

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 11/20/2025
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to ensure that essential equipment was in safe operating condition in the facility's kitchen. Findings include: Observations in the facility's kitchen on November 17, 2025, at 8:56 a.m. revealed that the dishwasher was not in use and not functioning properly. There was no evidence of a confirmed plan to repair or replace the dishwasher prior to the initial tour of the kitchen. Interview with the Assistant Dietary Manager on November 17, 2025, at 11:15 a.m. confirmed that the dishwasher was not being used due to not functioning properly. He indicated that the dishwasher had not been in use since October 25, 2025 and they were serving meals on Styrofoam products since then. 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.		

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 - Some	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 ten of 51 residents reviewed (Resident 3, 40, 44, 46, 52, 87, 96, 99, 115, and 158). 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 abuse or neglect 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 September 23, 2025, 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 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 3, dated August 28, 2025, indicated that the resident was cognitively intact, required assistance from staff with daily care needs, had diagnoses that included benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that causes urinary problems). Physician's order for Resident 3 dated October 30, 2024, revealed 0.4milligram (mg) of tamsulosin (a medication used to treat benign prostatic hyperplasia) was to be administered once a day between 3:00 p.m. and 5:00 p.m. A nursing note for Resident 3 dated September 29, 2025, at 1:30 a.m. and a review of the resident's Medication Administration Record (MAR) revealed that the resident was not administered 0.4mg tamsulosin on September 29, 2025. A quarterly MDS for Resident 40 dated September 11, 2025, revealed that the resident was cognitively intact, was dependent on staff for care and activities of daily living, and had diagnoses that included seizures and glaucoma (a group of eye conditions that damage the optic nerve that connects the eye to the brain). Physician's order for Resident 40 dated July 24, 2024, revealed the resident was to receive one drop of 1.4% polyvynal alcohol eye drops (artificial tears) in each eye three times a day; one drop of 0.2% brimonidine eye drops (a medication that is used to lower high pressure inside the eye caused by glaucoma) in the right eye three times a day; and 300 mg of Neurontin (a medication to prevent seizures) three times a day. A nursing note for Resident 40 dated September 29, at 9:40 p.m. and a review of the MAR revealed that the resident was not administered one dose each of the artificial tears, brimonidine eye drops, or 300mg Neurontin during the medication pass between 4:00 p.m. and 6:00 p.m. on September 29, 2025. A quarterly MDS for Resident 44 dated August 7, 2025, revealed that the resident was cognitively impaired, required maximum assistance from staff for care, and has diagnoses that included stroke, seizure disorder, dysphagia (difficulty swallowing), and gastroesophageal reflux disorder (GERD-a medical condition when stomach acid flows back up into the esophagus). Physician's orders for Resident 44 dated June 22, 2023, revealed the resident was to receive 5 mg metoclopramide (a medication used to treat gastrointestinal conditions and manage nausea and vomiting) 1 tablet twice a day. A nursing note for Resident 44 dated September 30, 2025, at 1:43 a.m. and a review of the MAR revealed that the second dose of 5 mg metoclopramide was not administered. New orders were received to administer the missed dose at bedtime on September 29, 2025. A quarterly MDS for Resident 46 dated October 1, 2025, revealed that the resident was cognitively impaired, was dependent on staff for care, and had diagnoses that included multiple sclerosis (a disease of the brain and spinal cord where the immune system mistakenly attacks the (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protective layer around nerve fibers, causing a disruption of communication between the brain and body), and was receiving hospice care. Physician's order for Resident 46 dated January 8, 2025, revealed the resident was to receive 650mg acetaminophen (Tylenol) every six hours. Physician's order for Resident 46 dated April 23, 2025, revealed the resident was to receive 0.5 milliliter (ml) of 5mg/ml diazepam (a medication used to treat central nervous system disorders including anxiety, seizures, and muscle spasms) twice a day and at bedtime. Physician's order for Resident 46 dated December 18, 2023, revealed the resident was to receive 25mg promethazine (a medication used to treat vomiting) every six hours. Physician's order for Resident 46 dated July 1, 2023, revealed the resident was to receive 2 tablets of 8.6-50mg Senna daily for constipation. A nursing note for Resident 46 dated September 29, 2025, at 10:08 p.m. and a review of the MAR revealed that the resident was not administered acetaminophen, diazepam, promethazine, and senna during the 4:00 p.m. medication pass on September 29, 2025. An annual MDS for Resident 52 dated August 7, 2025, revealed that the resident was cognitively intact, was independent with daily care needs, and had medical diagnoses of stroke, anxiety and depression. Physician's orders for Resident 52 dated March 22, 2025, revealed that the resident was to receive 15 mg of buspirone (a medication used to treat anxiety disorders) three times a day. A nursing note for Resident 52 dated September 29, 2025, at 10:15 p.m. and a review of the MAR revealed that the resident's afternoon dose of 15 mg of buspirone was not administered on September 29, 2025. A quarterly MDS for Resident 87 dated August 31, 2025, revealed that the resident was severely cognitively impaired, was dependent on staff for daily care needs, and had medical diagnoses of coronary artery disease, heart failure, high cholesterol, diabetes, and Parkinson's disease (a progressive neurological disorder that affects the nervous system). Physician's orders for Resident 87 dated August 25, 2025, revealed that the resident was to receive 5 mg of baclofen (a muscle relaxant) three times a day; 12.5-50-200 mg of carbidopa-levodopa-entacapone (a medication used to treat Parkinson's disease) three times a day; 200 mg of entacapone (a medication used to treat Parkinson's disease) three times a day; 12.5 mg of carvedilol (medication used to treat heart disease) twice a day with breakfast and supper; and 300 mg of tums twice a day for heartburn. A nursing note for Resident 87 dated September 29, 2025, at 9:11 p.m. and a review of the MAR revealed that the resident was not administered her afternoon doses of baclofen, carbidopa-levodopa-entacapone, entacapone, carvedilol, and tums on September 29, 2025. An admission MDS for Resident 96 dated September 24, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care, and had medical diagnoses of diabetes. Physician's orders for Resident 96 dated September 28, 2025, revealed that the resident was to receive Humalog Kwik Pen 100 units/ml depending on the sliding scale for blood glucose monitoring prior to meals. A nursing note for Resident 96 dated September 30, 2025, at 1:01 a.m. and a review of the MAR revealed that the resident did not have his blood sugar checked at 4:00 p.m. and was not administered his 4:00 p.m. dose of Humalog Kwik Pen sliding scale on September 29, 2025. A quarterly MDS for Resident 99 dated September 11, 2025, revealed that the resident was cognitively intact, was dependent on staff for care, and had medical diagnoses of osteoarthritis (a degenerative joint disease that causes pain, stiffness, swelling) and stroke. Physician's orders for Resident 99 dated October 12, 2024, revealed that the resident was to receive 25-100 mg of carbidopa-levodopa (a medication to treat Parkinsons) three times a day, and 0.5 mg of clonazepam (a medication use to treat seizure disorders) three times a day. A nursing note for Resident 99 dated September 30, 2025, at 1:50 a.m. and a review of the MAR for September 29, 2025 revealed that the resident was not administered the afternoon doses of carbidopa-levodopa and clonazepam on September 29, 2025. A quarterly MDS for Resident 115 dated September 22, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had medical diagnoses that included end stage kidney disease, diabetes, and dialysis. Physician's orders for Resident 115 dated August 12, 2025, revealed that the resident was to receive 150 mg of Lyrica for neuropathy (nerve pain) three times a day. A nursing note for Resident 115 dated September 29, 2025, at 9:57 p.m. and a review of the MAR (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed that the resident was not administered her afternoon dose of Lyrica on September 29, 2025. An annual MDS for Resident 158 dated September 22, 2025, revealed that the resident was cognitively intact, was independent with daily care needs, had medical diagnoses that included Parkinson's, and was receiving scheduled pain medications. Physician's order for Resident 158 dated December 28, 2025, revealed that the resident was to receive 5 mg oxycodone (a narcotic pain medication) three times a day. A nursing note for Resident 158 dated September 29, 2025, at 9:15 p.m. and a review of the MAR revealed that the resident was not administered her afternoon dose of oxycodone on September 29, 2025. The facility's investigation regarding the mentioned medications for the above residents determined that the medications for the residents were not administered due to omission by the nurse. Interview with the Director of Nursing on November 20, 2025, at 9:14 a.m. confirmed that the above medication errors were due to omission and were not reported to the Department of Health and should have been. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 51 residents reviewed (Resident 2, 4, 11, 16, 17, 115, 157). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that the intent of Section P0100B Trunk Restraint was to record the type of restraint used by the resident during the seven days of the assessment period. A quarterly MDS for Resident 2 dated October 25, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs and utilized a trunk restraint. However, a review of the medical record for Resident 2 revealed no documented evidence that the resident utilized a trunk restraint during the lookback period. An interview with the Director of Nursing on November 20, 2025 at 11:05 a.m. confirmed that Resident 2's MDS was coded incorrectly for trunk restraints. The RAI manual, dated October 2025, indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Sections N0415A Antipsychotic Medications (medication used for medications used for behaviors), Sections N0415I Antiplatelet Medications (medication used to prevent blood from clotting). Physician's orders for Resident 4 dated September 25, 2025, included an order for the resident to receive 81 milligrams (mg) of aspirin (antiplatelet) once a day. The resident's Medication Administration Record from October 28 through November 3, 2025, revealed that the resident received 81 mg of aspirin daily and did not receive an antipsychotic medication during the lookback period. However, a quarterly MDS assessment for Resident 4, dated November 3, 2025, revealed that Section N0415I was not coded for antiplatelet medication during the lookback period. Section N0415A was coded for antipsychotic during the lookback period. An interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m. confirmed that Resident 4's MDS was coded inaccurately and should have been coded for antiplatelet and not have been coded of antipsychotic medications. The RAI Manual, dated October, 2025, indicated that the intent of Section O0110J1 (Dialysis) was to be coded if the resident received dialysis services. Physician's orders for Resident 11 dated June 26, 2025, included orders for the resident to receive dialysis services. A quarterly MDS assessment for Resident 11 dated October 2, 2025, revealed that Section O0110J1 was not coded for dialysis during the lookback period. A interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that Resident 11's MDS assessment was coded inaccurately and should have been coded for dialysis. The RAI User's Manual, dated October 2025, revealed that if a wander/elopement alarm was used, then Section P0200E was to be coded as (0) not used, (1) used less than daily, or (2) used daily. A physician's order for Resident 16, dated August 29, 2025, included orders for the resident to use a wanderguard (device that alarms when close to exit doors), and to check the function daily and the placement every shift. The resident's Medication Administration Record for October 2025 revealed that the resident used a wanderguard from October 1-31, 2025. However, a quarterly MDS assessment for Resident 16, dated October 28, 2025, revealed that Section P0200E was coded with a (0), indicating that the resident did not use a wander/elopement alarm. Interview with the Nursing Home Administrator on November 19, 2018, at 1:48 p.m. confirmed that Section P0200E of Resident 16's MDS assessment of October 28, 2025, should have been coded (2) for daily use of a wander/elopement alarm. The RAI Manual, dated October, 2025, indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. N0415F Antibiotic medications were to be coded if the resident took the medication during the seven-day look-back period. A review of Resident 17's Medication Administration Record for September 27 through October (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3, 2025, revealed that the resident did not receive an antibiotic during the look back period. However, a significant change MDS for Resident 17 dated October 3, 2025, revealed that Section N0415F Antibiotic was coded that the resident received antibiotics during the lookback period. A interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that Resident 17's MDS assessment was coded inaccurately and that the resident did not receive an antibiotic during the lookback period. The RAI manual, dated October 2025, indicated that the intent of Section O0110J1 (Dialysis) was to be coded if the resident received dialysis services. Physician's orders for Resident 115 dated June 26, 2025, included orders for the resident to receive dialysis services. However, a quarterly MDS assessment for Resident 115 dated September 22, 2025, revealed that Section O0110J1 was not coded for dialysis during the lookback period. An interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that Resident 115's MDS assessment was coded inaccurately and should have been coded for dialysis. The RAI manual, dated October, 2025, indicated that the intent of Section N0300A (Insulin) was to be coded if the resident received insulin during the assessment period. There was no documented evidence in Resident 157's clinical record of the resident receiving insulin during the lookback period. However, a quarterly MDS assessment for Resident 157 dated September 22, 2025, revealed that Section N0300A was coded for insulin during the lookback period. An interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that Resident 157's MDS assessment was coded inaccurately and should not have been coded for insulin. 28 Pa. Code 211.5(f) Clinical records.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies and observations, as well as resident and staff interviews, it was determined that the facility failed to serve food that was palatable and at appetizing temperatures. Findings include: The facility's policy regarding food temperatures, dated September 23, 2025 indicated that hot foods should be at least 135 degrees Fahrenheit (F) when plated and should be palatable at the point of delivery. Foods were to be transported as quickly as possible to maintain temperatures for delivery and service, and appropriate hot/cold holding equipment was to be used as needed. An interview with Resident 129 on November 17, 2025, at 1:53 p.m. revealed that she believed the quality and quantity of the food served for meals was poor, and that the food was often served cold when it should have been served hot. The lunch meal on November 18, 2025, consisted of fried chicken with poultry gravy, garlic mashed potatoes, seasoned spinach, and corn bread. The recipes for the seasoned spinach only called for salt; the garlic mashed potatoes called for minced garlic, margarine and salt; and the cornbread called for water to be added to a cornbread mix. Observations in the main kitchen for the lunch meal service on November 18, 2025, at 12:09 p.m. revealed that Styrofoam containers were used instead of regular plates and bowls. A test tray left the kitchen and arrived on the third floor at 12:12 p.m. Styrofoam containers of food were passed to the residents in their rooms, and the last resident was served and eating at 12:21 p.m. The test tray on November 18, 2025, at 12:22 p.m. revealed that the temperature of the fried chicken was 127.0 degrees F and the spinach was 122.9 degrees F. The fried chicken had a hard border, and the mashed potatoes, seasoned spinach, and cornbread lacked seasoning and flavor. Interview with the Assistant Dietary Manager at that time confirmed that food should be served at correct temperatures and be palatable. 28 Pa. Code 211.6(f) Dietary Services.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for an annual survey ending January 30, 2024, and a complaint survey's ending January 26; April 8; June 16; July 2; July 31; August 27, 2025, revealed that the facility developed a plan of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending November 20, 2025, identified a repeated deficiency related to right to be informed/make treatment decisions; safe, clean, comfortable homelike environment; reporting of alleged violations; accuracy of assessments; develop/implement comprehensive care plans; care plan timing and revision; quality of care; free of accident hazards/supervision/devices; and essential equipment safe operating condition. The facility's plan of correction for a deficiency regarding safe, clean, comfortable and homelike environment, cited during the survey ending April 8, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F584, revealed that the facility's QAPI committee failed to successfully implement their plan regarding safe, clean, comfortable and homelike environment. The facility's plan of correction for a deficiency regarding reporting of alleged violations cited during the survey ending August 27, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F609, revealed that the facility's QAPI committee failed to successfully implement their plan regarding reporting of alleged violations. The facility's plan of correction for a deficiency regarding inaccurate MDS assessments, cited during the survey ending January 30, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan regarding completing accurate MDS assessments. The facility's plan of correction for a deficiency regarding develop/implement comprehensive care plans cited during the survey ending January 30, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan regarding develop/implement comprehensive care plans. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending January 30, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan regarding care plan timing and revision. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending January 30 and June 16, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan regarding quality of care. The facility's plan of correction for a deficiency regarding safety/accident hazards, cited during the surveys ending January 30, April 8, July 31, and August 27, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to successfully implement their plan regarding safety/accident hazards. The facility's plan of correction for a deficiency regarding essential equipment safe operating condition cited during the survey ending January 30, 2025, revealed that the facility would complete audits and (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F908, revealed that the facility's QAPI committee failed to successfully implement their plan regarding essential equipment safe operating condition Refer to F552, F584, F609, F641, F656, F657, F684, F689, F908 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of clinical records and staff interviews, it was determined that the facility failed to inform the resident representative in advance of the risks and benefits of a psychotropic medication (medications that affect the persons mental state, emotions and behavior) use and the treatment alternatives prior to initiating the administration of the medication for two of 51 residents reviewed (Residents 1 and 16). Findings Include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated October 8, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnosis that included chronic obstructive pulmonary disease (COPD- condition involving constriction of the airways and difficulty or discomfort in breathing).Physician's orders for Resident 1, dated October 3, 2025, included an order for the resident to receive 25 milligrams (mg) of hydroxyzine hydrochloride (psychotropic medication used to treat anxiety and tension) three times a day as needed for anxiety. Physician's orders dated October 8, 2025, included an order for the resident to receive 25 milligrams (mg) of hydroxyzine hydrochloride three times a day, every day. A nurse's note for Resident 1 dated October 3, 2025, at 3:08 p.m. indicated that the resident was reporting increased anxiety and was unable to be redirected with therapeutic distraction activities. The certified registered nurse practitioner (CRNP-registered nurse with advanced education and clinical training) was notified, and new orders were obtained to administer 25 mg of hydroxyzine hydrochloride three times a day as needed for anxiety.There was no documented evidence in the clinical record to indicate that that Resident 1 or the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the dose of hydroxyzine hydrochloride.Interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m., confirmed that there was no documented evidence in the Resident 1's clinical record that the resident or the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating hydroxyzine hydrochloride medication. A quarterly MDS assessment for Resident 16, dated October 28, 2025, revealed that the resident could usually make his needs known, was moderately cognitively impaired, received antipsychotic medications, and had diagnoses that included schizophrenia (a serious mental health condition that affects how people think, feel and behave).Physician's orders for Resident 16, dated August 12 and September 5, 2025, included an order for the resident to receive 3.8 mg/24 hours of Secuado (antipsychotic medication) transdermal patch daily.There was no documented evidence in the resident's clinical record to indicate that Resident 16 or the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating Secuado.Interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m., confirmed that there was no documented evidence in Resident 16's clinical record that the resident or the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating Secuado. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on review of a policy and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for one of 51 residents reviewed (Resident 18). Findings include: A review of the facility policy titled Call Light Resident Communication System, dated September 23, 2025, indicated that it is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas. When the resident is in bed or confined to a chair, be sure the call light is within easy reach. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 18 dated October 30, 2025, indicated that the resident was able to make herself understood and could understand others, required assist from staff for daily care needs, and had diagnosis that included noninfective gastroenteritis and colitis (inflammations of the digestive tract that are not caused by an infection) Observation of Resident 18 on November 17, 2025, at 1:44 p.m. revealed that the resident was sitting in her chair on the left side of her bed facing the wall. She was leaning forward in her chair and across her bed attempting to reach her call bell that was on the upper right side of her bed. Upon this surveyor entering the room, Resident 18 asked if I could help her reach her call box for her because she couldn't reach it and she needed to call for a nurse. Interview with Registered Nurse 1 on November 17, 2025, at 1:48 p.m. revealed that Resident 18 could not self-propel herself in her chair and a call bell should have been within her reach for her to use. Interview with the Nursing Home Administrator on November 18, 2025, at 1:03 p.m. confirmed that Resident 18 should have had a call bell within reach while she is in her room. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment for one of 51 residents reviewed (Resident 142). Findings include: The facility's policy regarding routine environmental cleaning and disinfecting, dated September 13, 2025, indicated that proper cleaning and disinfecting of environmental surfaces is necessary to break the chain of infection. A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 142, dated September 5, 2025, revealed that the resident was cognitively intact, usually understood and understands, was highly hearing impaired and had diagnoses that included a stroke with residual right sided weakness. Observations on November 17, 2025, at 12:17 p.m. and November 18, 2025, at 8:45 a.m. and 2:35 p.m. revealed that the resident was lying in her bed resting. The bilateral enablers located on her bed were noted to have a thick amount of a blackish/brown removable substance on them, especially the inside aspect of the left enabler. Interview with Licensed Practical Nurse 2 on November 18, 2025, at 2:45 p.m. indicated that the resident frequently used the enablers to assist in positioning herself. She confirmed that both enablers, especially the left one, had a large amount of removable dirt and grime on them, and they should not. Interview with Director of Nursing on November 18, 2025, at 2:45 p.m. confirmed that Resident 142's bilateral enablers should be clean, and they were not. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a baseline care plan was developed for one of 51 residents reviewed (Resident 173). Findings include: The facility's policy regarding Comprehensive Care Plans, dated September 23, 2025, included that an interdisciplinary plan of care be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. An interim care plan was to be developed within 48 hours of admission to ensure that the resident's needs were met until a comprehensive care plan was completed. A nursing note dated November 13, 2025, at 7:45 p.m. revealed Resident 173 was admitted to the facility from the hospital. Physician's orders, dated November 13 and 14, 2025, included orders for the resident to receive 500 milligrams (mg) of levetiracetam (anticonvulsant medication) twice a day for seizures, 50 mg of Tramadol (narcotic pain medication) every six hours as needed for pain, and a wanderguard (device that alerts when exiting a door) bracelet to be used for safety. The Medication Administration Record (MAR) for Resident 173, dated November 2025, revealed the resident received 500 mg of Levetiracetam twice a day from November 13 through 20, 2025, received 50 mg of Tramadol as needed every six hours November 14 through 20, 2025, and used a wanderguard daily from November 14 through 20, 2025. There was no documented evidence that any individualized interventions were developed to meet Resident 173's immediate care needs for seizures/ anticonvulsant medications, pain, and the use of a wanderguard within 48 hours of admission. Interview with the Director of Nursing on November 20, 2025, at 2:56 p.m. confirmed that there were no baseline care plans developed to address the resident's seizure/anticonvulsant medications, pain, and wanderguard use, and should have been. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for two of 51 residents reviewed (Residents 18 and 38). Findings include: A facility policy for Comprehensive Care Planning, dated September 23, 2025, included that an interdisciplinary plan of care be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. The comprehensive care plan will be developed within seven days after completion of the comprehensive assessment. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 18 dated October 30, 2025, indicated that the resident was able to make herself understood and could understand others, required assist from staff for daily care needs, received routine and as needed pain medication, had almost constant pain, and had diagnosis that included noninfective gastroenteritis and colitis (inflammations of the digestive tract that are not caused by an infection). Physician orders for Resident 18 dated October 24, 2025, indicated that the resident was to receive 450 micrograms (mcg) of Belbuca (a strong pain medicine used for the management of severe and persistent chronic pain) twice a day for chronic pain (pain that lasts or recurs for more than three months and can interfere with daily life) and 5-325 milligrams (mg) of hydrocodone-acetaminophen (medication used to treat moderate to severe pain) every eight hours as needed for pain. There was no documented evidence that a care plan was developed to address Resident 18's care and treatment related to pain, and her care and treatment related to her use of pain medications. An interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m. confirmed that there was no active care plan for Resident 18's care and treatment related to chronic pain and her care and treatment related to her use of pain medication. A significant change MDS assessment for Resident 38 dated August 29, 2025, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnosis that included dementia. Physician's orders for Resident 38 dated October 15, 2025, indicated that the resident was to receive 100 milligrams of sertraline (antidepressant) once a day. There was no documented evidence that a care plan was developed to address Resident 38's care and treatment needs related to his use of antidepressants. An interview with the Nursing Home Administrator on November 19, 2025, at 1:53 p.m. confirmed that there was no active care plan for Resident 38's care and treatment related to his use of antidepressant medication. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for four of 51 residents reviewed (Residents 23, 28, 38, and 129). Findings include: A facility policy for Comprehensive Care Planning, dated September 23, 2025, included that an interdisciplinary plan of care be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. The care plan is reviewed on an ongoing basis and revised as indicated by the residents' needs, wishes, or a change in condition. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated October 24, 2025, indicated that the resident was moderately cognitively impaired, required assistance from staff for daily care tasks and, had diagnoses that included malignant melanoma of the left upper limb and shoulder. Physician's orders for Resident 23, dated September 24, 2025, included an order for the resident, while lying in bed, to have a bed positioning wedge along her left side from her hip down. Resident 23's care plan, last reviewed/revised on September 17, 2025, indicated that the resident was at risk for falls related to muscle wasting with related weakness. Interview with the Director of Nursing on November 18, 2025, at 2:45 p.m. confirmed that Resident 23's care plan was not updated to reflect that while lying in bed the resident was to have a bed positioning wedge along her left side from her hip down. An admission MDS assessment for Resident 28, dated October 20, 2025, indicated that the resident had moderate cognitive impairment, required assistance with daily care needs, used a wheelchair, had recent falls, and had diagnosis that included dementia. A facility investigation, dated March 9, 2025, at 10:00 p.m. revealed Resident 28 had an unwitnessed fall in the bathroom. The resident took herself to the bathroom to wash up and slid out of her wheelchair. She complained of knee pain and had some swelling and bruising. An x-ray was obtained and the resident was diagnosed with a left tibia (lower leg bone) fracture. To prevent further sliding from her wheelchair, dycem (anti-slip material) was added to the top of her wheelchair cushion. There was no documented evidence that the resident's current care plan included dycem to the top of her wheelchair cushion. Interview with the Director of Nursing on November 20, 2025, at 10:35 a.m. confirmed that Resident 28's care plan was not updated to include dycem, following the fall on March 9, 2025. A significant change MDS assessment for Resident 38 dated August 29, 2025, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnosis that included dementia. A care plan for Resident 38 dated July 10, 2025, indicated that the resident was receiving an antipsychotic medication. Review of the Medication Administration Record (MAR) and nurses notes for Resident 38 dated November 2025 revealed no documented evidence that the resident was receiving antipsychotic medication. An interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m. revealed that Resident 38 was not receiving antipsychotic medication and his care plan should have been revised to reflect that, however it was not. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 129 dated August 31, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included diabetes and cancer. Care plan for Resident 129 dated April 24, 2024, indicated that the resident was receiving antianxiety and antidepressant medications. A care plan dated August 14, 2023, indicated that the resident required supplemental oxygen therapy. Review of the Medication Administration Record (MAR) and nurses notes for Resident 129 dated November 2025, revealed no documented evidence that the resident was receiving antianxiety medication, antidepressant medication or oxygen therapy. An interview with the Director of Nursing on November 20, 2025, at 10:26 a.m. revealed that Resident 129 was not receiving antianxiety medication, antidepressant medication or oxygen therapy and her care plan should have been revised to reflect that, however it was not. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medications and treatment administration were followed for 12 of 51 residents reviewed (Residents 3, 4, 40, 44, 46, 52, 87, 96, 99, 115, 157, and 158). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated August 28, 2025, indicated that the resident was cognitively intact, required assistance from staff with daily care needs, had diagnoses that included benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that causes urinary problems). Physician's order for Resident 3 dated October 30, 2024, revealed 0.4milligram (mg) of tamsulosin (a medication used to treat benign prostatic hyperplasia) was to be administered once a day between 3:00 p.m. and 5:00 p.m. A nursing note for Resident 3 dated September 29, 2025, at 1:30 a.m. and a review of the resident's Medication Administration Record (MAR) revealed that the resident was not administered 0.4mg tamsulosin on September 29, 2025. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated November 3, 2025, revealed that the resident was cognitively impaired, required assistance with personal care needs, and had diagnoses that included hypotension (low blood pressure). Physician's orders for Resident 4, dated October 20, 2025, included an order for the resident to receive 5 milligrams (mg) of Midodrine (used to treat low blood pressure) three times a day and to hold the medication if the resident's systolic blood pressure (SBP-the top number in a blood pressure reading) is greater than 110. Review of the Medication Administration Record (MAR) for Resident 4, dated October 2025, revealed that 5 mg of Midodrine was administered on October 22 at 6:00 a.m. when the resident's SBP was 136; on October 22 at 6:00 p.m. when the resident's SBP was 124; on October 25 at 6:00 a.m. when the resident's SBP was 114; on October 25 at 12:00 when the resident's SBP was 118; on October 29 at 4:00 p.m. when the resident's SBP was 114; on October 29, 2025 at 8:00 p.m. when the resident's SBP was 124. Review of the resident's MAR, dated November 2025, revealed that 5 mg of Midodrine was administered on November 3 at 3:00 p.m. when the resident's SBP was 125; on November 4 at 3:00 p.m. when the resident's SBP was 115; on November 11 at 7:00 p.m. when the resident's SBP was 132; on November 13 at 7:00 a.m. when the resident's SBP was 126; On November 13 at 3:00 p.m. when the resident's SBP was 126; on November 13 at 7:00 p.m. when the residents SBP was 123; on November 14, at 3:00 p.m. when the resident's SBP was 112; and on November 17, 2025 at 3:00 p.m. when the resident's SBP was 120. Interview with the Nursing Home Administrator on November 19, 2025, at 1:53 p.m. confirmed that Midodrine was administered to Resident 4 on the above-mentioned dates and times when it should have been held per physician's orders. A quarterly MDS for Resident 40 dated September 11, 2025, revealed that the resident was cognitively intact, was dependent on staff for care and activities of daily living, and had diagnoses that included seizures and glaucoma (a group of eye conditions that damage the optic nerve that connects the eye to the brain). Physician's order for Resident 40 dated July 24, 2024, revealed the resident was to receive one drop of 1.4% polyvinyl alcohol eye drops (artificial tears) in each eye three times a day; one drop of 0.2% brimonidine eye drops (a medication that is used to lower high pressure inside the eye caused by glaucoma) in the right eye three times a day; and 300 mg of Neurontin (a medication to prevent seizures) three times a day. A nursing note for Resident 40 dated September 29, at 9:40 p.m. and a review of the MAR revealed that the resident was not administered one dose each of the artificial tears, brimonidine eye drops, or 300mg Neurontin during the medication pass between 4:00 p.m. and 6:00 p.m. on September 29, 2025. A quarterly MDS for Resident 44 dated August 7, 2025, revealed that the resident was cognitively impaired, required maximum assistance from staff for care, and has diagnoses that included stroke, seizure disorder, dysphagia (difficulty swallowing), and gastroesophageal reflux disorder (GERD-a medical condition when stomach acid flows back up into the esophagus). Physician's orders for Resident 44 dated June 22, 2023, revealed the resident was to (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive 5 mg metoclopramide (a medication used to treat gastrointestinal conditions and manage nausea and vomiting) 1 tablet twice a day. A nursing note for Resident 44 dated September 30, 2025, at 1:43 a.m. and a review of the MAR revealed that the second dose of 5 mg metoclopramide was not administered. New orders were received to administer the missed dose at bedtime on September 29, 2025. A quarterly MDS for Resident 46 dated October 1, 2025, revealed that the resident was cognitively impaired, was dependent on staff for care, and had diagnoses that included multiple sclerosis (a disease of the brain and spinal cord where the immune system mistakenly attacks the protective layer around nerve fibers, causing a disruption of communication between the brain and body), and was receiving hospice care and was at risk for developing pressure ulcers. A care plan dated October 27, 2025 revealed that revealed that barrier cream was to be applied after each incontinent episode and as needed. Current physician's orders for Resident 46 revealed that the resident was to receive 650mg acetaminophen (Tylenol) every six hours; 0.5 milliliter (ml) of 5mg/ml diazepam (a medication used to treat central nervous system disorders including anxiety, seizures, and muscle spasms) twice a day and at bedtime; 25mg promethazine (a medication used to treat vomiting) every six hours; 2 tablets of 8.6-50mg Senna daily for constipation; and an order for the resident to receive a pressure ulcer preventative foam dressing to the lower extremity every 5 days. A nursing note for Resident 46 dated September 29, 2025, at 10:08 p.m. and a review of the MAR revealed that the resident was not administered acetaminophen, diazepam, promethazine, and senna during the 4:00 p.m. medication pass on September 29, 2025. The Treatment Administration Record (TAR) for Resident 46 revealed that the pressure ulcer preventative treatment was completed on October 21, 27, November 2, 8, and 14, 2025 and not every 5 days as ordered. Additionally, there was no documented evidence in Resident 46's clinical record to indicate that barrier cream was applied to prevent MASD. A nursing note for Resident 46 dated November 17, 2025, at 6:18 p.m. revealed that the resident developed moisture associated with skin damage (MASD). Interview with the Nursing Home Administrator on November 19, 2025, at 11:25 a.m. and 2:27 p.m. respectively, confirmed that Resident 46 did not receive medications and treatments as ordered and confirmed that there was no documented evidence of barrier cream being applied to prevent MASD. An annual MDS for Resident 52 dated August 7, 2025, revealed that the resident was cognitively intact, was independent with daily care needs, and had medical diagnoses of stroke, anxiety and depression. Physician's orders for Resident 52 dated March 22, 2025, revealed that the resident was to receive 15 mg of buspirone (a medication used to treat anxiety disorders) three times a day. A nursing note for Resident 52 dated September 29, 2025, at 10:15 p.m. and a review of the MAR revealed that the resident's afternoon dose of 15 mg of buspirone was not administered on September 29, 2025. A quarterly MDS for Resident 87 dated August 31, 2025, revealed that the resident was severely cognitively impaired, was dependent on staff for daily care needs, and had medical diagnoses of coronary artery disease, heart failure, high cholesterol, diabetes, and Parkinson's disease (a progressive neurological disorder that affects the nervous system). Physician's orders for Resident 87 dated August 25, 2025, revealed that the resident was to receive 5 mg of baclofen (a muscle relaxant) three times a day; 12.5-50-200 mg of carbidopa-levodopa-entacapone (a medication used to treat Parkinson's disease) three times a day; 200 mg of entacapone (a medication used to treat Parkinson's disease) three times a day; 12.5 mg of carvedilol (medication used to treat heart disease) twice a day with breakfast and supper; and 300 mg of tums twice a day for heartburn. A nursing note for Resident 87 dated September 29, 2025, at 9:11 p.m. and a review of the MAR revealed that the resident was not administered her afternoon doses of baclofen, carbidopa-levodopa-entacapone, entacapone, carvedilol, and tums on September 29, 2025. An admission MDS for Resident 96 dated September 24, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care, and had medical diagnoses of diabetes. Physician's orders for Resident 96 dated September 28, 2025, revealed that the resident was to receive Humalog Kwik Pen 100 units/ml depending on the sliding scale for blood glucose monitoring prior to meals. A nursing note for Resident 96 dated September 30, 2025, at 1:01 a.m. and a review of the MAR revealed (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the resident did not have his blood sugar checked at 4:00 p.m. and was not administered his 4:00 p.m. dose of Humalog Kwik Pen sliding scale on September 29, 2025.A quarterly MDS for Resident 99 dated September 11, 2025, revealed that the resident was cognitively intact, was dependent on staff for care, and had medical diagnoses of osteoarthritis (a degenerative joint disease that causes pain, stiffness, swelling) and stroke. Physician's orders for Resident 99 dated October 12, 2024, revealed that the resident was to receive 25-100 mg of carbidopa-levodopa (a medication to treat Parkinsons) three times a day, and 0.5 mg of clonazepam (a medication use to treat seizure disorders) three times a day. A nursing note for Resident 99 dated September 30, 2025, at 1:50 a.m. and a review of the MAR for September 29, 2025 revealed that the resident was not administered the afternoon doses of carbidopa-levodopa and clonazepam on September 29, 2025.A quarterly MDS for Resident 115 dated September 22, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had medical diagnoses that included end stage kidney disease, diabetes, and dialysis. Physician's orders for Resident 115 dated August 12, 2025, revealed that the resident was to receive 150 mg of Lyrica for neuropathy (nerve pain) three times a day. A nursing note for Resident 115 dated September 29, 2025, at 9:57 p.m. and a review of the MAR revealed that the resident was not administered her afternoon dose of Lyrica on September 29, 2025.A Quarterly MDS for Resident 157, dated August 28, 2025, revealed that the resident was cognitively intact, was independent for daily care needs, had diagnoses that included hip fracture and received scheduled narcotics (a controlled substance used for pain). Physician's orders for Resident 157, dated July 9, 2025, included an order for the resident to receive 7.5-325 milligrams of oxycodone-acetaminophen (a narcotic) every 4 hours.A review of Resident 157's Medication Administration Record for April 2025 revealed no documented evidence that the resident received the oxycodone-acetaminophen on September 3, 2025, at 2:00 a.m., October 7, 2025, at 8:00 a.m., and October 8, 2025, at 12:00 a.m.Interview with the Director of Nursing on November 13, at 2:36 p.m. confirmed that there was no documented evidence that Resident 157 received the oxycodone-acetaminophen on the above dates and times.An annual MDS for Resident 158 dated September 22, 2025, revealed that the resident was cognitively intact, was independent with daily care needs, had medical diagnoses that included Parkinson's, and was receiving scheduled pain medications. Physician's order for Resident 158 dated December 28, 2025, revealed that the resident was to receive 5 mg oxycodone (a narcotic pain medication) three times a day. A nursing note for Resident 158 dated September 29, 2025, at 9:15 p.m. and a review of the MAR revealed that the resident was not administered her afternoon dose of oxycodone on September 29, 2025.Interview with the Director of Nursing on November 20, 2025, at 9:14 a.m. confirmed that the medications and treatments for the 12 residents listed were not administered per the physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's environment remained free of accident hazards by failing to ensure care-planned interventions were in place for two of 51 residents reviewed (Resident 15, 23) who were at risk for falls. Findings include: The facility's policy regarding fall prevention and management, dated September 13, 2025, indicated that the facility will identify those residents at risk for falls upon admission, readmission, and quarterly and provide appropriate interventions to modify and/or compensate for risk factors. The care plan will be updated to reflect resident-specific safety needs and interventions. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated October 22, 2025, revealed that the resident was severely cognitively impaired, required a mechanical lift for transfers, had a recent fall and had diagnoses that included Alzheimer's dementia. Physician's orders for Resident 15, dated October 17 and 27, 2025, included orders for staff to keep the resident's bed in the lowest position utilize bilateral floor mats, bilateral assistive handrails, a bolster overlay, and a gap filler for the mattress. The current fall risk care plan for Resident 15 indicated that the resident was at [NAME] for falls related to dementia, psychotic disturbances and anxiety. Observations of Resident 15 on November 20, 2025, at 1:15 p.m. revealed that the resident was in her bed and it was not in the lowest position, had no bilateral fall mats, no bilateral assistive handrails, no bolster overlay, and no gap filler for the mattress. Interview with Registered Nurse Supervisor 3 on November 20, 2025, at 1:24 p.m. confirmed that Resident 15 was recently moved to room [ROOM NUMBER] A from the third floor. She confirmed that the resident was in the correct bed as per documentation. She also confirmed that Resident 15's bed was not in the lowest to floor locked position, and had no bilateral fall mats, no bilateral assistive handrails, no bolster overlay, and no gap filler for the mattress. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated October 24, 2025, revealed that the resident was moderately cognitively impaired, was on a bariatric bed, required assistance for bed mobility, had diagnoses that included muscle weakness and malignant melanoma of the left upper limb and shoulder. Physician's orders for Resident 23, dated October 10, 2025, included orders for staff to keep a wedge for bed positioning along her left side from her hip down, while lying in bed, and bilateral fall mats on either side of the resident's bed. A fall risk care plan dated June 23, 2025, indicated that the resident was at [NAME] for falls related to muscle wasting and atrophy. Observations of Resident 23 on November 18, 2025, at 11:00 a.m. revealed that the resident was lying in her bed and there was no wedge for bed positioning along her left side from her hip down, and no bilateral fall mats on either side of her bed. Interview with Nurse Aide 4 on November 18, 2025, at 11:35 a.m. confirmed that Resident 23 was in bed and her wedge for positioning was on the floor on the left side of her bed, instead of in her bed as ordered and that she had no bilateral fall mats in place. Interview with the Director of Nursing on November 20, 2025, at 2:47 p.m. confirmed that Residents 15 and 23 should have had all fall prevention interventions in place as ordered and care planned, and they did not. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to ensure that a dialysis emergency kit was at the resident's bedside for two of 51 residents reviewed (Residents 10 and 11). Findings include: A hemodialysis care policy dated September 23, 2025, indicated that a smooth clamp should be kept at bedside of resident with a dialysis vascular access dialysis catheter in place. An admission MDS assessment for Resident 10, dated October 24, 2025, indicated that the resident was cognitively intact and required hemodialysis (a process of cleaning the blood of toxins and returning it into the body). Physician's orders, dated October 18, 2025, included an order for the resident to have dialysis. Observations of Resident 10 on November 20, 2025, at 11:40 a.m. revealed that she was sitting beside her bed in a wheel chair, and had a hemodialysis port in her left chest. There was no emergency equipment at her bedside. Interview with Licensed Practical Nurse 5 on November 20, 2025, at 11:45 a.m. indicated that if the emergency equipment was in the room, it would be taped on the wall or in the resident's top dresser drawer beside the bed. She confirmed that the equipment was not in place in Residents 10's room and should have been. A quarterly MDS assessment for Resident 11, dated October 2, 2025, indicated that the resident was cognitively impaired and required hemodialysis (a process of cleaning the blood of toxins and returning it into the body). Physician's orders, dated June 26, 2025, included an order for the resident to have hemodialysis. Observation of Resident 11 on November 20, 2025, at 12:00 p.m. revealed that she was sitting up in broda chair and had a hemodialysis port on her chest. There was no emergency equipment at her bedside. Interview with Licensed Practical Nurse 6 on November 20, 2025, at 12:00 p.m. revealed that if the emergency equipment was in the room, it would be taped on the wall or in the resident's top dresser drawer beside the bed. She confirmed that the equipment was not in place in Resident 11's room and should have been. Interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that there should have been a dialysis emergency kit at Resident 11's bedside. Interview with the Director of Nursing on November 20, 2025, at 12:53 p.m. confirmed that there should have been a dialysis emergency kit at the bedsides of Residents 10 and 11. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent. Findings include: The facility's medication Administration Policy, dated September 23, 2025, revealed that staff were to verify each time a medication was administered that it was the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident and with the correct technique. Observations during medication administration on November 19, 2025, revealed that two medications errors were made during 27 opportunities for error, resulting in a medication administrator error rate of 7.41 percent. Current manufacturer's instructions for use of Breo ellipta (fluticasone furoate and vilanterol inhalation powder) 100 micrograms (mcg) /25 mcg (used to treat chronic obstructive pulmonary disease (COPD) and Asthma) revealed that serious side effects including thrush (a fungal infection in the mouth and throat) can occur. Directions include to rinse the mouth with water without swallowing after use to reduce the chance of getting thrush. Physician's orders for Resident 49, dated September 18, 2025, included an order for the resident to receive 100 mcg/25 mcg of Breo ellipta (fluticasone furoate and vilanterol inhalation powder) with instructions to inhale 1 puff orally daily and to rinse mouth after each use. In addition, printed instructions on the Breo ellipta box stated to rinse mouth with water and spit out water after administration. Observations during medication administration on November 19, 2025, at 10:32 a.m. revealed that Licensed Practical Nurse 7 administered the Breo ellipta and did not have the resident rinse his mouth after administration. Interview with Licensed Practical 7 on November 19, 2025, at 8:55 a.m. confirmed that she should have had Resident 49 rinse his mouth after administering the Breo ellipta inhaler. Physician's orders for Resident 135, dated November 3, 2025, included orders for the resident to receive 20 milligrams (mg) of Citalopram (antidepressant medication) once a day. Observations during medication administration on November 19, 2025, at 8:59 a.m. revealed that Licensed Practical Nurse 8 administered 10 mg of Citalopram to the resident. Interview with Licensed Practical Nurse 8 on November 19, 2025, at 8:38 a.m. confirmed that she only administered 10 mg of Citalopram to Resident 135, instead of the ordered 20 mg. Interview with the Director of Nursing on November 19, 2025, at 1:10 p.m. confirmed that the nurse should have had Resident 49 rinse his mouth after administering the Breo ellipta inhaler, and Resident 135 should have been given the correct dose of Citalopram. 28 Pa Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for three of 51 residents reviewed (Residents 12, 46, 157). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated September 21, 2025, revealed that the resident was cognitively impaired, was frequently incontinent of urine, was receiving an anticoagulant, and had diagnoses that included dementia. A nursing note, dated September 17, 2025, at 8:51 a.m. revealed there was a moderate amount of bright red blood in Resident 12's toilet. The Certified Registered Nurse Practitioner (CRNP) was notified. A nursing note, dated September 19, 2025, at 1:40 a.m. revealed Resident 12 urinated in the toilet and it was blood tinged. A verbal order was received from the physician to place the resident's Xarelto on hold related to hematuria (blood in the urine) and obtain a urinalysis with a culture and sensitivity (UA C&S, test used to identify a urinary tract infection). There was no documented evidence that staff obtained Resident 12's UA C&S. Interview with the Nursing Home Administrator on November 19, 2025, at 1:48 p.m. confirmed that there was no evidence that Resident 12's UA C&S was obtained. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated October 1, 2025, revealed that the resident was cognitively impaired, was dependent on staff for daily care and had diagnoses that included high blood pressure, peripheral vascular disease (a circulation disorder where blood flow is restricted due to narrow, weakened, or blocked blood vessels), and multiple sclerosis (an autoimmune disease of the central nervous system). A physician's order for Resident 46 dated October 3, 2025, revealed that the resident was to have liver function tests (blood test) completed on the 3rd day of January, April, July and October. There was no documented evidence that staff obtained Resident 46's Liver Function Tests. Interview with the Director of Nursing on November 19, 2025, at 2:48 p.m. confirmed that there was no evidence that Resident 46's Liver Function Tests. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 157, dated August 28, 2025, revealed that the resident was cognitively intact, was independent with daily care needs and had diagnoses that included high cholesterol. A physician's order for Resident 157 dated March 4, 2025, revealed that the resident was to have liver function tests (blood test) completed on the 1st Tuesday of March and September. There was no documented evidence that staff obtained Resident 157's Liver Function Tests. Interview with the Director of Nursing on November 19, 2025, at 2:47p.m. confirmed that there was no evidence that Resident 157's Liver Function Tests. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions. Findings include: The facility's policy for the storage of refrigerated foods, dated September 23, 2025, revealed that refrigerated foods, prepared and held more than 24 hours would be marked to indicate the date the food would be consumed or discarded. Refrigerators in the facility used to store facility purchased food for residents would be equipped with an internal thermometer, were to be checked at least two times a day, and the unit temperature logs were to be retained for one year. Observations of the reach-in freezer in the main kitchen on November 17, 2025, at 8:56 a.m. revealed there was a block of sliced cheese in a plastic bag that was not dated or labeled when it was opened. Interview with the Dietary Manager on November 17, 2025, at that time confirmed that staff should have labeled and dated the bag of cheese. Observations in the main kitchen on November 17, at 8:50 a.m. revealed that there was a piece of ceiling tile that was loose and hanging down, in the dishwasher room there were large pieces of loose paint hanging down from the bulk head/duct work and clean pans were stored below it, a large piece of loose paint was hanging down from the bulk head near the double doors leading to the hallway, and a large fan had an accumulation of dust and debris on the back cage and was blowing onto clean cups. Interview with the Dietary Manager on November 17, 2025, at 9:00 a.m. confirmed that the ceiling tile needed replaced, clean pans should not have been stored under the loose hanging paint, the fan should be cleaned, and the bulk heads needed painted. Observations of the fourth floor pantry on November 20, 2025, at 10:19 a.m. revealed there was no temperature log for the refrigerator. Observations of the third floor pantry on November 20, 2025, at 2:01 p.m. revealed there was a full Dairy Queen Blizzard in the freezer and a full box of pizza in the refrigerator that was not labeled or dated, and there was no thermometer located in the refrigerator or temperature log for the refrigerator. Interview with the Director of Nursing on November 20, 2025, at 2:55 p.m. confirmed that staff should have been logging the refrigerator temperatures. 28 Pa. Code 211.6(f) Dietary Services.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on review of hospice contracts and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for four of 51 residents reviewed (Residents 17, 23, 36 and 46). Findings include: The Hospice care policy dated September 23, 2025, indicated that the facility and hospice provider (provider of end-of-life services) would work collaboratively and indicated that the hospice provider would provide information to the facility to facilitate coordination of care that included the most recent hospice plan of care specific to each patient, physician certification or recertification, a hospice benefit of elections form (a form signed to indicate that the individual waives all rights to traditional Medicare Part A payments for treatment related to the terminal illness) and updated nursing documentation. Physician's order for Resident 17, dated September 25, 2025, revealed that the resident was receiving hospice services for terminal diagnosis of protein malnutrition. As of November 20, 2025, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice benefit of elections form and certification of terminal illness form, resident's hospice plan of care and current nursing documentation. Interview with the Director of Nursing on November 20, 2025, at 12:25 p.m. confirmed that the election of benefits, physician certification, hospice plan of care, and updated nursing notes for Resident 17 were not in the clinical record. Physician orders for Resident 23 dated November 3, 2025, revealed that the resident was receiving hospice services for a diagnosis of malignant melanoma of the left upper limb and shoulder. As of November 18, 2025, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice benefit of elections form, physician certification of terminal illness form, resident's hospice plan of care and up to date nurse aide charting. Interview with the Nursing Home Administrator on November 18, 2025, at 12:25 p.m., confirmed that the hospice benefit of elections, physician certification of terminal illness, resident's hospice plan of care and up to date nurse aide charting were not on the resident's clinical record, and they should be. Physician's orders for Resident 36 dated August 8, 2025, revealed that the resident was receiving hospice services for hypertensive heart disease without heart failure. As of November 20, 2025, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained nursing notes from hospice. Interview with the Director of Nursing on November 20, 2025, at 12:25 p.m. confirmed that the facility did not have hospice nursing notes for Resident 36. Physician's order for Resident 46 dated November 17, 2023, revealed that the resident was receiving hospice services. There was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice benefit of elections form and certification of terminal illness form, resident's hospice plan of care for the current certification period. Interview with the Director of Nursing on November 20, 2025, at 12:25 p.m. confirmed that the most recent election of benefits, physician certification, and hospice plan of care for Resident 46 were not in the clinical record. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper medication handling procedures were followed, and that proper infection control practices were followed for one of 18 residents reviewed (Resident 9). Findings include: The facility's policy regarding medication administration, September 25, 2025, indicated medication should not come in contact with any surface except the medication cup, and staff should avoid touching medication with bare hands when opening a bottle or unit does package. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated December 22, 2025, indicated that the resident was severely cognitively impaired, and received anticonvulsant (blood thinner) medications. Current physician orders for Resident 9, included an order for the resident to receive 300 milligrams (mg) of Gabapentin (anticonvulsant) in the morning. Observations on January 30, 2026, at 9:16 a.m. revealed that Licensed Practical Nurse 1 prepared and administered medications to Resident 9. She dropped the 300 milligram (mg) yellow capsule of Gabapentin on the medication cart, picked it up with a bare hand, placed it in the medication cup and administered the medication to Resident 9. The top of the medication cart had a white removable substance on the medication preparation area, and there was a lidded iced coffee and a closed plastic bottle of iced coffee on the medication cart. During an interview with Licensed Practical Nurse 1 on January 30, 2026, at 9:22 a.m. she was asked if she should have administered a capsule that made contact with the medication cart and her bare hands and her only response was okay. When asked if those circumstances were a concern for infection control, her response again was okay. Interview with Licensed Practical Nurse/Infection Preventionist 3 on January 30, 2026, at 2:29 p.m. confirmed that a capsule that was dropped on the medication cart on an unclean surface and handled with bare hands should not have been administered to Resident 9. The facility's environmental services policy for laundry, dated September 25, 2025, indicated that linens will be handled, transported, and processed in a manner which reduces the risk of contamination or cross-contamination in a safe sanitary manner. Facility will handle all used linen as potentially contaminated and use standard precautions when handling, sorting or rinsing. Soiled linens will be bagged at point of care and placed in a soiled linen container in the soiled utility room or deposited into a laundry chute. Observations on January 30, 2026, at 2:07 p.m. revealed that there was soiled linen and clothing lying on the floor inside a resident room. There was no staff in the room or in the hallway. Interview with Nurse Aide 3 on January 30, 2026, at 2:10 p.m. confirmed that the soiled linen and clothing should not be on the floor, it should have been bagged and placed in the soiled linen container and taken to the dirty utility room. Interview with the Nursing Home Administrator on January 30, 2026, at 3:05 p.m. confirmed that the soiled linen and clothing should not have been on the floor and that staff should place all laundry in bags and take them to the dirty utility room. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		