STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515194	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Healthcare Center	1081 Maplewood Drive Bridgeport, WV 26330

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on facility documentation and staff interviews, the facility failed to have/keep the required documentation for Quality Assessment meetings (QAA). Additionally, the facility did not have required attendees present or sign in at the Quality Assessment and Assurance (QAA) meeting logs. This failed practice had the potential to affect all residents residing at the facility. Facility Census: 76. Findings included: During an interview with both the Director Of Nursing and Regional Director Clinical Operations (RDCO) on 01/14/26 at approximately 8:50 AM, both stated they had been looking for the Quality Assurance (QAPI/QAA) books or records since the survey team entered the facility. Unfortunately, they were unable to locate documentation to show their meetings and what was discussed. They provided the names of the active participants from the meetings, but only a few sign in sheets had been found. They stated the main focus of the facility had been wounds, falls and weights. If they locate any documentation before exit they will bring it to surveyors. RDCO was able to locate sign in sheets for the last twelve (12) months. However, they were missing the necessary signatures from the Medical director, Infection preventionist, and ADMIN/Executive director for each of the required quarterly meetings in Q1,Q2,Q3 and Q4. No other documentation was found/provided to the survey team prior to exiting the facility.

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on Interview and Record review the facility did not evidence of the required attendees being present or having them sign in to verify their presence at the Quality Assessment and Assurance (QAA) meeting. This was discovered during the regular survey process and has the ability to effect more then a limited number of residents. Census 76.During an interview with both the Director of Nursing (DON) and Regional Director Clinical Operations (RDCO) on 01/14/2026 at approximately 8:50 AM, both stated they have been looking for the Quality Assurance (QAPI/QAA) books or records since the survey team entered the facility. Unfortunately, they were unable to locate documentation to show their meetings and what was discussed. They provided the names of the active participants from the meetings, but only a few sign in sheets had been found. They stated the main focus of the facility has been wounds, falls and weights. They said If they located any documentation before exit they will bring it to surveyors. RDCO was able to locate sign in sheets for the last twelve (12) months. However, they were missing the necessary signatures from Medical director, Infection preventionist, and ADMIN/Executive director for each of the required quarterly meetings in Q1,Q2,Q3 and Q4. No other documentation was found/provided to the survey team prior to exiting the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, medical record review, and staff interview the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases and infections including Covid-19 in regard to, precaution signage on resident doors. This had the potential to affect all residents that reside in the facility. Resident identifiers: #60 and #62. Facility Census: 76. a) Observations on 01/06/26 at 1:13 PM revealed no signs near the door frames of room B2. Interview on 01/06/26 at 1:13 PM with Nurse Aid #38 she verified that both residents in room B2 were on isolation precautions. Continues review revealed Resident # 60's clinical record revealed that theresident was diagnosed with Covid-19 on 01/02/26 and was placed on precautions. Subsequent review revealed Resident # 62's clinical record revealed that theresident was diagnosed with Covid-19 on 01/06/26, was placed on precautions. During an interview on 01/06/26 at 1:25 PM Licensed Practical Nurse #46 verified there was no precautionary signage for Covid-19 on room B2 where resident's #60 and #62 were residing. She stated there should be precaution signs on the door. A sign was placed on the door at this time

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, resident interview, staff interview and Operation Policy review the facility failed to ensure they implemented the facility written abuse policy in regard to investigating and reporting to proper agencies an alleged allegation of abuse or neglect. This has potential to affect all residents that reside at the facility. Resident identifier: #47 and #9. Facility census: 76. Findings included: a) Resident #47 Record review of the facility's policy titled, [NAME] Virigina Abuse, Neglect, & Misappropriation, showed: Protection from AbuseIn the event the alleged abuse involves a resident to resident altercation, the resident will be separated by staff, and the appropriate physical assessment will be completed on each resident. All alleged violations involving abuse, neglect, exploitation or mistreatment, injury of unknown source, and misappropriation of property will be reported to the Executive Director immediately. The Executive Director / Designee will report incidents to OHFLAC, APS, The Regional Ombudsman, and other local authorities.If the event that caused the allegations involving abuse (physical, verbal, sexual, mental) the self-report must be made immediately, not later than 2 hours after the allegation is made. During an observation on 01/05/26 at 10:25 AM Resident #47 screaming, she hit me. Resident #62 present in Resident 47's doorway. Staff redirected Resident #62 from the area. During an interview on 01/05/26 at 11:00 AM Resident #47 stated that Resident #62 hit her. She continued to say she comes in here all the time and takes things. A record review of grievances, concerns and reportables found no documented issues from Resident #47. Resident #47's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/15/25 noted the resident had a score for Brief Interview for Mental Status (BIMS) of 14. A BIMS score of 14 indicates that the resident is cognitively intact and has capacity. Review of the Social Workers (SW) documentation found Resident #47 stated that she felt fearful during the incident with Resident #62, and does feel uneasy at times with the other resident who does wonder around. During an interview the Director of Nursing (DON) stated that the facility did not report the incident between Resident #47 and Resident #62 because the Social worker interviewed Resident #47 after the allegation, and Resident #47 stated that she felt safe in the facility. b) Resident #9During an interview, on 01/06/26 at 9:55 AM, Resident #9 said he fell while being transferred by a Certified Nursing Assistant (CNA) on 01/12/25 and fractured his other femur.On 01/07/26 at 10:00 AM this surveyor spoke with the Director of Nursing (DON) about Resident #9's fall. The surveyor asked for the reportable and the five (5) day follow-up for the incident. She said she could not provide it because it was not completed. On 01/12/26 at 2:45 PM this surveyor spoke to the DON again about Resident #9 two (2) falls. She told me the social worker was terminated on 05/08/25 for not completing the reportable or the five-day follow-up. The Certified Nursing Assistant (CNA) had a teachable moment on 01/13/25 for her involvement with the fall on 01/12/25.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, staff interview, and operation policy the facility failed to report alleged violations related to, neglect, or abuse, and report the results of all investigation to the proper authorities within prescribe time frames. This was a random opportunity for discovery. Resident identifier: #9 and #47. Facility census: 76. Findings include: a) Resident #9 During an interview, on 01/06/26 at 9:55 AM, Resident #9 said he fell while being transferred by a Certified Nursing Assistant (CNA) on 01/12/25 and fractured his other femur. On 01/07/26 at 10:00 AM this surveyor spoke with the Director of Nursing (DON) about Resident #9's fall. The surveyor asked for the reportable and the five (5) day follow-ups for the incident. She said she could not provide it because it was not completed. On 01/12/26 at 2:45 PM this surveyor spoke to the DON again about Resident #9 two (2) falls. She told me that the social worker was terminated on 05/08/25 for not completing the reportable or the five-day follow-up. The Certified Nursing Assistant (CNA) had a teachable moment on 01/13/25 for her involvement with the fall on 01/12/25. b) Resident #47 During an observation on 01/05/26 at 10:25 AM Resident #47 screaming, she hit me. Resident #62 present in Resident 47's doorway. Staff redirected Resident #62 from the area. During an interview on 01/05/26 at 11:00 AM Resident #47 stated that Resident #62 hit her. She continued to say she comes in here all the time and takes things. A record review of grievances, concerns and reportables found no documented issues from Resident #47. Resident #47's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/15/25 noted the resident had a score for Brief Interview for Mental Status (BIMS) of 14. A BIMS score of 14 indicates that the resident is cognitively intact and has capacity. Review of the Social Workers (SW) documentation found Resident #47 stated that she felt fearful during the incident with Resident #62, and does feel uneasy at times with the other resident who does wonder around. During an interview the Director of Nursing (DON) stated that the facility did not report the incident between Resident #47 and Resident #62 because the Social worker interviewed Resident #47 after the allegation, and Resident #47 stated that she felt safe in the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on resident interview, staff interview, and operation policy, the facility failed to report the results of an investigation to the appropriate officials in accordance with State law, within five (5) working days of the incident. This has the potential to affect all residents in the facility. Resident identifier #9, #47 and #40. Facility census: 76 Findings include: Record review of the facility's policy titled, Abuse, Neglect & Misappropriation, showed: - In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. If the alleged violation is verified, appropriate corrective action will be taken by the facility. - The Director of Nursing (DON) and Executive Director (ED) receives reports of resident incidences. - The Executive Director / designee will report appropriate incidents to OHFLAC, APS, the Regional Ombudsman, and other local authorities, including but not limited to local law enforcement (if appropriate), as required by State law. - If the events that cause the allegations involve abuse and / or serious bodily injury, the self-report must be made immediately, but not later than 2 hours after the allegation is made. - The results of the facility's investigation must be reported to the Executive Director / designee, OHFLAC, APS, Regional Ombudsman, and other officials as required by State law, within five working days of the incident. a) Resident #9 During an interview on 1/06/26 at 9:55 AM he then told this surveyor that he fell while being transferred by a Certified Nursing Assistant (CNA) on 01/12/25 and fractured his femur. On 01/08/26 at 9:35 AM this surveyor spoke with the Director of Nursing (DON) about Resident #9 two (2) falls. I asked for the reportable and the five (5) day follow ups for both incidents. She could not provide those because they were not completed. The care plan was not updated for either fall. Record review of the care plan verified that is was not updated. On 01/12/26 at 2:45 PM this surveyor spoke to the DON again about Resident #9 two (2) falls. She told me that the Social worker was terminated on 05/08/25 for not completing the reportable or the five day follow up. The Certified Nursing Assistant (CNA) had a teachable moment on 01/13/25 for her involvement with the fall on 01/12/25. b. Resident #47 During an observation on 01/05/26 at 10:25 AM Resident #47 screaming, she hit me. Resident #62 present in Resident 47's doorway. Staff redirected Resident #62 from the area. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/05/26 at 11:00 AM Resident #47 stated that Resident #62 hit her. She continued to say she comes in here all the time and takes things. A record review of grievances, concerns and reportables found no documented issues from Resident #47. Resident #47's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/15/25 noted the resident had a score for Brief Interview for Mental Status (BIMS) of 14. A BIMS score of 14 indicates that the resident is cognitively intact and has capacity. Review of the Social Workers (SW) documentation found Resident #47 stated that she felt fearful during the incident with Resident #62, and does feel uneasy at times with the other resident who does wonder around. During an interview the Director of Nursing (DON) stated that the facility did not report the incident between Resident #47 and Resident #62 because the Social worker interviewed Resident #47 after the allegation, and Resident #47 stated that she felt safe in the facility. During the investigation of a Facility Reported Incident (FRI), the facility failed to complete the five (5) day report to the state agency. On 01/12/26 at 3:24 PM the Director of Nursing (DON) stated that the former Nursing Home Administrator (NHA) had been in charge of reporting FRI's. The DON stated there was no evidence that the five (5) day follow up was completed for Resident #40.