

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395828	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Maple Heights Health & Rehab Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained free of accident hazards for one of ten residents (Resident 2). Findings Include: The facility's policy regarding elopement, dated December 30, 2024, indicated that if staff discover a resident is missing a head count will be completed, and if the resident is unable to be found a code green will be announced. The designee will notify the administrator, director of nursing, and the attending physician. If the resident is not found in a reasonable period of time the local emergency responders will be notified. A social services admission note for Resident 2 dated July 10, 2025, revealed that the resident was admitted from the hospital. He was recently evicted from his home, and they are working with senior life to try and find placement for him. The resident would like to return to his father's home that he inherited. The resident stated that he likes to drink and smoke cigarettes and marijuana, and plans to be at the facility short term for physical and occupational therapy. A social services note for Resident 2 dated July 16, 2025, revealed that the resident was requesting to leave against medical advice (AMA), and that he planned to go to a hotel. Social services indicated that she was able to talk Resident 2 into staying at the facility while she was working with senior life to find placement for him. A late entry nursing note for Resident 2 dated July 28, 2025, at 4:45 p.m. revealed that on July 27, 2025, at around 12:00 p.m. a nurse aide saw the resident when he asked her for a cookie and thanked her for all that they do. At 2:30 p.m. the nurse aide notified the licensed practical nurse that Resident 2's lunch tray was untouched, and that he had not been seen since noon. The Registered Nurse was notified. A nursing note for Resident 2 dated July 27, 2025, at 4:31 p.m. revealed that Registered Nurse 1 notified the physician and the resident's emergency contact that the resident had eloped from the building. A late entry nursing note for Resident 2, dated July 31, 2025, at 9:11 a.m. revealed that on July 27, 2025 at 2:40 p.m. Registered Nurse (RN) 2 was made aware of the missing resident. The building was searched and RN 2 spoke with reception who stated they saw the resident walk out of the building at 12:30 p.m. The protocol for a missing resident was activated at that time. Interview with Resident 2's emergency contact #3 on July 31, 2025, a 9:35 a.m. revealed that the facility had contacted him on July 27, 2025 to inform him that Resident 2 had eloped and they couldn't find him. They wanted to know if he was with me. Interview with Registered Nurse 1 on July 31, 2025, at 10:28 a.m. revealed that she was not at the facility at the time of the elopement; however, she was on-call and was notified at 2:40 p.m. that the resident had eloped. She called the code green for an eloped resident and made the proper notifications while driving into the facility. The local police were notified and when she arrived at the facility Registered Nurse 2 went with the police to search the surrounding areas for the resident. The resident was found on July 27, 2025 around 4:45 p.m. several miles away and was taken to the hospital for evaluation. Interview with Registered Nurse 2 on July 31, 2025, at 10:38 a.m. revealed that when she was notified that the resident's lunch tray was not touched, and that no one had seen the resident for over two hours she began to search the facility. She spoke with reception, and she was informed the resident walked out of the facility at 12:30 p.m. She then notified Registered Nurse 1 and was told to call the code green for eloped resident. Interview with Police (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Officer 4 on July 31, 2025, at 1:20 p.m. revealed that they responded to a missing person report on July 27, 2025, around 2:45 p.m. The resident was found at approximately 4:45 p.m. several miles away from the facility. They were then directed by the Pennsylvania State Police to take the resident was taken to the hospital for evaluation. Interview with Receptionist 5 on July 31, 2025, at 1:10 p.m. revealed that he observed the resident leaving that facility on July 27, 2025, at 12:30 p.m. and believed the resident was an employee based on how he was dressed, and that he did not leave with any belongings. Interview with the Nursing Home Administrator on July 31, 2025, at 11:53 p.m. revealed that the resident left against medical advice and did not elope. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(5) Nursing services.		