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	07/02/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of facility policies, investigation reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse or neglect for 14 of 14 residents reviewed (Residents 1,2,3,4,5,6,7,8,9,10,11,12,13 and 14). This deficiency is being cited as past non-compliance. Findings include:The facility's policy regarding abuse, neglect, and exploitation, dated December 30, 2024, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Neglect was defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Facility investigation documents, dated June 18, 2025, revealed that Agency Licensed Practical Nurse 1, did not give multiple residents on the 3rd floor their medications between the hours of 7:00 p.m. and 3:00 a.m. The facility's Electronic Medication Administration Record (EMAR) went down, causing a short system outage. Registered Nurse 2 called the nursing units and there were no reported issues except for the system being down. Registered Nurse 2 placed a ticket in for IT to let them know of the outage. Licensed Practical Nurse 1 told Registered Nurse 2 that she did not give any of the medications because the system was down and stated, what else was she supposed to do. The Director of Nursing arrived at the facility around 5:00 a.m. and spoke with Licensed Practical Nurse 2 about the incident. Licensed Practical Nurse 2 said the system went down and did not know what else could be done. The Director of Nursing told Licensed Practical Nurse 2 that she should have notified the RN supervisor as soon as she realized she was unable to pass the medications so a plan could have been put into place to address the issue instead of just neglecting to give them. A whole house audit with medication compliance was checked to identify which residents did not receive medications. The whole house audit revealed that 14 residents identified on 3rd floor did not receive physician ordered medications between 7:00 p.m. and 3:00 a.m. The medical director was notified, as well as Certified Registered Nurse Practitioners (CRNP-a registered nurse (RN) who has advanced education and clinical training in a health care specialty area) 3 and 4. Nursing assessments were completed on all of the residents with no adverse reactions noted. All responsible parties were notified of medication omissions. Local Township Police and Adult Protective Services were notified, and documentation was completed on each resident. The agency that Licensed Practical Nurse 1 was employed by was made aware of the incident and were made aware that she will no longer be permitted to work at the facility. The Pennsylvania State Licensing Board of Nursing was also notified of the incident, and a Provider Bulletin 22 report was completed. Physician's orders for Resident 1, dated October 24, 2024, included an order for the resident to receive 20 milligrams (mg) of Oxycodone (a controlled opioid pain medication) every six hours for pain. The Medication Administration Record (MAR) for June 2025, revealed that on June 18, 2025, Licensed Practical Nurse 1 documented that due to the system being down she did not administer the 2:00 a.m. dose of Oxycodone. Current physician's orders for Resident 2 included orders for the resident to receive one application of ammonium lactate lotion 12% twice a day for dry skin; 1 drop of artificial tears 1.4% in each eye three times a day for dry eyes; 40 mg of atorvastatin at bedtime for hyperlipidemia (elevated lipids in the blood); 1 drop of brimonidine 0.2% to right eye three times a day for glaucoma (an eye condition that damages the optic nerve); one application of calmoseptine ointment 0.44-20.6% to both sides of the buttocks twice a day for skin protection; 1 drop of dorzolamide 2% drops to the right eye twice a day for glaucoma; 5 mg of Eliquis (blood thinner) twice a day for blood clot prevention; 300 mg of gabapentin three times a day for pain; 5-325 mg of Norco (controlled opioid pain medication) twice a day for pain; 250 mg of Keppra twice a day for seizure prevention; and 8.6 mg of senna twice a day for constipation. The MAR for June 2025 revealed that Licensed Practical Nurse 1 documented that due to the system being down she did not give the 7:00-11:00 p.m. doses of ammonium lactate lotion, artificial tears, atorvastatin, brimonidine, calmoseptine, dorzolamide, Eliquis, gabapentin, Norco, Keppra and senna.Current physician's orders for Resident 3 included orders to receive 10 mg of cyclobenzaprine twice a day for muscle spasms; 500 mg of levetiracetam twice a day for seizures; 45 mg of mirtazapine at bedtime for depression; 8 mg of ramelteon at bedtime for insomnia (difficulty sleeping); and 1 gram (gm) of sucralfate for GERD (gastroesophageal reflux disease). The MAR for

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of policies and clinical records, as well as staff and resident interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in significant medication errors for three of 14 residents reviewed (Residents 2, 7 and 14). This deficiency is being cited as past non-compliance. Findings include:The facility's policy for medication administration, dated December 30, 2024, indicated that medication would be administered according to physician orders.Facility investigation documents, dated June 18, 2025, revealed that Agency Licensed Practical Nurse 1, did not give multiple residents on the 3rd floor their medications between the hours of 7:00 p.m. and 3:00 a.m. The facility's Electronic Medication Administration Record (EMAR) went down, causing a short system outage. Registered Nurse 2 called the nursing units and there were no reported issues except for the system being down. Registered Nurse 2 placed a ticket in for IT to let them know of the outage. Licensed Practical Nurse 1 told Registered Nurse 2 that she did not give any of the medications because the system was down and stated, what else was she supposed to do. The Director of Nursing arrived at the facility around 5:00 a.m. and spoke with Licensed Practical Nurse 2 about the incident. Licensed Practical Nurse 2 said the system went down and did not know what else could be done. The Director of Nursing told Licensed Practical Nurse 2 that she should have notified the RN supervisor as soon as she realized she was unable to pass the medications so a plan could have been put into place to address the issue instead of just neglecting to give them. A whole house audit with medication compliance was checked to identify which residents did not receive medications. The whole house audit revealed that 14 residents identified on 3rd floor did not receive physician ordered medications between 7:00 p.m. and 3:00 a.m. The medical director was notified, as well as Certified Registered Nurse Practitioners (CRNP-a registered nurse (RN) who has advanced education and clinical training in a health care specialty area) 3 and 4. Nursing assessments were completed on all of the residents with no adverse reactions noted. All responsible parties were notified of medication omissions. Local Township Police and Adult Protective Services were notified, and documentation was completed on each resident. The agency that Licensed Practical Nurse 1 was employed by was made aware of the incident and were made aware that she will no longer be permitted to work at the facility. The Pennsylvania State Licensing Board of Nursing was also notified of the incident, and a Provider Bulletin 22 report was completed. The omission of medications resulted in significant medication errors for Residents 2, 7 and 14. Current physician's orders for Resident 2 included orders for the resident to receive 5 mg of Eliquis (blood thinner) twice a day for blood clot prevention; 300 mg of gabapentin three times a day for pain; 5-325 mg of Norco (controlled opioid pain medication) twice a day for pain; and 250 mg of Keppra twice a day for seizure prevention. The MAR for June 2025 revealed that Licensed Practical Nurse 1 documented that due to the system being down she did not give the 7:00-11:00 p.m. doses of Eliquis, gabapentin, Norco, and Keppra Current physician's orders for Resident 7 included orders for the resident to receive 12.5-50-200 mg of carbidopa-levodopa-entacapone three times a day for Parkinson's disease; 200 mg of entacapone three times a day for Parkinson's disease; 20 units of Insulin glargine 100 units/1 milliliter (ml) subcutaneously (injected just under the skin into the fatty layer) at bedtime for type 2 diabetes mellitus; and Novolin insulin (an intermediate-acting insulin) subcutaneously per sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) that included calling the MD if the blood sugar is below 60, giving 0 units for a blood sugar of 1-150 mg/dL, 2 units of insulin for a blood sugar of 151-180 mg/dL, 4 units for a blood sugar of 181-220 mg/dL, 6 units for a blood sugar of 221-260 mg/dL, 8 units for a blood sugar of 261-300 mg/dL, 10 units for a blood sugar of 301-350 mg/dL, 12 units for blood sugar of 351-400 mg/dL, 14 units for a blood sugar of 401-450 mg/dL, 16 units for a blood sugar of 451-500 mg/dL and if blood sugar is greater than 500, call MD before meals and at bedtime for type 2 diabetes. The MAR for June 2025 revealed that on June 17, 2025, Licensed Practical Nurse 1 documented that due to the system being down she did not give the 7:00 p.m. to 11:00 p.m. doses of carbidopa-levodopa-entacapone, entacapone, insulin glargine and Novolin insulin. Current physician's orders for Resident 14 included an order for the resident to receive 5 mg of Eliquis twice a day for atrial fibrillation (a type of irregular heartbeat). The MAR for June 2025 revealed that on June 17, 2025, Licensed Practical Nurse 1 documented that due to the system being down she did not give the 7:00 p.m. to 11:30 a.m. dose Eliquis.An interview with the Director of Nursing on July 2, 2025, at 1:00 p.m. confirmed that the facility's investigation was completed on June 19, 2025, and that significant medication errors did occur.Following the incident/investigation on June 18, 2025, the facility's corrective actions