STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395828	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Heights Health & Rehab Center, LLC	429 Manor Drive Ebensburg, PA 15931

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48809 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that facility failed to determine if residents were safe to self-administer medications for one of 11 residents reviewed (Resident 1). Findings include: The facility's policy regarding the self-administration of medications, dated December 20, 2024, indicated that residents who desired to self-administer medications would have a physician's order to do so. An quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 31, 2025, indicated that the resident was understood and could understand. Current physician's orders did not include orders for self-administration of medication, the resident's record contained no documented evidence that an evaluation was completed to determine if the resident was capable of self-administering medications, and the resident did not have a care plan in place regarding the self-administration of medication. Observations on April 8, 2025, at 9:40 a.m. revealed that Resident 1 had medications sitting at her bedside without any staff in attendance. The resident was taking the medications as the surveyor entered the room. The medications included one round orange tablet, one large oval white tablet, one small tan oval tablet and one medium size white round tablet. Interview with Licensed Practical Nurse 5 and Registered Nurse 6 on April 8, 2025, at 9:46 a.m. indicated that Resident 1 was not evaluated for nor does she have a physician's order to self-administer medications, and should not have had medications at her bedside. Interview with the Nursing Home Administrator on April 7, 2025, at 10:20 a.m. confirmed that Resident 1 was not evaluated and did not have a physician's order to self-administer medications and should not have had medications at her bedside. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48809 Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment for five of 11 residents reviewed (Residents 7, 8, 9, 10, 11). Findings include: Observations of Resident 7's wheelchair on April 8, 2025, at 11:42 a.m. revealed that the resident's wheelchair was beside her bed and it had a moderate accumulation of removable, dried-on debris on the metal supports of the chair. Observations of Resident 8's wheelchair April 8, 2025, at 11:47 a.m. revealed that the resident's wheelchair had a moderate to large amount of thick, removable dust/debris on the metal supports under the seat. Observations of Resident 9's wheelchair on April 8, 2025, at 11:55 a.m. revealed that there was a large amount of removable dust/debris on the wheels and the metal supports under the chair, as well as removable dirt on the seat cushion. Observations of Resident 10's wheelchair on April 8, 2025, at 12:10 p.m. revealed that the wheels of the wheelchair had an accumulation of removable, dried-on debris. Interview with Licensed Practical Nurse 4 and Nurse Aide 7 on April 8, 2025, at 12:18 p.m. revealed that in the past the facility had staff that would deep clean the wheelchairs on a routine rotating basis, but that staff no longer exists. Interview with Housekeeper 3 on April 8, 2025, at 12:25 p.m. confirmed that Resident 7's, 8's, 9's, and 10's wheelchairs should have been clean. She revealed that since they decreased the amount of staff it has been difficult to keep up with cleaning the wheelchairs. Observations of Resident 11's wheelchair on April 8, 2025, at 12:30 p.m. revealed that the wheels of the wheelchair and all metal parts of the chair had an accumulation of very thick removable, dried-on grime and debris. Interview with the Housekeeper 8 on April 8, 2025, at 12:34 p.m. confirmed that Resident 11's wheelchairs should have been clean. She indicated that it was the job of housekeeping to clean the residents' wheelchairs. The housekeeper then got a cleaning rag and cleaned the wheelchair. Interview with the Nursing Home Administrator on April 8, 2025, at 1:22 p.m. confirmed that the removable dust, dirt, grime and debris on Resident 7's, 8's, 9's, 10's, and 11's wheelchairs should not have been there, and should have been cleaned. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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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 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. 48809 Based on review of clinical records and employee records, as well as staff interviews, it was determined that the facility failed to maintain an environment free of potential safety hazards related to resident transportation to appointments for one of 11 residents (Resident 6). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated March 16, 2025, indicated that the resident was cognitively impaired, was usually understood, and sometimes understood others. A nursing note for Resident 6, dated March 20, 2025, at 5:41 p.m., revealed that the resident was unable to go to her orthopedic appointment on the above date due to transportation issues. Interviews with Nurse Aide 2 on April 8, 2025, at 11:09 a.m. revealed that she was escorting Resident 6 to her orthopedic appointment on March 20, 2024. She waited for 45 minutes on the floor for Van Driver 1 to arrive and help escort Resident 6 to the van. When Van Driver 1 arrived he was just making statements that he was hungry. When he started to drive the van, he was going excessively slow, around 20 miles per hour, and a mile down the road he started to fall asleep behind the wheel and swerve off the road. As soon as she realized and felt unsafe, she faked a call to the orthopedic office and told the driver that the appointment was canceled because they were 45 minutes late. Upon returning to the facility, she immediately told the Registered Nurse Supervisor, the Director of Nursing, and the Nursing Home Administrator. A reasonable suspicion report for Van Driver 1, dated March 20, 2025, revealed that the employee was sleepy, drowsy, had blood shot and droopy eyes, had to lean against a chair while standing, was slurring his speech, and while driving Resident 6 to her orthopedic appointment, appeared to fall asleep while driving the van, swerving and driving off the road. The employee was taken to a MedExpress for a blood alcohol test, and the results revealed the employee had a blood alcohol level of 0.122 percent. Interview with the Nursing Home Administrator on April 8, 2025, at 11:03 a.m. confirmed that Van Driver 1 should not have been driving under the influence, and when it was brought to his attention, he immediately did a urine test, and he took him to MedExpress for a blood alcohol test. He fired Van Driver 1 the next day due to failed alcohol test after reasonable suspicion. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.