

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 01/06/2026
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on review of facility policy, manufacturer's instructions, US Consumer Product Safety Division warnings, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure the environment was free from accident hazard, placing the safety of the residents in an Immediate Jeopardy situation by not adequately securing water absorbing beads from residents on the dementia unit who wander, resulting in the ingestion and ICU hospitalization for one resident (Resident 1). Findings include: The facility's policy for storage of activities items, dated September 23, 2025, revealed that items that are to be used with close supervision must be stored in locked cabinets or other designated secure storage areas. Access to these areas is limited to authorized personnel only. Staff must ensure that cabinets remain locked and secured at all times when not in active use. Manufacturer's instructions for the use of the water absorbing beads (water beads), dated 2022, revealed that ingestion of the water beads is a serious medical emergency, as the beads can expand up to 400 times their original size in the body and cause life threatening intestinal blockages or choking. Water beads are made from super- absorbent polymer that, while usually non-toxic chemically, presents a significant physical hazard as it absorbs bodily fluids and expands. This expansion can occur in the esophagus, stomach, or intestines and lead to a potentially fatal obstruction. The US Consumer Product Safety Division's safety warning for the use of water absorbing beads on January 7, 2026 revealed that dry water beads can be the size of a pinhead, making them nearly undetectable if dropped on the floor or spilled in a playroom; Ingested water beads can continue to grow inside the body. This can cause severe discomfort, vomiting, dehydration, intestinal blockages and life-threatening injuries, and surgery may be required to remove the water beads; and water beads inserted into ears can damage ear structures, causing hearing loss and require surgery. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 23, 2025, revealed that the resident was cognitively impaired, was independent with mobility, and had diagnoses that included dementia and dysphagia (impaired swallowing foods and liquids). A care plan for Resident 1, dated November 7, 2025, revealed that he exhibits wandering and is to be in a secure environment. A witness statement from Nurse Aide 1 on January 2, 2026, revealed that during 5:00 a.m. rounds she entered Resident 1's room with another nurse aide and found the resident in bed and the floor was covered in water beads. The resident was coughing and spitting the water beads out of his mouth and she went to get the licensed practical nurse. She did not see the resident get into anything. A witness stated from Nurse Aide 6, dated January 2, 2025 revealed that Resident 1 was in bed at 2:15 a.m. and nothing unusual was visualized. A witness statement from Nurse Aide 5 on January 2, 2026, revealed that she was assisting Nurse Aide 1 with nursing rounds at 5:00 a.m. and noticed that the north lounge activity room door was open and the light was on. The cabinet where the water beads are kept was open. A witness statement from Licensed Practical Nurse 2 on January 2, 2026, revealed that she was called to Resident</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395828
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1's room by Nurse Aide 1 and observed him in his room. He was coughing up water beads and mucous, his vital signs were stable. His lung sounds had rattles (popping, bubbling, or clicking noises heard with a stethoscope) bilaterally and she notified the registered nurse. Investigative documents for Resident 1 dated January 2, 2026, at 4:54 a.m. revealed that Registered Nurse 3 was called to the resident's room. Upon assessment resident was awake and alert with confusion and was spitting up water beads. His respirations were even and unlabored with cough observed. Lung sounds were diminished with congestion. The physician was notified and Resident 1 was transferred to the hospital. Interview with Activity Aide 4 on January 6, 2026, at 10:43 a.m. confirmed that the water beads were kept in a closet in the north lounge activity/dining room. Interview with the Director of Nursing on January 6, 2026, at 10:13 a.m. confirmed that the water beads were unsecured in the north lounge activity/dining room on the dementia unit. She stated that it was unknown how many water beads Resident 1 had ingested. A nursing note dated January 2, 2026, at 4:25 p.m. revealed that the resident was admitted to the local hospital and was in the intensive care unit. Observations of the north lounge activity/dining room on January 6, 2026 at 10:00 a.m. revealed that it was three doors from Resident 1's room and neither room was visible from the nursing station. The storage cabinet located in the north lounge activity/dining room had two doors with a knob on each and the cabinet could be locked using a key. On January 6, 2026, at 12:14 p.m. the Nursing Home Administrator was given the Immediate Jeopardy template and informed that the health and safety of the residents were placed in Immediate Jeopardy due to the facility's failure to ensure that water beads were properly secured from residents. An immediate action plan was submitted and contained the following: The water beads were removed from the facility. Staff will identify like residents that have the potential to be affected. The Director of nursing/designee has done a house review on rooms and lounges for any like foreign objects and any other potentially noted items that would pose a like issue. Education was provided to nursing and activities staff on removing items that would pose a potential risk for residents to ingest. All activity cabinets have been locked and secured. Newly hired staff and staff on paid time-off will be educated before working the next shift. The facility will monitor and maintain ongoing compliance. The Director of Nursing or designee will complete observation audits to ensure items that have potential to be ingested are removed and activity cabinets are locked. The Immediate Jeopardy was lifted on January 6, 2026, at 1:47 p.m. when it was confirmed that water beads were removed from resident use, staff were educated on identifying potential choking hazards and storage for items used by activities. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of employee job descriptions, as well as observations and staff interviews, it was determined that the facility's administration, Nursing Home Administrator and Director of Nursing, failed to effectively use its resources to promote resident safety and maintain the highest practicable physical well being of residents in the facility by failing to ensure that water absorbing beads were secured, placing the residents on the dementia unit at risk for serious harm which created an Immediate Jeopardy situation. Findings include: The job description for the NHA, dated September 23, 2025, indicated that the primary purpose of the job is to lead, direct, and manage the overall operations of the community in accordance with policies and procedures and current federal, state and local standards, guidelines and regulations that governs the community. As the Administrator, it is their responsibility to organize, develop, and director resources to maintain the highest degree of quality care is maintained for each resident at all times. The Administrator will also plan, implement and achieve the community's business objectives. The position description for the DON, dated September 23, 2025, indicated that the DON is responsible for organizing, developing, managing and directing the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the community. The Director of Nursing is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. Follows all health, sanitary and infection control polices and maintains established standards of practice set forth by the community's administration and Nursing Policies and Procdures. The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (F689) revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free of accident hazards. Refer to F689. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		