

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 01/23/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on a review of policies, clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of five residents reviewed (Resident 2). This deficiency was cited as past non-compliance. Findings include: The facility's policy regarding abuse, dated September 23, 2025, revealed that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriations of resident property by anyone. An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 2, dated December 7, 2025, indicated that the resident was cognitively impaired, was dependent on staff for all care needs, and had a diagnosis of Alzheimer's disease. A nurse's note for Resident 2 dated December 15, 2025, at 6:11 p.m. revealed that a nurse aide reported that another nurse aide hit the resident on the left hand while the resident was grabbing onto another resident's bed during dinner time. The alleged perpetrator was sent home. A skin check completed on the resident revealed small areas of bruising, deep purple in color, to his bilateral hands. The resident was able to move both hands without signs or symptoms of pain or discomfort and there was no swelling noted. Review of an event report dated December 15, 2025, revealed that on December 15, 2025, at 6:11 p.m. Nurse Aide 1 informed the nursing supervisor that Nurse Aide 2 was noted punching Resident 2. An interview with Nurse Aide 1 who witnessed the incident reported that the resident was attempting to self-propel out of the room when he grabbed hold of another resident's bed to help himself wheel out. When he did this, Nurse Aide 2 grabbed Resident 2's hands to get him to let go of the bed and pushed the resident away from the bed. This caused Resident 2 to become agitated, and then again grabbed onto the bed. Nurse Aide 2 intervened again and pushed the resident's hands off the bed. When he did this, the resident grabbed Nurse Aide 2 by the arm and told Nurse Aide 2 to stop it. Nurse Aide 2 removed the resident's hands from his arm and struck the resident's left wrist with his fist. Nurse Aide 2 pushed the residents out of the room. Nurse Aide 1 who witnessed the event stated it happened quickly and she was unsure of how to intervene but immediately reported it to the registered nurse supervisor. The registered nurse supervisor notified the Director of Nursing and Nurse Aide 2 was sent home immediately pending an investigation. Assessment of Resident 2 noted small bruises to both hands. A witness statement from Nurse Aide 1 dated December 15, 2025, revealed that she and Nurse Aide 2 were feeding residents in Resident 2s room. Resident 2 was attempting to wheel himself out of the room after eating supper and his wheelchair wheel got stuck on the bedside table and he was dragging it with him. Nurse Aide 2 got up and got the table off the wheel and removed the meal tray from the table and put it in the cart. Nurse aide 2 then brought Resident 2 a cup of coffee and Resident 2 stated he did not want the coffee and to dump it out. Resident 2 stated I'll dump it on your head and sat down to continue feeding another resident. Resident 2 then grabbed hold of the bed to help wheel himself out the door when Nurse Aide 2 aggressively slid his chair out and grabbed hold of the resident's hands to make</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: 395828	Facility ID: 395828 If continuation sheet Page 1 of 4

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>him let go of the bed. Resident 2 then became agitated and grabbed back onto the bed. Nurse Aide 2 ripped the resident's hand off again and the resident grabbed Nurse Aide 2's arm and said, stop it. Nurse Aide 2 then forced the resident's hands off him and with his fist slammed down on the resident's left wrist bone area. The resident said, ouch that hurt and was holding his arm. Nurse aide 2 then pushed him out of his room and into the lounge. Interview with the regional director of clinical services on January 21, 2026, at 2:25 p.m. revealed that the allegation of abuse to Resident 2 by Nurse Aide 2 was immediately investigated upon report of it, the allegation was substantiated, and Nurse Aide 2 was terminated from employment. Following identification of the allegation of abuse, the facility's corrective actions included: Nurse Aide 2, who was involved in the allegation of abuse to Resident 2, was terminated upon completion of the facility's investigation. To identify like residents that have the potential to be affected, nursing staff/designee completed skin checks on incapable residents for signs and symptoms of abuse. To identify like residents that have the potential to be affected, nursing staff/designee completed interviews on capable residents on that unit. No capable residents were identified on that unit. Education was provided to all staff on the facility's abuse policy and abuse and de-escalation of behaviors on December 15 and 16, 2025. To monitor and maintain ongoing compliance, observations of residents were to be performed weekly four times, then monthly twice to ensure there are no issues with abuse. A review of the facility's corrective actions revealed that they were in compliance with F600 on December 16, 2025. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.28 Pa. Code 211.12 (d)(5) Nursing services.</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on a review of policies, clinical record review and staff interviews, it was determined that the facility failed to develop and implement a discharge planning process to align with the resident's goals and failed to provide discharge instructions, including medication times and doses for one of five residents reviewed (Resident 3). Findings include: Review of Resident 3's clinical record revealed that the facility admitted him on December 8, 2025 after falling at home and suffering a traumatic brain bleed. A comprehensive Minimum Data Set (MDS) assessment (a mandatory assessment of a residents abilities and needs) dated December 14, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and that his overall goal was to remain in the facility for long term care. The resident's care plan, dated December 10, 2025, indicated that the resident was to reside in the facility for long term care. Social services note for Resident 3, dated December 10, 2025, revealed that the resident told the social worker that he did not want to return home to his townhouse because he could not manage the stairs necessary to get in and out, he lived alone and had no one to help him and that he preferred to stay in the nursing facility for long term care. A Certified Registered Nurse Practitioner's (CRNP, a higher practice nurse) note for Resident 3, dated December 11, 2025 revealed that the resident told her he had no family in the area and that he could not return home alone as he was unable to care for himself as evidenced by his recent fall with subdural hematoma (brain bleed). An Interdisciplinary Team meeting for Resident 3 on December 12, 2025, revealed that the resident did not want to return to his prior living arrangements and was willing to apply for the state insurance to stay at the nursing facility for long term care. A social services note for Resident 3, dated December 18, 2025 indicated that the resident was issued a Notice of Medicare Non-Coverage (NOMNC) letter and that he would be discharging home to his previous living arrangements on December 21. A review of Resident 3's physical therapy and occupation therapy assessments, dated December 9, 2025, revealed that the resident's goal was long term care, and not discharge to home. There was no evidence in Resident 3's clinical record that the facility followed up with the resident or the resident's family regarding the change in his plans to assure his safety upon discharge. A review of Resident 3's discharge instructions revealed that he was not provided with a list of medications with the times and dosages that he would need to take, or instructions on the medications that he should no longer take. Interview with the Social Services Director on January 21, 2026 at 12:42 p.m. revealed that the resident did want to stay long term and that he applied for the state's insurance. However, he had to spend down his \$40,000 Individual Retirement Account (IRA) by paying the nursing facility for his stay before he would qualify for the state's insurance. When he learned he would have to use his IRA monies, he decided to return to his apartment. She stated that his goal in therapy was not changed in order for him to receive the training needed to return to his home. An interview with the Rehab Program Manager on January 21, 2026 at 12:57 p.m. revealed that the resident's goals while in therapy were for him to remain in the facility for long term care, therefore, the resident was to be cut from therapy. She stated that the therapy department was not notified that the resident's goal had changed from long term care to home until December 18, and that therapy should have made changes to his plan in therapy at that time. She stated that therapy had not worked with the resident on any home goals, such as housework, cooking, laundry, or stairs. She stated she was aware that he had 12 stairs to get in and out of his apartment, but that therapy had not worked with him on stairs because his goal was long term care. Interview with Casemanager on January 21, 2025 at 1:21 p.m. revealed that he did not inform the resident's insurance that the resident's goal had changed from long term care to going home and</p> <p>(continued on next page)</p>		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therefore the NOMNC cut letter was issued and the resident had decided to go home instead of paying for his room. Interview with the Nursing Home Administrator on January 22, 2026 at 8:39 p.m. revealed that the resident was not provided with discharge instruction which included a list of medications that he was to take and when to take them. 28 Pa. Code 201.18 (3)(e)(1) Management 28 Pa. Code 211.10(a) Resident care plan		