

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: 366433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, interview and review of facility policy, the facility failed to ensure medications were obtained timely from the pharmacy and were administered according to physician orders. This affected one (Resident #81) of three residents reviewed for medication administration. The facility census was 90. Findings include: Review of the medical record for Resident #81 revealed an admission date of 01/30/24 with diagnoses including prostate cancer, chronic pain syndrome, Parkinson's Disease, osteoarthritis and neuropathy. Review of the care plan dated 01/31/24 for Resident #81 revealed he had the risk for pain and discomfort related to prostate cancer, Parkinson's Disease, osteoarthritis, chronic pain and neuropathy. Interventions included to administer pain medication per the physician's order. Review of the physician's orders for Resident #81 revealed he had an order for Pregabalin 100 milligrams (mg) (medication for neuropathic pain) three times a day dated 02/01/25. Resident #81 also received topical pain treatments including Lidocaine Patch four percent to his left knee one time a day with a start date of 12/19/25 and Voltaren External Gel one percent, apply to bilateral knees every day and evening shift with a start date of 04/05/26. Acetaminophen Extra Strength 500 mg tablet give two tablets by mouth three times a day for pain was ordered on 03/02/25. Review of the Medication Administration Record (MAR) for April 2026 revealed Resident #81 did not receive his doses of Pregabalin 100 mg on 04/13/26 at 8:00 P.M.; 04/14/26 at 6:00 A.M., 1:00 P.M. and 8:00 P.M.; 04/15/26 at 6:00 A.M., 1:00 P.M. and 8:00 P.M.; 04/16/26 at 6:00 A.M., 1:00 P.M. and 8:00 P.M.; 04/17/26 at 6:00 A.M.; and on 05/01/26 at 1:00 P.M. Review of pain levels recorded on the MAR for these dates revealed the pain levels were checked each shift and Resident #81 had pain levels of zero (no pain). Review of the nursing progress notes for Resident #81 revealed on 04/13/26 at 8:42 P.M. the nurse was unable to administer his Pregabalin due to it being unavailable. The nurse stated a new script was to be sent by the nurse practitioner and it would be administered when available. On 04/14/26 at 6:02 A.M. Pregabalin was not administered due to awaiting from the pharmacy. On 04/14/26 at 1:35 P.M. Pregabalin was not administered. On 04/14/26 at 8:13 P.M. Pregabalin was not administered. On 04/15/26 at 5:57 A.M. Pregabalin was not administered due to awaiting from the pharmacy. On 04/15/26 at 2:00 P.M. Pregabalin was not administered. On 04/15/26 at 9:46 P.M. Pregabalin was not administered due to the pharmacy. On 04/16/26 at 6:10 A.M. Pregabalin was not administered due to medication pending. There was no indication the nursing staff had contacted the pharmacy to inquire on the status of Resident #81's Pregabalin during 04/14/26 through 04/16/26 at 6:00 A.M. On 04/16/26 at 9:55 A.M. the physician was notified of needing new scripts for the Pregabalin. An order was given to place Resident #81's Pregabalin on hold until the medication arrived from the pharmacy. On 04/16/26 at 7:46 P.M. the nurse stated they were waiting on the Pregabalin 100 mg to arrive and the family was concerned about withdrawal. The note stated the physician and nurse practitioner were aware of missed doses and the plan was to start Pregabalin 75 mg as it was available in their starter kit. On 05/01/26 at 12:46 P.M. Resident #81's Pregabalin 100 mg was again not able to be administered due to it not being in stock and on the way to the facility. Interview on 06/04/26 at 10:14 A.M. with Nurse Practitioner (NP) #205 revealed she had sent a prescription on 04/13/26 to the pharmacy for Resident #81's Pregabalin. She (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unable to state why the facility had not updated her sooner about needing his prescription prior to it running out. She stated she provided an order on 04/13/26 to hold the Pregabalin until it arrived from the pharmacy. NP #205 stated the pharmacy had lost the prescription that she sent to them on 04/13/26 and she had to send another prescription on 04/16/26. She stated Resident #81's daughter had initially refused a dosage change of the medication when he first ran out of the Pregabalin, however, had changed her mind on 04/16/26. NP #205 stated Resident #81 was at his baseline, and she did not feel he was having withdrawal symptoms from the medication. Interview on 06/04/26 at 10:31 A.M. with the Director of Nursing (DON) verified NP #205 was updated on 04/13/26 that Resident #81's Pregabalin needed a new prescription. The DON stated NP #205 also provided an order to hold the medication until it arrived from the pharmacy. The DON was unable to provide documentation to show staff had attempted to reorder Resident #81's Pregabalin prior to 04/13/26 nor had inquired about his prescription between 04/13/26 to 04/16/26 while awaiting the medication. The DON stated the night shift nursing supervisor was to check the medications and ensure residents would not run out of their medications. She was unsure why the medication was not reordered prior to it running out and why the nursing staff had not requested a new prescription from NP #205 in a timely manner so that Resident #81 did not go without his medication. Review of the facility policy titled, Medication Administration, dated November 2021, revealed medications were to be administered in accordance with the physician's orders. This deficiency represents non-compliance investigated under Complaint Number 2989616.		