

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Mapleview Country Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 775 South Street Chardon, OH 44024	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observations, interviews and record review, the facility failed to ensure residents received adequate nail care. This affected one resident (#8) of three residents investigated for activities of daily living (ADL) care. The facility census was 85. Findings include: Review of Resident #8's medical record revealed an admission date of 01/09/26 and pertinent diagnoses including severe protein-calorie malnutrition, basal cell carcinoma of the skin of scalp and neck, secondary malignant neoplasm of the bone, convulsions, type two diabetes mellitus without complications, anxiety disorder, and acquired absence of the right eye. Review of Resident #8's Minimum Data Set (MDS) 3.0 dated 01/16/26 revealed a Basic Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Further review of the MDS also revealed Resident #8 required maximum assistance with upper body dressing, was dependent on staff for lower body dressing, toileting, showering and personal hygiene and was dependent on staff for mobility. Review of Resident #8's Care Plan dated 01/09/26 revealed the Resident had an ADL self-care, mobility and functional ability performance deficit due to cancer, diabetes mellitus and seizures and her goal was to maintain current functional status related to ADLs. Resident #8 was dependent on staff for personal hygiene tasks. On 02/23/2026 at 3:32 P.M., an interview with and observation of Resident #8 revealed her fingernails were long and dirty. During the observation, the resident stated that staff cleaned and trimmed her fingernails only if she asked them to do so. The resident also stated she was unsure when her fingernails were last cleaned but would like to have them cleaned more often. She also stated her nails were not cleaned as part of routine bathing or hygiene. On 02/24/2026 at 3:23 P.M., an additional observation of Resident #8 revealed long and dirty fingernails which was confirmed by the resident and Certified Nursing Assistant (CNA) #640. An interview with CNA #640 during the observation revealed fingernails got cleaned during shower days but Resident #8 received a bed bath only. CNA #640 stated she was unsure when the resident last had a bed bath or when her nails were last cleaned. Review of the facility's policy titled ADL Care reviewed 01/06/25 revealed staff were expected to assist dependent residents with maintenance of personal hygiene including planning the task and gathering supplies which included assistance with nail care. This deficiency represents noncompliance investigated under Complaint Numbers 2687981 and 1390001.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366433
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