STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396128	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Farm	604 Oak Street Akron, PA 17501

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 34631 Based on review of facility policy, staff interviews, and clinical record review, it was determined that the facility failed to discuss the risks/benefits and obtain consent for newly ordered antipsychotic and opioid medications for three of twelve residents records reviewed (Residents 2, 22, and 29). Findings include: Review of Resident 2's clinical record revealed diagnoses that included Alzheimer's disease (loss of cognitive functioning such as thinking, remembering, and reasoning and interferes with a person's daily life) and dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory, and abstract thinking) with psychosis (a mental health condition characterized by a loss of touch with reality). Review of Resident 2's physician orders included: Seroquel 25 milligrams (MG) give 0.5 tablet (12.5 MG) one time a day for psychosis, start date December 21, 2024, and discontinue date December 30, 2024; Seroquel 25 MG give 0.5 tablet (12.5 MG) two times a day, start date December 30, 2024, and discontinue date January 21, 2025; Seroquel 25 MG two times a day, start date January 21, 2025, discontinue date January 24, 2025 (due to hospitalization); and Seroquel 50 MG two times a day, start date January 31, 2025. Review of clinical record on May 28, 2025, at 11:00 AM, failed to include documentation that the risk/benefit for Seroquel was reviewed with the Responsible Party or that consent was obtained. Interview with Nursing Home Administrator (NHA) on May 28, 2025, at 12:58 PM, revealed the facility does not have a consent and risk/benefit form, but they are in the process of formulating one. The facility calls the Resident Representative to inform of the new medication and discuss risks and benefits. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional clinical record review on May 29, 2025, documented the facility form Informed Consent for Psychotropic Medication Use was completed for Resident 2 for an antipsychotic, which included review of the risks and benefits, and verbal consent from her grandson. Review of Resident 22's clinical record revealed diagnoses that included depression (feelings of severe despondency and dejection), psychosis (a mental health condition characterized by a loss of touch with reality), schizoaffective disorder (a mental health condition that is marked by a mix of hallucinations, delusions, depression and mania), anxiety (a feeling of worry, nervousness, or unease), vascular dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), insomnia (difficulty sleeping), and hemiplegia (paralysis or severe weakness on one side of the body) on right dominant side. Review of Resident 22's physician orders included: Seroquel 25 MG give 0.5 tablet two times a day for psychosis, start date May 13, 2025; Sertraline 25 MG one time a day related to depression, start date May 13, 2025. Review of clinical record on May 28, 2025, at 10:00 AM, failed to include documentation that the risk/benefit of Seroquel and Sertraline use was reviewed with the Responsible Party and that consent was obtained. Interview with NHA on May 28, 2025, at 12:58 PM, revealed the facility does not have a consent and risk/benefit form, but they are in the process of formulating one. The facility will call the Resident Representative to inform them of the new medication and discuss risks and benefits. Additional clinical record review on May 29, 2025, documented the facility form Informed Consent for Psychotropic Medication Use was completed for Resident 22 for an antidepressant and antipsychotic, which included review of the risks and benefits, and verbal consent from his Resident Representative/ Power of Attorney. Review of Resident 29's clinical record revealed diagnoses that included psychotic disorder (a severe mental disorder characterized by a significant disconnect from reality, involving abnormal thinking, perceptions, and behavior) and vascular dementia (a common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes). Review of Resident 29's physician orders revealed the medication Seroquel 25 MG with directions of give 0. 5 tablet by mouth at bedtime related to psychotic disorder with hallucinations. Review of Resident 29's clinical record revealed no documentation to support the Resident and/or Representative were informed of the risks/benefits of the use of the antipsychotic medication. An interview with the NHA on May 29, 2025, at 11:56 AM, revealed Resident 29's Representative was informed of the addition of the Seroquel, however, no discussion of the risks/benefits was found. 28 Pa. Code 201.29(j) Resident rights

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 34631 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of a statement of the resident's appeal rights, including the name, address (mailing and email), telephone number of the entity which receives such requests, and the name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman; and failed to provide notice of the transfer to the Office of the State Long-Term Care Ombudsman for one of two residents reviewed for hospital transfers (Resident 7). Findings Include: Review of Resident 7's physician orders revealed diagnoses that included age-related macular degeneration (an eye disease that affects central vision) and muscle weakness. Review of Resident 7's clinical record revealed a transfer to the hospital on March 4, 2025. Review of Resident 7's hospital transfer information failed to include documentation of written notice of appeals information provided to the Resident and/or the Representative. Review of the facility's documentation of the monthly notice to the Long-Term Care Ombudsman failed to include Resident 7's hospital transfer. An interview with the Nursing Home Administrator, on May 29, 2025, at 12:06 PM, revealed the facility is not providing appeals information during resident hospital transfers, and also revealed the facility only notifies the Long-Term Care Ombudsman of residents not returning to the facility and does not include residents transferred to the hospital with plans to return. 28 Pa. Code 201.14 (a) Responsibility of licensee

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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. 34631 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan for one of 12 residents reviewed (Resident 7). Findings Include: Review of the facility's policy, titled Comprehensive Care Plans, recently reviewed May 21, 2025, reads [Facility] will develop a comprehensive care plan for each resident which includes measurable goals and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of Resident 7's physician orders revealed diagnoses that included age-related macular degeneration (an eye disease that affects central vision) and muscle weakness. Review of Resident 7's clinical record revealed outpatient consults with eye professionals for treatment of macular degeneration, including eye injections. Review of Resident 7's interdisciplinary plan of care revealed no care plan regarding the Resident's vision or eye consultations and treatments. An interview with the Nursing Home Administrator on May 29, 2025, at 11:07 AM, confirmed that a care plan related to Resident 7's vision was developed and added to the plan of care. 28 Pa. Code 211.12 (d) (5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37817 Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to provide appropriate care and services to residents receiving tube feedings for one of one resident's reviewed receiving a tube feeding (Resident 3). Findings include: Review of facility policy, Medication Administration, revision date June 19, 2023, read, in part, the nurse who administers the medication and/or treatment (medications, IV feedings, etc.) shall document such by initialing electronically signing the MAR (Medication Administration Record - form used to document physician's orders as well as when and how medications are administered to a resident) as soon as possible following administration. If the resident refuses medications, the nurse shall notify the physician after two consecutive refusals and document the refusal in the Medical Record. Supplementary feeding that is withheld shall be designated in the electronic system as held on the MAR or TAR. The nurse shall document the reason the supplementary feeding was not administered. Review of facility policy, Enteral Feeding and Medication Administration, revised February 3, 2023, read, in part, the container holding feeding is labeled with date and time started. The orders will include the formula name, the rate (cc/hr.) for how many hours. The orders will also include the amount of water to flush the tube with to meet the resident's hydration needs. Review of Resident 3's clinical record revealed diagnoses that included traumatic brain injury (brain dysfunction caused by an outside force), paraplegia (loss of motor and sensory functions in the lower half of the body typically affecting both legs), dysphagia (difficulty swallowing), aphasia (language disorder that affects a person's ability to communicate), anxiety (a feeling of worry, nervousness, or unease), and depression (feelings of severe despondency and dejection). Observation May 27, 2025, at 11:19 AM, revealed an Isosource (a dense complete nutrition formula) supplement bag and bag of fluid/flush not labeled, or date marked. Interview on May 27, 2025, at 11:24 AM, Employee 1 (Licensed Practical Nurse) stated the aforementioned bags were put up on evening shift and are taken down on dayshift. It was also revealed that both bags should contain a sticker noting the contents and the date and time the bags were hung; it was confirmed neither bag were labeled, or date marked. Review of Resident 3's physician orders included: Isosource 1.5 tube feeding @ 60cc/hr. x 18 hours or until 1080cc total volume has infused. Water flushes 10cc/hr. take down/stop at 1:00 PM and start tube feed at 7:00 PM daily, start date May 16, 2025; Isosource 1.5 tube feeding @ 64cc/hr. x 18 hours or until 1152cc total volume has infused. Water flushes 10cc/hr. take down/stop at 1:00 PM and start tube feed at 7:00 PM daily, start date April 30, 2024, discontinued May 15, 2025; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Isosource 1.5 tube feeding @ 68cc/hr. x 18 hours or until 1224cc total volume has infused. Water flushes 10cc/hr. take down/stop at 1:00 PM and start tube feed at 7:00 PM daily, start date April 4, 2025, discontinued April 30, 2025; Isosource 1.5 tube feeding @ 74cc/hr. x 18 hours or until 1332cc total volume has infused. Water flushes 10cc/hr. take down/stop at 1:00 PM and start tube feed at 7:00 PM daily, start date March 15, 2025, discontinued April 3, 2025; and Isosource 1.5 tube feeding @ 78cc/hr. x 18 hours or until 1404cc total volume has infused. Take down/stop at 1:00 PM and start tube feed at 7:00 PM daily, start date January 18, 2024, discontinued March 14, 2025. Review of Resident 3's May 2025 MAR documentation for total volume of Isosource at 2:00 PM was less than the physician ordered total volume of 1080cc on: 22nd= 825cc; 24th= 990c; 25th= 995cc; and 26th= 990cc. Review of Resident 3's April 2025 MAR documentation for total volume of Isosource at 2:00 PM was less than the physician ordered total volume of 1224cc on the 23rd = 1118cc. Review of Resident 3's March 2025 MAR documentation for total volume of Isosource at 2:00 PM was less than the physician ordered total volume of 1404cc on the 10th = 918cc, and 13th = 507cc. Progress notes failed to document rational for not infusing to total amount of Isosource per physician order for the aforementioned dates. During an interview with the Nursing Home Administrator on May 29, 2025, at 10:57 AM, it was revealed that the tube feeding bags are to be labeled with a sticker and staff have been educated. It was also revealed that the stickers fall off sometimes. During an interview with Employee 2 (Registered Nurse) on May 29, 2025, at 12:26 PM, it was revealed that the tube feeding orders were written for 18 hours or until a specific total volume was infused. 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 211.10(c) Resident care policies