

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 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>Based on observation, staff interview, review of facility menu, and review of diet spreadsheets, the facility failed to ensure residents who were ordered a puree diet received all food items on the menu. This affected five residents (#2, #24, #50, #68 and #70) who were identified as ordered a pureed diet. The facility census was 85. Findings include: Observation on 02/24/26 from 11:45 A.M to 12:50 P.M. of the lunch meal service revealed pureed bread was not available on the steam table or served to residents ordered a pureed diet. Interview on 02/24/26 at 12:53 P.M. with Dietary Manager (DM) #515 confirmed pureed bread was not served to Residents #2, #24, #50, #68 and #70. Interview on 02/24/26 at 12:55 P.M. with [NAME] #513 confirmed she had not prepared pureed bread for the lunch meal. Review of the facility menu titled Week at a Glance Fall/Winter 25-26 for cycle week one revealed the lunch meal included chicken teriyaki, fried rice, steamed broccoli, dinner roll with margarine, black forest cake, and a beverage. Review of the diet spreadsheet for lunch meal on 02/24/26 revealed pureed diet consisted of pureed chicken teriyaki, pureed fried rice, pureed steamed broccoli, pureed dinner roll with margarine, smooth and thick sweet and sour sauce, and pureed black forest cake.</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to maintain the call light in reach of Resident #7. This affected one resident (#7) and had the potential to affect all 85 residents residing in the facility. Findings include: Observation on 02/24/26 at 12:20 P.M. revealed Resident #7 was lying down in his bed. The pressure sensitive call light was observed placed in the middle of the floor mat to the left side of the bed. The floor mat was lower than the bed height. Interview at the time of the observation with Resident #7 revealed that if he needed help he would press his call light, but didn't know where the light was. Resident # 7 was unable to see or reach the call light on the floor mat. Additional interview at the time of the above observation with Certified Nursing Assistant (CNA) #632 verified the call light was placed on the floor mat next to the resident's bed. CNA #632 stated she was instructed by Licensed Practical Nurse (LPN) #553 to place the call light on the floor mat so if the resident fell out of the bed, it would activate the call light. Continued interview at the time of the above observation with LPN #553 stated she had instructed CNA #632 to place the call light on the side of the resident's bed and not on the floor mat. Review of Resident #7's current care plan for fall risk revealed an intervention for the touch sensitive call light to always be in reach of the resident when in the room. Review of the facility policy, Use of Call Light, reviewed 01/06/25, revealed to be sure call lights are always placed within reach of the resident.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to notify the appropriate state agency (The Ohio Department of Mental Health) of a significant change in a resident's mental health condition as required. This affected one resident (Resident #1) of one resident reviewed for preadmission screening and resident review (PASRR). The facility census was 85. Findings include: Medical record review revealed Resident #1 was admitted to the facility on [DATE] with pertinent diagnoses including bipolar disorder, acute kidney failure, diabetes, Parkinsonism, post-traumatic stress disorder, mild cognitive impairment of uncertain or unknown etiology, chronic kidney disease, neuromuscular dysfunction of bladder, sleep apnea, osteoarthritis, insomnia, low back pain, and a personal history of suicidal behavior. Further review of Resident #1's medical record revealed an in-patient psychiatric hospitalization from 04/08/25 to 04/23/25 due to suicidal ideations with a plan. Resident #1 returned to the facility on [DATE] with additional pertinent diagnoses of generalized anxiety disorder and suicidal ideations per review of her discharge summary. Review of both the electronic and hard charts revealed no evidence the appropriate state agency (The Ohio Department of Mental Health) was notified of the new diagnoses for PASRR review as required. An interview on 02/25/26 at 3:55 P.M. with Social Service Designee #568 verified the appropriate state agency was not notified of the new diagnoses/decline.</p>		

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<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>		