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	08/27/2025

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of policies, clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 10 residents reviewed (Resident 1).Findings include:The facility's abuse policy, dated December 30, 2024, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 10, 2025, indicated that the resident was cognitively intact, required assistance from staff with daily care needs, had recent falls, and had diagnoses that included diabetes mellitus, atrial fibrillation (irregular heartbeat) and seizures.Facility investigation documents dated August 21, 2025, at 4:00 a.m. revealed that Resident 1 had a witnessed fall, nursing reports that resident was observed stumbling in bathroom and lost his balance and was assisted to the floor.A witness statement dated August 22, 2025 from Nurse Aide 1 revealed that she heard Licensed Practical Nurse 2 tell the resident You can f******g stay on the floor.A statement from Resident 1 dated August 22, 2025, revealed that he fell in the bathroom and Licensed Practical Nurse 2 stated that she should leave me on the f*****g floor. He stated that he did not want her to care for him anymore.During an interview with Resident 1 on August 27, 2025, at 11:55 a.m. he stated that he had fallen a couple night ago in his bathroom and that agency nurse Licensed Practical Nurse 2 told him that he could lay on the f*****g floor all night.Interview with the Interim Administrator on August 27, 2025, at 2:34 p.m. confirmed that Resident 1 had fallen and that it was substantiated that Licensed Practical Nurse 2 told the resident he could stay on the f******g floor.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 201.29(a) Resident rights28 Pa. Code 201.29(j) Resident rights28 Pa. Code 211.12(d)(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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of state laws, facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that all alleged violations involving abuse were reported to the State Survey Agency (Department of Health) and to other state agencies in accordance with state law for one of 10 residents reviewed (Resident 1). Findings include: The Older Adult Protective Services Act of November 6, 1987, amended by Act 1997-13, Chapter 7, Section 701, requires that all administrators or employees who have reasonable cause to suspect that a resident was a victim of sexual abuse, that abuse/neglect resulted in serious physical injury and/or serious bodily injury, or that a death was suspicious, were to make an immediate report to the Protective Services Agency, the Pennsylvania Department of Aging (PDA), and to law enforcement officials. The facility's policy regarding abuse, dated December 30, 2024, revealed that facility staff all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing and to the applicable state agency. The facility will notify the department of health within two hours when the facility receives a complaint of alleged abuse, neglect or misappropriation of resident property. The administrator or designee will provide a written report for employees, using the PB22 (a form for reporting abuse), to the department of health within five calendar days of the incident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 10, 2025, indicated that the resident was cognitively intact, required assistance from staff with daily care needs, had recent falls, and had diagnoses that included diabetes mellitus, atrial fibrillation (irregular heartbeat) and seizures. Facility investigation documents dated August 21, 2025, at 4:00 a.m. revealed that Resident 1 had a witnessed fall, nursing reports that resident was observed stumbling in bathroom and lost his balance and was assisted to the floor. A witness statement dated August 22, 2025 from Nurse Aide 1 revealed that she heard Licensed Practical Nurse 2 tell the resident You can f*****g stay on the floor. A statement from Resident 1 dated August 22, 2025, revealed that he fell in the bathroom and Licensed Practical Nurse 2 stated that she should leave me on the f*****g floor. He stated that he did not want her to care for him anymore. During an interview with Resident 1 on August 27, 2025, at 11:55 a.m. he stated that he had fallen a couple night ago in his bathroom and agency nurse Licensed Practical Nurse 2 told him that he could lay on the f*****g floor all night. The allegation of abuse by Licensed Practical Nurse 2 was not reported to the Department of Health, the Ombudsman, Protective Services, the resident's representative, or law enforcement. Interview with the Director of Nursing on August 27, 2025, at 1:28 p.m. revealed that she was not aware that she was required to report the allegation of abuse to the agencies. Interview with the Interim Administrator on August 27, 2025, at 2:34 p.m. confirmed that Resident 1 had fallen and it was substantiated that Licensed Practical Nurse 2 told the resident he could stay on the f*****g floor. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.

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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 clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for one of ten residents reviewed (Resident 8). Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated May 16, 2025, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia (a group of conditions that cause a decline in cognitive abilities sever enough to interfere with daily life).Physician's orders for Resident 8, dated May 15, 2025, included an order for the resident to be out of bed to a high back wheelchair with bilateral elevating leg rests for transport and outside. Observations of Resident 8 on August 27, 2025, at 11:50 a.m. revealed that the resident was transported in his chair by Nurse Aide 3 from a common area near the nurse's station to his bedroom for lunch with no leg rests on his chair. An interview with Nurse Aide 3 at that time confirmed that she did not apply leg rests to Resident 8's chair prior to transporting the resident and she should have. An interview with the Nursing Home Administrator on August 27, 2025, at 2:21 p.m. confirmed that leg rests should have been used as ordered when transporting Resident 8 and they were not.28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.