49 A.M. with RN/Wound Nurse #449 verified Resident #43 had a wound culture completed of his coccyx area that indicated it was infected, and he was started on IV antibiotics on 03/02/25 for 42 doses that continued at this time. RN/Wound Nurse #449 verified the right gluteal fold was not cultured and to her knowledge there was nothing documented that the right gluteal had an infection. RN/Wound Nurse #449 verified she had removed both dressings at the same time, changed her gloves and did not wash her hands. She verified she had cleansed each wound with the same gloved hands with vashe wound care solution and then packed each wound with the same gloved hands without washing her hands and/or changing her gloves. RN Wound Nurse #449 verified that she then applied Skin Prep to the skin surrounding the wounds and applied the silicone border dressing with the same gloved hands. RN/Wound Nurse #449 verified there was the potential to cross contaminate the already known wound infection to the coccyx wound to the right gluteal fold. RN/Wound Nurse #449 verified she should have completed each wound dressing separately including cleaning the wound, packing the wound, and covering the wound and not with the same gloved hands as well as washing her hands after removing the old dressings before applying new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/25 at 11:49 A.M. with Director of Nursing (DON) verified Resident #43's coccyx wound culture had come back positive indicating he had an infection and was on an IV antibiotic. The DON verified RN/ Wound Nurse #449 should have washed her hands after removing the old dressings. The DON also verified RN/ Wound Nurse #449 should not have cleansed, packed and covered the coccyx and right gluteal fold wounds with the same gloved hands as there was a potential for cross contamination of infection especially since the coccyx wound already had a known infection. Review of undated facility policy, Wound Care and Dressing Change revealed the purpose of the policy was to ensure consistent, safe and effective wound care to reduce the risk of infection and promote wound healing. The policy revealed the dressing change process included to perform hand hygiene and don gloves, remove old dressing carefully noting any drainage or odor, remove gloves and perform hand hygiene. The nurse was to don new gloves, cleanse wound per orders, apply new dressing as prescribed and secure dressing. There was nothing in the policy regarding the process the nurse should follow when there was more than one wound.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review and interview the facility failed to provide single rooms with at least 100 square feet of living space in each room. This affected six residents (#2, #13, #16, #22, #38, and #41) of 46 residents residing in the facility. Findings included: On 04/08/25 at 8:30 A.M. an interview with the Administrator confirmed the facility had six single rooms with less than the required 100 square footage of living space. Six of the six rooms were occupied by residents at the time of the survey. Review of the space/occupancy certification waiver, dated 11/22/22, revealed Resident #2, #13, #22, #38, and #41 were in single rooms that measured less than the required 100 square feet of living space. The room measurements and residents affected were as follows. room [ROOM NUMBER] (Resident #41) 96.47 square feet. room [ROOM NUMBER] (Resident #2) 93.15 square feet. room [ROOM NUMBER] (Resident #38) 96.46 square feet. room [ROOM NUMBER] (Resident #13) 93.55 square feet. room [ROOM NUMBER] (Resident #16) 97.75 square feet. room [ROOM NUMBER] (Resident #22) 91.50 square feet.